Tennessee Health Link Provider Operating Manual

Version 11.1

Released: January 22, 2026

This operating manual outlines the PCMH program guidelines and policies effective January 1, 2026. The guidelines for 2025 are still valid for all claims with dates of service in 2025.

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1. Versions and Revisions

Version	Date	Changes
11.0	January 1, 2026	• Added Criterion 2: Program Integrity Violation to Remediation process in section 3.3 • Added clarity to attribution modifications language in section 4.5.1 • Updated exclusionary criteria in section 4.3 to include ICC and CAST/FITT • Clarified Health Link Activities language in section 5.1 • Added section 5.1.1 Engagement Evaluation Integration, and 5.1.2 Best Practices • Updated 5.2 Health Link Service Delivery language and included examples • Updated thresholds for CBP, FUH, and SSD in Table 5 • Updated Ambulatory Threshold in Table 6 • Added TSC to reporting only in Table 7 • Added timeline criteria to chart selection for EE in section 8.2.1
11.1	January 22, 2026	• Updated language regarding RTF from fixed denominator to minimum denominator in section 6.4.1

2. Tennessee Health Link Overview

Tennessee Health Link (THL) is a program designed to meet the complex needs of individuals requiring behavioral health services by promoting better coordination between behavioral and physical health care. The program is built on the principle that integrated care leads to:

1. Improved patient outcomes
2. Greater provider accountability and flexibility in delivering individualized care
3. Better cost control for the State

THL encourages the integration of physical and behavioral health services, supports mental health recovery, and helps individuals achieve their highest potential for living rewarding, independent lives in the community.

How the THL Program Works:

- THL uses a team-based care model focused on whole-person, patient-centered, and coordinated care for individuals with mental health conditions and co-occurring physical health needs.
- Participating mental health providers receive value-based incentives for delivering efficient, effective care. While these incentives are directed to behavioral health providers, the program fosters collaboration across primary care providers (PCPs), specialists, and mental health teams to ensure comprehensive care.
- Providers have flexibility to allocate resources based on each individual's level of need at any given time and are encouraged to perform additional activities beyond those explicitly outlined when necessary to maintain progress.
- Providers are accountable for performance across behavioral and physical health outcome measures, reinforcing quality and integration.

TennCare's Health Link program is dedicated to ensuring that Tennessee residents receive the comprehensive healthcare they need. By fostering coordinated care and addressing the unique challenges faced by its members, Health Link strives to enhance overall health and well-being throughout the community. In short, THL

rewards providers for improving outcomes through coordinated, whole-person care while promoting collaboration across the entire healthcare system

2.1 Objectives of Tennessee Health Link

Tennessee Health Link is a value-based care program that maintains a "triple aim" of three primary objectives:

- Aim #1: Manage and Reduce Costs
- Aim #2: Improve Member Experience
- Aim #3: Achieve Better Health Through Improved Outcomes

A successfully executed Health Link will deliver a number of benefits to members, providers, and the healthcare delivery system as a whole. A few of the most important benefits are outlined in the table below.

Table 1: Sources of Value

Members	Practices	System
• Better access to behavioral health care providers • Specialized care for those most in need • Care coordination services leading to improved navigation of the healthcare system • Greater emphasis on preventive care • Less unnecessary or duplicative treatment due to increased coordination between providers	• Financial incentive to deliver high quality care • Tailored support for performance improvement • Specialized training for practice transformation • Opportunity to earn outcome payments based on performance • Improved collaboration across the care delivery team, leading to more productive and efficient workflows	• Higher quality outcomes • Greater emphasis on preventive care • Reduced total cost of care • Reduced utilization of secondary care through better management of secondary conditions • Reduced utilization of unnecessary procedures and visits • More cost-conscious referrals • Systemic shift towards greater

Members	Practices	System
• Improved health education and self-management skills	• Access to more accurate and timely member information	coordination and information sharing

2.2 Background on Tennessee Health Link

Tennessee Health Link was developed with input from a Technical Advisory Group of clinicians and administrators, ensuring that the program meets the diverse needs of Tennessee's population. Since its statewide launch on December 1, 2016, the program has been designed to align with federal Health Home requirements and work in conjunction with the Patient-Centered Medical Home (PCMH) program, which began in January 2017.

Members previously receiving Level 2 Case Management services were transitioned into the Health Link program. In addition to these members, the program also targets high-needs members who were not previously receiving care coordination under Level 2 Case Management. This programmatic change aimed to move services from a traditional “case management model” to a more advanced “care coordination model.” While there were several different changes that evolved the model of care delivery, the primary differentiating feature between case management and care coordination is that the role of the primary member advocate shifts from the case manager to the care coordinator The care coordinator is specifically tasked with improving the efficiency of health systems by reducing silos of care.

Of note, there has been no change to the existing fee for service reimbursement process, which is not covered by Health Link. The following services remain paid for through fee for service: evaluation and management services, medication management, therapy services, psychiatric and psychosocial rehabilitation services, and Intensive Community Based Treatment (ICBT).

3. Program Eligibility and Requirements

All rules, processes, and requirements detailed herein apply only to the Tennessee Health Link program.

3.1 Organization Eligibility

To be an eligible Tennessee Health Link organization, the organization must:

1. Be recognized as either:
    a. A Community Mental Health Center; or
    b. Another type of qualified organization (i.e., mental health clinic, Federally Qualified Health Center, primary care provider, or provider with a behavioral health specialty);
2. Have a physical location in the State of Tennessee;
3. Be contracted as a Medicaid provider in Tennessee with at least one Managed Care Organization (MCO):
    a. Wellpoint; or
    b. BlueCare Tennessee; or
    c. UnitedHealthcare;
4. Meet, or have a documented plan to meet, the Centers for Medicare and Medicaid Services (CMS) E-Prescribing requirements within one year of joining Health Link;
5. Have, or be in the process of obtaining, a stated commitment to collaboration with a TennCare primary care provider for each Health Link location. Letters of collaboration for each site are expected to be completed in 6 months following entry into Health Link;
6. Commit to adopting and using the program's provider reports as actionable data to drive improvement in health outcomes and quality of care; and
7. Commit to meeting with assigned MCO coaches monthly or as needed and other training and learning opportunities as identified by MCO coach. MCO assignments and coaching schedules will be designated by TennCare and MCOs.

3.1.1 Organization Application

Organizations meeting **all** the eligibility criteria above who are interested in providing Health Link services in future program years should contact their MCO provider representative.

3.1.2 Organization Contracting

Contracting with Health Link organizations will be completed by the MCOs. Organizations will not be required to contract with health plans with which they do not have an existing contract.

If selected to participate in the program, an organization must update its contract(s) with the relevant health plan(s). The MCOs will work with the Health Link organization(s) of their choice to modify provider contract language to incorporate the incentive structure of Health Link, including the activity payments and outcome payments detailed in section 9.

MCO contracting must be completed **prior** to joining the program. Once a provider is contracted with their respective MCO(s), they will be eligible to begin participation January 1 of the following program year. (For example, if contracting is completed on September 1, 2026, then the provider will begin participation in the program on January 1, 2027, also known as Program Year 2027.)

3.2 Program Requirements

All participating Health Link Organizations must adhere to the following program requirements:

1. The organization must maintain all eligibility requirements as listed in section 3.1.
2. The organization has established collaborative partnership as evidenced by active and updated letters of collaboration and partnership.
3. Have a designated Health Link Administrator who serves as the main point of contact for THL-related matters and attends THL meetings.
4. If THL Administrator is unable to attend any THL related matters a designated proxy may attend on behalf of the administrator but must be approved prior to scheduled meeting and approved by MCO and TennCare.
5. There is a designated lead clinical care coordinator who has an active unrestricted RN license in the state of TN. If the lead clinical care coordinator is not an RN there must be a clear documented consulting process.

6. Clearly defined case managers who act as a primary contact for member and family relationship and are licensed as an LPN, RN, or have obtained a bachelor's degree.
7. Have the ability provide behavioral health services either with a psychiatrist or primary care physician (MD/DO), a masters-level clinician (possessing a master's degree tied to mental health practice or related subjects, with an active TN license, or a psychologist.
8. The organization has a clear onboarding process that clearly presents the goals and aims of the THL program to new staff.
9. The organization has a continuous learning plan enabling employed and affiliated personnel involved with Health Link to continue to grow and refine their skill set and understanding of the program.
10. Participate in all coaching sessions at a cadence determined by MCOs and TennCare
11. Established process to utilize data to drive actionable results in health outcomes and quality measures.

3.3 Remediation & Suspension

To uphold the high standards and expectations of the THL program, a robust remediation process is essential to ensure that all participants are held to the same criteria and supported in their growth. The remediation process is initiated when a THL organization fails to meet required deadlines or performance targets across program activities with any of their contracted MCOs. Depending on the severity and frequency of issues, a THL organization may be placed on **probation**, enter **remediation**, or face **removal** from the program under any of the following circumstances:

- **Criterion 1: Performance Deficiency**
  The organization receives an overall score below 85% on the Engagement Evaluation, indicating failure to meet core program requirements.
- **Criterion 2: Program Integrity Violation**
  The organization is found- through investigation by a state regulatory agency or an MCO investigations unit- to be operating the program in a manner that violates program integrity standards. This includes, but is not limited to,

fraudulent practices, misrepresentation of services, or failure to comply with contractual and regulatory obligations.

- **Criterion 3: Repeated Non-Engagement**
  The organization demonstrates a pattern of non-engagement by failing to respond to or attend scheduled meetings with the MCO and/or TennCare on three or more separate occasions within a calendar year. This includes missed check-ins, failure to provide requested documentation, or lack of participation in required technical assistance or performance improvement discussions.

If an organization fails to meet program requirements, deadlines, or performance targets, the remediation process will take place in the three phases detailed below:

1. **Phase One: Probation**

   A THL that is determined deficient by criteria one (1), two (2), or three (3) listed above will be issued a letter by TennCare initiating probation and outlining the reason for the six-month probation period. TennCare will provide a copy of the probation letter to the MCO(s).

   A Corrective Action Plan (CAP) must be developed in collaboration with the MCO(s) and submitted to TennCare within 30 days for review and approval. TennCare has 5 business days to approve the revised CAP.

   At the end of the six-month probation period, if a THL Organization has resolved all outstanding issues and requirements they are removed from probation status, and no further action is required. If a THL organization has not met the terms of the CAP or requirements detailed in the probation letter, the organization will move into phase two: remediation.

2. **Phase Two: Remediation**

   A THL who is deficient in meeting requirements detailed in their probation letter or goals and targets of their CAP will be issued a remediation letter by TennCare. This letter outlines the reason for remediation, the specific

requirements, and the timeline for the remediation period. The letter also details a financial penalty, reducing the shared savings opportunity from 15% to 10%. TennCare will send this letter to the organization within three (3) calendar days after the probation CAP review, officially placing the THL organization into remediation status. A copy of the remediation letter will also be provided to the MCO(s).

Once the remediation letter is issued, the MCO(s) will reduce the shared savings from 15% to 10%. A revised Corrective Action Plan (CAP) must be developed in collaboration with the MCO(s) and submitted to TennCare within 30 days for review and approval. TennCare has 5 business days to approve the revised CAP.

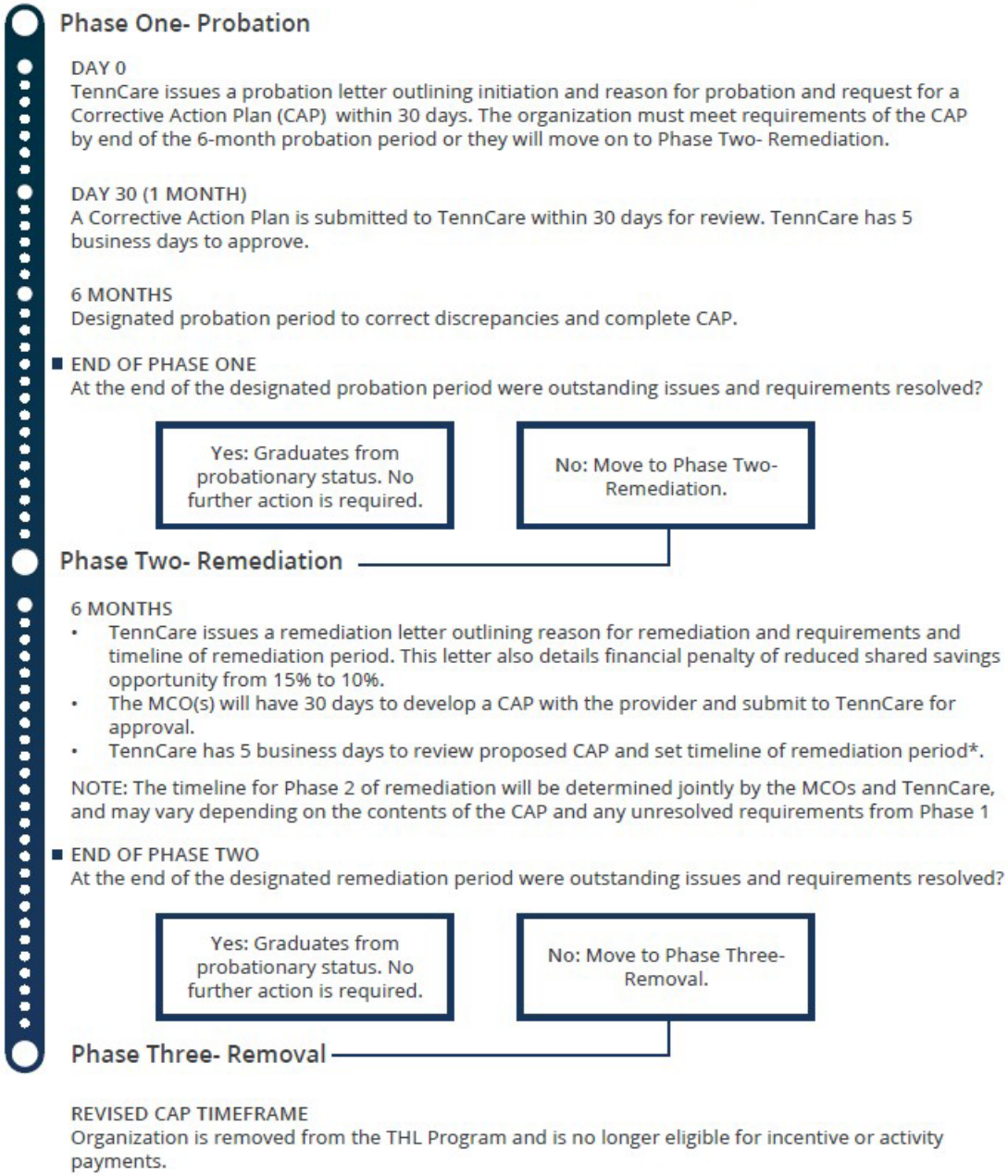
If the THL organization resolves all outstanding issues and meets the requirements, it will be removed from remediation status, and no further action will be needed. However, if the organization fails to meet the terms of the CAP by the end of the specified period, it will progress to phase three: removal from the program.

3. **Phase Three: Removal from the THL Program**

   After receiving a removal letter from TennCare, MCO(s) will terminate all THL related payment streams to the organization. Members who are attributed to the terminated THL will be notified and re-assigned by each MCO.

TennCare reserves the right to modify these phases in response to extreme situations or extenuating circumstances. For instance, TennCare may, at its sole discretion, move a THL organization from remediation back to probation. If an organization is returned to phase one, it will be required to submit a revised corrective action plan. Alternatively, TennCare may, at its discretion, move a THL organization from phase two to phase three, which would result in removal from the THL program.

Table 2: Remediation



NOTE: Each participating MCO evaluates remediation independently. Consequently, the remediation process will be determined by the specific MCO that identifies the organization as delinquent in one or more remediation criteria. As a result, an organization may be in remediation with one MCO while remaining in good standing with others.

3.4 Organization Withdrawal

To withdraw from Tennessee Health Link, the participating organization must email intent to withdraw to payment.reform@tn.gov and to their contracted MCO(s) 60 days prior to withdrawal. An organization who does not follow this process would not be considered in good standing should they decide to provide services in the future.

In addition, if a Health Link provider would like to add a service location, they must email intent to add a service location to payment.reform@tn.gov and to their contracted MCO(s).

4. Member Eligibility & Member Panels

Member eligibility is determined using a combination of claims and non-claims data sources. TennCare members can qualify for Health Link in three ways:

- **Category 1: Diagnostic criteria only**
  This criterion is met by a new or existing diagnosis or code of:
    - Attempted suicide or self-injury
    - Bipolar disorder
    - Homicidal ideation
    - Schizophrenia
- **Category 2: Diagnostic and utilization criteria**
  This criterion is met by one or more behavioral-health related admissions:
    - Inpatient admissions; or
    - Crisis stabilization unit admissions (18 or over); or
    - Emergency department (ED) admissions (under 18); or
    - Residential treatment facility (RTF) admissions;

  AND a diagnosis of one or more of the following:

    - Abuse and psychological trauma
    - Adjustment reaction
    - Anxiety
    - Conduct disorder
    - Emotional disturbance of childhood and adolescence

    - Major depression
    - Other depression
    - Other mood disorders
    - Personality disorders
    - Psychosis
    - Psychosomatic disorders
    - Post-Traumatic Stress Disorder (PTSD)
    - Somatoform disorders
    - Substance use
- **Category 3: Functional need**
  This criterion is met by provider documentation of functional need, to be attested to by the provider.

4.1 Category 3 Medical Necessity and Eligibility

THL eligibility for individuals who do not meet the criteria by diagnosis or by utilization will be based on medical necessity and must meet the medical necessity criteria per TennCare Rule 1200-13-16-.05, including the recommendation of a licensed physician who is treating the individual or other licensed healthcare provider practicing within the scope of his or her license who is treating the individual to include the individuals' treatment team that are located at the provider site.

For a service recipient to be eligible for Health Link based on functional need, the THL eligibility criteria should include the following key components:

- Has a diagnosable mental health or a combination of physical and mental health illness that causes or contributes to functional impairment for the individual within the community; **AND**
- Is actively participating in treatment at an outpatient setting or is reasonably expected to participate in outpatient treatment because of referral and/or education. These individuals exhibit behaviors to suggest that they are not able to coordinate their own treatment resulting in frequent readmissions. These individuals require education in the areas of mental health/physical health to engage in treatment and adhere to appointments; **AND**

- Needs assistance utilizing or accessing behavioral health, medical, and/or community-based services to function in the community as necessary for recovery; **OR**
- **Any two of the following conditions** due to mental health or a combination of physical and mental health illness must apply, with service goal being to impact quality of life in areas of recovery, including supportive services that maintains an individual's baseline functioning once stable as determined by the clinical judgment of the licensed provider as clinically necessary for that individual's quality of life and prevention of relapse to acute care.
    - Demonstrates a pattern of inconsistency or failure in scheduling or keeping appointments at an outpatient facility in order to meet the needs related to the mental/physical health symptoms of his/her mental and/or physical illness within the last six (6) months;
    - Demonstrates a pattern of inconsistency in his/her adherence to prescribed behavioral health or medical treatment within the last six (6) months;
    - Has received a medication adjustment in the previous six (6) months due to instability of symptoms and has developed additional conditions which require assessment, planning, linkage, and referral monitoring and follow up;
    - Has had at least two psychiatrically driven presentations at an ER within the last six (6) months;
    - Demonstrates a pattern of inconsistency or failure to identify and/or communicate with natural supports to assist with access or utilization of needed medical, educational, social, or other services within the last six (6) months;
    - Has experienced clinically significant changes in social factors in the last (12) months leading to decreased ability to function independently or within current support system due to the individual's mental health or a combination of physical and mental health illness needs, documentation as indicated within the referral;
    - Involvement with law enforcement or the criminal justice system within the last six (6) months;

- Individual is unable to obtain or sustain employment due to their mental health or a combination of physical and mental health illness condition within the last 6 months;
- Individual has experienced a disruption in previously stable housing within the past 6 months, as a direct result of symptoms related to the individual's mental health or a combination of physical and mental health illness condition;
- Exhibits financial mismanagement which impacts or is impacted by their symptoms within the past 6 months.

The service goal is to impact quality of life in areas of recovery, including supportive services, that maintains an individual's base line functioning once stable as determined by the clinical judgment of the licensed provider as clinically necessary for that individual's quality of life and prevention of relapse to acute care.

Based on any of the above criteria selected, the Tennessee Health Link program is meant to produce a positive impact on the lives of individuals in one or more of the following applicable domains:

- Medical / Psychiatric
- Mental Health / Substance Abuse
- Activities of Daily Living
- Vocational / Educational
- Social / Family Supports
- Leisure / Recreation
- Legal Issues
- Community Resources
- Financial Assistance
- Housing
- Transportation

4.2 Provider Attestation

To ensure members gain access to Health Link in a timely manner, providers may communicate directly with MCOs to gain Health Link eligibility for members prior to claims verification of member eligibility.

Attestation for newly identified members not actively enrolled in Health Link services can occur in one of two ways:

1. Communication directly from hospitals: Member is granted eligibility if the hospital provides a referral to a Health Link provider and the Health Link provider provides attestation to the relevant MCO that the member meets medical necessity criteria. Hospital referrals will follow existing referral protocol.
2. Communication directly from Health Links: Member is granted eligibility if the provider provides attestation to the relevant MCO that the member meets medical necessity criteria.

NOTE: Attestations should be submitted on or before the initial date of service. A member must be attributed to a Health Link provider in order to be eligible for services, and initial date of service cannot be before a member is attested in the MCO portal.

For modifications of members already attributed, refer to section 4.5.1.

4.3 Losing Eligibility for Health Link

Members can lose eligibility for Health Link for any of the following reasons:

1. **Member loses TennCare eligibility**
2. **Member is discharged from Health Link**: The MCO and/or Health Link provider is unable to identify, as evidenced by clinical documentation, member progress toward treatment goals in response to Health Link interventions or the MCO and/or Health Link provider has identified, as evidenced by clinical documentation, member completion of treatment goals in response to Health Link interventions. Deceased members may also be discharged from the program provided that there is appropriate documentation. In addition to clinical documentation, for a member to be considered discharged from Health Link the provider must discharge the member within the respective MCO portal
3. **Member begins receiving a duplicative care coordination service,** such as:

a. **TennCare for Prisoners Program**: The member was enrolled in the TennCare for Prisoners Program after being incarcerated for 90 days or immediately upon entering state or federal prison. This program only covers acute inpatient hospital services.
b. **Katie Beckett Part B**: The member was enrolled in Katie Beckett Part B.;
c. **Member has a long-term nursing home stay**: The member has one or more nursing home facility claims that cover more than 90 consecutive days that is ongoing as of the most recent eligibility update. The member must be discharged to home from a previous nursing home stay to become eligible for Health Link again.
d. **Member has a long-term residential treatment facility stay**: The member has one or more residential treatment facility (RTF) claims that cover more than 90 consecutive days that is ongoing as of the most recent eligibility update. The member must be discharged to home from a previous RTF stay to become eligible for Health Link again.
e. **Member is enrolled in certain programs by the Department of Children's Services (DCS)**: The member was enrolled in level 3 and above programs by the DCS for more than 30 consecutive days, unless the MCO makes an explicit decision to include. Further detail regarding DCS eligibility can be found in the appendix of this document.
f. **Member is receiving Systems of Support (SOS) Level 1 or Level 2 services**: The member was enrolled in SOS Level 1 or Level 2 for more than 30 consecutive days, including the date of the member eligibility data extract. The comprehensive care coordination at the core of SOS Level 1 and Level 2 services is duplicative with the activities of the Health Link.
g. **Member is receiving Intensive Community-Based Treatment (Continuous Treatment Team or Comprehensive Child and Family Treatment (CTT/CCFT))**: The member is receiving CTT or CCFT services determined by service authorization. Effective October 01, 2022, the member must be discharged from CTT or CCFT to become eligible for the Health Link program again.

h. **ICF- Intermediate Care Facility**: A member receives active treatment through intensive specialized supports and services designed to assist individuals with intellectual disabilities to develop increased skills and independence in life areas where the individual needs additional supports to live in a more independent, integrated setting.
i. **Intensive Care Coordination (ICC)** is a service that facilitates care planning and coordination of services for TennCare youth, with serious emotional disturbance (SED), under the age of 21. ICC is designed to facilitate a collaborative relationship among a youth with SED, his/her family and involved child-serving systems to support the parent/caregiver in meeting their youth's needs. The ICC care planning process ensures that a care coordinator organizes and matches care across providers and child serving systems to enable the youth to be served in their home community.
j. **Community Assessment and Stabilization Team (CAST)** also known as Family Intervention Treatment Team (FITT)) can provide rapid and intensive community-based interventions for children and families experiencing acute and chronic behavioral health issues in an effort to prevent unnecessary inpatient psychiatric hospitalizations or long term out of home placements. CAST interventions may last in duration up to 100 days to promote safety, stability and improved functioning in the home and community for the child and family.

Once deemed ineligible, a member may become eligible again if his or her exclusion status changes. Losing eligibility is different than a member becoming inactive. Details outlining how a Health Link member can become inactive after attribution or enrollment can be found below in section 4.4.

4.4 Member Status

As a member moves through Health Link the following designations define where they are in the program and how members impact a provider's panel for the purpose of quality measures, activity payments, and outcome payments.

Table 3: Member Status Designations

Member Status	Description of Status
Attributed	All members (enrolled and attributed not enrolled) who are eligible for the Tennessee Health Link (THL) program and have been assigned to a specific organization or care provider as a part of their panel. The number of attributed members is not on the quarterly reports but is rather something that is provided by the MCOs weekly on their portals in the attribution reports. This term is sometimes interchangeable with "attribution panel". The number of attributed members will always be larger than the number of enrolled members.
Attributed Not Enrolled (ANE)	All members who have been identified as eligible for the Tennessee Health Link (THL) program and assigned to a specific provider but have not yet engaged in or received any services from that provider. Although they are eligible for care coordination, they have not actively enrolled in or participated in the THL program's services.
Enrolled	All members who have been attributed to a Tennessee Health Link (THL) provider and have consented to participate in Health Link services from the organization they are attributed to. Unlike attributed not enrolled members, enrolled members have begun participating in the program, though they may not have received one of the designated care coordination services in every month.
Inactive No Behavioral Health (BH)	All members (enrolled or attributed not enrolled) who do not receive qualifying behavioral health treatment within a designated timeframe. See section 4.7 for additional details.
Inactive Opt-Out	All members who have declined THL services. This status must be member-initiated and indicates that a member will be removed from the attribution panel in future counts.
Discharged	All members who have completed the program, or no longer benefit from the program, and are discharged. This status is provider-initiated and indicates that a member will be removed from the attribution panel in future counts.

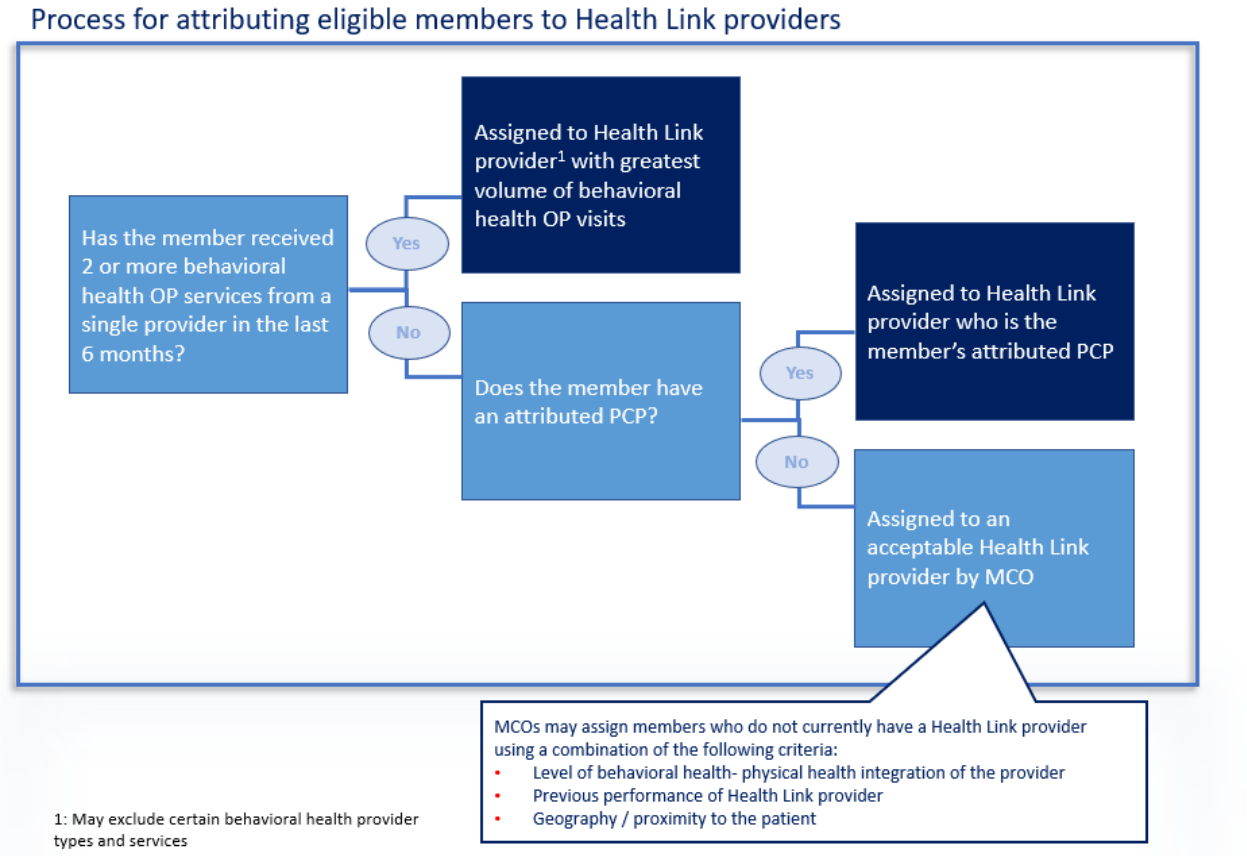
4.5 Member Attribution

Eligible members are initially attributed to Health Links based on the following criteria, in the following order:

1. If the member had two or more behavioral health outpatient visits (must be of a clinical nature) with any Health Link during the last 180 days before attribution, the member will be attributed to the Health Link with the most visits. If there was a tie, the member was attributed to the Health Link with the most recent behavioral health outpatient visit;
2. If the member is attributed to a primary care practice that is a Health Link, then the member will be assigned to that Health Link; **OR**
3. If an eligible member does not have an attribution based on the previous two criteria, then the MCO will manually attribute the member to an appropriate Health Link, incorporating factors such as provider performance, geographic proximity, or member characteristics.

NOTE: Members switching MCOs remain attributed to their current Health Link if they also contract with the new MCO.

Table 4: Member Attribution Process Flowchart



4.5.1 Attribution Modifications

If a member is already attributed to a Health Link, their assignment can be changed in one of two ways:

1. **Member-Initiated Change**:
   The member contacts their MCO's customer service (via the phone number found on the back of their insurance card) to request a change.

2. **Provider-Initiated Switch**:
   Depending on the MCO, the following guidance outlines the steps to be taken.
   a. **BlueCare**: A Health Link provider can assist the member by calling customer service number on the member ID card to request the switch or once consent has been obtained email the switch request to BlueCare_THL@bcbst.com.

b. **UnitedHealthcare**: A Health Link provider submits the switch through the THL Attestation Portal.
c. **Wellpoint**: A Health Link provider submits the switch through the THL Attestation Portal.

4.5.2 Important Considerations Prior to Providing Services

If a provider is modifying a member's attribution at the member's request, the following steps must be taken before providing Health Link services:

1. **Verify Member Attribution**
   Use the Weekly Attribution Report, the Member Change Report, or the MCO-specific THL portal to confirm current attribution and exclusion status if applicable. Important: Members marked as Excluded are not eligible for services, regardless of attribution status. If the member is not currently attributed to a THL, providers must attest that the member meets the Medical Necessity for THL.
2. **Understand the Reports**
   The Member Change Report indicates if a member is New, Unchanged, Removed, or Excluded. The Weekly Attribution Report shows:
   a. Members currently attributed (either Attributed Not Enrolled or Active).
   b. Members who are Discharged or Inactive will appear for one week before being removed from the report.
   c. Members marked as Excluded can be identified under the Exclusion reason column.
3. **Establish an Internal Process**
   Ensure your team checks member status before rendering services and use the Attribution Report or MCO-specific THL portal regularly to stay updated on eligibility.
4. **Verify Date of Service (DOS) and Attestation Requirements**
   The following requirements must be met:
   a. The initial DOS must be on or after the Attestation Date.
   b. DOS cannot be before the Attribution Date.
   c. If a Switch is submitted, the first DOS must be on or after the 1st of the following month. For example:

- Member seen: 10/19/2022
- Switch submitted: 10/19/2022
- First billable DOS: 11/1/2022 or later

4.6 Member Enrollment

Every member, regardless of their MCO, must consent to the receipt of Health Link services before they may be provided. Regarding consent, the Centers for Medicare and Medicaid Services (CMS) gives the following guidance: "Enrollment must be documented by the provider, and that documentation should at a minimum indicate that the individual has received information explaining the Health Home program and has consented to receive health home services noting the effective date of their enrollment".

The THL consent process should be documented, updated annually, and include educating the member on the purpose, scope, and modalities of the THL services. THLs should provide education about the collateral contacts they will make as needed on behalf of the member that can be submitted as an approved activity in claims.

An attributed member can only be enrolled by the Health Link to which the member is attributed. An attributed member is considered enrolled or "Active" once there is a signed consent **AND** the Health Link follows the MCO-specific method for enrolling the member:

- **United Healthcare and Wellpoint:** The enrollment process is completed by receiving the first claim from the members attributed Health Link.
- **BlueCare:** The member must be enrolled via the BlueCare THL Portal to be considered "Active."

4.6.1 Enrollment of Members in Crisis

While THL activity payments can be billed when an Active/Enrolled member is receiving care at a higher level, it is both expected and encouraged that outreach efforts are made to facilitate seamless transitions of care for Attributed Not Enrolled (ANE) members as well. To bridge this gap, licensed professionals and master's level behavioral health professionals under supervision may conduct and

bill for an intake assessment using CPT Code 90791 for ANE members. This intake allows for the member's enrollment in the THL program, enabling the THL to bill for coordinating discharge planning, building rapport, and integrating the member into their system while the patient is being stabilized at a higher level of care. This ensures that the member is prepared to continue receiving THL and other behavioral health services immediately upon discharge.

4.7 Inactivity of Members in Health Link

In certain situations, a Health Link member may become inactive after attribution or enrollment. Inactive members are defined as:

a) If a member in Active Status does not receive any behavioral health related treatments, as evidenced in the claims data, within a 6-month window (plus 4 months claims run out), then the member is considered inactive, effective the date when the claims-based enrollment update was finalized; or
b) If a member in Attributed Not Enrolled status does not receive any behavioral health related treatments, as evidenced in the claims data, within a 24-month window (plus 4 months claims runout), then the member is considered inactive, effective the date when the claims-based enrollment update was finalized.

Members in ANE status within the THL program who have not generated a behavioral health claim for a continuous period as outlined above will be removed from the THL provider's attributed panel. This allows for enhanced effectiveness of the THL program by directing outreach and care coordination efforts toward members with active behavioral health needs.

4.8 Member Opt-Outs from Health Link

If the member chooses to opt out of Health Link by notifying their MCO or attributed Health Link, then the member is recorded as inactive effective the date of the opt-out indication. If the member chooses to opt out of Health Link by notifying their attributed Health Link, then the Health Link must notify the member’s MCO. The decision to opt out must be member initiated. MCO specific instructions for member opt-out are included below:

Wellpoint:

- Members may call the customer service number on the back of their TennCare card to opt out.
- If a member requests to opt out of Health Link, the interaction with the member should be documented and then the provider may submit an opt out request via the Wellpoint portal.

BlueCare:

- Members may call the customer service number on the back of their TennCare card to opt out.
- If a member requests to opt out of Health Link, the interaction with the member should be documented and then the provider may submit an opt out request via the BlueCare portal.

UnitedHealthcare:

- Members may call the customer service number on the back of their TennCare card to opt out.
- If a member requests to opt out of Health Link, the interaction with the member should be documented and then the provider may submit an opt out request via the UnitedHealthcare portal

4.9 Activity Resumption of Previously Inactive Members

Members who became inactive through the opt-out process or due to lack of qualifying behavioral health treatment may resume activities under 2 conditions:

1. For members who had previously opted out: Members can opt back into the program by contacting his/her MCO or by receiving qualified services at a Health Link, if they are identified as eligible for Health Link in the most recent eligibility update. If the member chooses to opt back into the program by notifying a Health Link, then the Health Link must notify the member's MCO either by phone or via MCO portal. The member can choose to remain with

their prior Health Link provider or change Health Link providers. Each MCO has the following Opt-in process:

Wellpoint:

- Members may call the customer service number on the back of their TennCare card to opt back in.
- If a member requests to opt back in to Health Link, the interaction with the member should be documented and then the provider may submit a provider attestation via the Wellpoint portal. This will switch a member in the "Inactive Opt Out" status to either "Active" or "Attributed Not Enrolled", depending on the presence of Health Link claims, to the organization that submitted the attestation.
- Any provider may submit a provider attestation via the portal for a member in the "Inactive Opt Out" status.

BlueCare:

- A member who is in an Inactive Opt Out status can only be reattributed by a BlueCare portal user. BlueCare will perform the reattribution based on a direct request from the member.
- The THL may provide BlueCare with a new consent from the member to initiate the reattribution. Once the member is reattributed to the THL, the THL must go into the portal to enroll the member for the member to become Active in the THL's panel.

UnitedHealthcare:

- Members may call the customer service number on the back of their TennCare card to opt back in.
- If a member requests to opt back in to Health Link, the interaction with the member should be documented and then the provider may submit a provider attestation via the UnitedHealthcare portal. This will switch a member in the "Inactive Opt Out" status to either "Active" or "Attributed Not Enrolled", depending on the presence of Health Link claims, to the organization that submitted the attestation.

- Any provider may submit a provider attestation via the portal for a member in the “Inactive Opt Out” status.

2. For members who resume behavioral health treatment: Members are no longer considered inactive if they receive a qualifying behavioral health treatment while they are still eligible for Health Link. In this instance, the member returns to the Attributed Not Enrolled status. The change becomes effective the date of the behavioral health treatment service.
3. For members who were previously Discharged: Members can resume activity in the program by receiving qualified services at a Health Link. The member can choose to remain with their prior Health Link provider or change Health Link providers.

4.10 Member Panels

Member panels for each Health Link are defined differently for the following 2 purposes:

1. Activity payment calculation
2. Outcome payment calculation

4.10.1 Activity Payment Calculation

The member panel for activity payment calculation is defined as or incorporates all members enrolled in a Health Link who receive a qualifying Health Link activity during the month for which they are enrolled. Refer to section 9.2 for further details on activity payments.

4.10.2 Outcome Payment Calculation

Payments are calculated for the quarterly report for the last quarter of each performance period. The performance periods for Health Link are from January 1-December 31 of the calendar year.

For outcome payment calculations, members are considered to be a part of the member panel of the Health Link for which they meet the following requirements:

1. The member has been attributed to the Health Link for at least 9 months of the performance period;

2. The Health Link is the attributed Health Link for the most months during the period covered by the quarterly report. Months during which the member opted out of Health Link are not taken into account in identifying the member panel for quarterly reporting; **and**
3. If there is a tie, the Health Link which the member was attributed to in the most recent month is the Health Link to which the member is assigned for the purpose of quarterly reporting.

Members are excluded from the Health Link performance evaluation and therefore excluded from the outcome payment calculation under any of the following scenarios (i.e., these members are not counted in quality and efficiency metrics):

- **Member is dual-eligible but is not enrolled in an aligned D-SNP**: Health Link explicitly includes individuals who are dually eligible in Medicare and Medicaid if they are enrolled in an aligned D-SNP. However, members are excluded from performance evaluation if they are dual-eligibles not enrolled in an aligned D-SNP health plan. Being "aligned" means that the member is enrolled in a Medicare Advantage D-SNP plan with the same MCO participating in the TennCare Medicaid program. Examples of not being enrolled in an aligned D-SNP health plan include cases where the member is dual-eligible but enrolled in a Medicare Advantage health plan that is not a D-SNP, a D-SNP health plan with another insurer, or Medicare fee-for-service.
- **Member has or obtains third-party liability (TPL) coverage:** Members with confirmed TPL coverage or with a claim within the previous quarter indicating TPL coverage could be excluded from the Health Link performance evaluation.
- **Member has less than 9 months of attribution to their Health Link**: Only those members with at least 9 months of cumulative attribution to their Health Link are counted towards performance outcomes. These 9 months do not have to be consecutive. This policy is in place to ensure that the provider has had adequate time with the member to affect their quality and efficiency outcomes.
- **Member meets any of the exclusionary criteria:** outlined in section 4.3.

5. Health Link Services & Activities

5.1 Care Coordination Activities Overview

Health Link providers are expected to deliver a comprehensive set of care coordination activities that are both member-centered and outcome-driven. Health Link services must be documented and delivered in a manner that reflects the six types of clinical activities eligible for activity payments. These include:

Comprehensive Care Management: Providers are expected to initiate and maintain an individualized, person-centered care plan. The care plan includes at least one behavioral health goal and a physical health goal. All goals should follow the SMART framework (Specific, Measurable, Attainable, Relevant, and Time-based). Care plans are reviewed and updated regularly to reflect ongoing engagement, progress toward goals, and any changes in the member's condition, care needs, or available supports.

Stakeholders: Member, Care Coordinator, Licensed Clinician

- **Examples:**
  - A care coordinator completes a DLA-20 functional assessment and develops a care plan for a member with bipolar disorder and COPD. The plan includes monthly psychiatric visits, pulmonary follow-ups, smoking cessation goals, and a referral to a peer support group.
  - The care plan is reviewed and updated after the member experiences a medication-related hospitalization. The updated plan includes medication education, pharmacy coordination, and a new goal to reduce ER visits.
  - The member, care coordinator, and licensed clinician sign the care plan, which includes SMART goals such as "Member will attend 3 therapy sessions per month for 3 months to address anxiety."

Care Coordination: Involves active collaboration with primary care providers and specialists, particularly for members with chronic or complex conditions. Activities include outreach, follow-up, and documentation of communication efforts to ensure continuity and alignment of care.

Stakeholders: Member, PCP, Psychiatrist, Case Manager, Specialist

- **Examples:**
  - The THL team organizes a multidisciplinary case conference with the member's PCP, psychiatrist, and housing case manager to align treatment goals and share lab results.
  - A care coordinator assists the member with a follow-up to a specialty clinic to ensure the member with diabetes and schizophrenia receives a scheduled eye exam and lab work

Health Promotion: Focuses on supporting members in developing self-management skills and understanding their health conditions. This includes education on medication adherence, nutrition, and preventive care, tailored to the member's needs and preferences.

Stakeholders: Member, Caregiver, Care Coordinator

- **Examples:**
  - A care coordinator provides one-on-one education to a member with schizoaffective disorder about managing hypertension, including how to use a blood pressure cuff and track readings.
  - The member and caregiver collaboratively review resources on nutrition, exercise, and medication side effects. After the review, the care coordinator uses the teach-back method by asking the member and caregiver to explain, in their own words, how they will apply the information to the member's daily routine, ensuring understanding and identifying any areas needing clarification.
  - The care coordinator helps the member set a goal to walk 15 minutes daily and checks in weekly to track progress and provide encouragement.

Transitional Care: Addresses member needs during transitions between care settings (e.g., hospital to home). Activities include discharge planning, medication reconciliation, and coordination of follow-up appointments to reduce gaps in care.

Stakeholders: Member, Inpatient Team, Care Coordinator

- **Examples:**

- A member is discharged from a psychiatric hospital. The care coordinator visits the member at home within 72 hours, reviews the discharge plan, confirms medication pickup, and schedules timely follow-up appointments with the PCP and therapist.
- The care coordinator communicates with the inpatient team prior to discharge to ensure continuity of care and updates the care plan to reflect new diagnoses and medications.
- The member is connected to a crisis stabilization unit for short-term support while awaiting outpatient services.

Patient and Family Support: Engages families and caregivers in the care process to enhance treatment adherence and address social determinants of health. Support may include education, emotional support, and connection to community-based services.

Stakeholders: Member, Family, Care Coordinator

- **Examples:**
  - A care coordinator meets with a member's spouse to explain the member's treatment plan, medication regimen, and how to support adherence.
  - A family meeting is held to address caregiver burnout, and the care coordinator refers the family to a local support group and respite services.

Referrals to Social Supports: Connects members to community resources such as housing, food, transportation, and legal aid. Follow-through on referrals is documented to ensure access and address barriers to care.

Stakeholders: Member, Care Coordinator, Community Agencies

- **Examples:**
  - A member facing eviction is referred to a housing agency. The care coordinator helps complete the application, provides documentation from the behavioral health provider, and follows up weekly until housing is secured.

- The care coordinator identifies food insecurity during a home visit and connects the member to a local food pantry and Meals on Wheels.
- After a missed appointment, the care coordinator contacts the member to explore the reason for the no-show. During the conversation, the coordinator identifies transportation challenges as a barrier and assists the member in arranging non-emergency medical transportation. The appointment is rescheduled, and the behavioral health provider is notified to adjust outreach strategies accordingly.

5.1.1 Engagement Evaluation Integration

Health Link activities are not only essential for supporting monthly activity payments, but they also form the foundation of Engagement Evaluations, which assess the quality, consistency, and person-centeredness of care coordination services. These evaluations are designed to ensure that providers are not only completing required tasks but are doing so in a way that meaningfully engages members and improves outcomes.

To meet the standards of the Engagement Evaluation, providers are expected to demonstrate the following:

- Initiate an individualized, person-centered care plan within 30 days of member enrollment. The care plan must include at least one behavioral health goal and a physical health goal. All goals should follow the SMART framework (Specific, Measurable, Attainable, Relevant, and Time-based).
- Review and update the care plan at least every 6 months, or more frequently if there is a significant change in the member's condition, care needs, or service delivery. Updates should reflect ongoing engagement, progress toward goals, and any new barriers or supports identified.
- Obtain timely signatures from all relevant members of the treatment team, including the member (or legal representative), care coordinator, and licensed clinician. Signatures should confirm agreement with the care plan and any updates, ensuring shared accountability and alignment across the care team.
- Maintain timely documentation of key care coordination elements, including consent, functional assessments, and care plan development and revisions.

Documentation should be clear, current, and aligned with the members' evolving needs.

- Complete and document monthly care coordination activities, such as outreach, follow-up, referrals, and communication with care team members. These activities should be tied to the care plan and demonstrate active support of the members' goals.
- Demonstrate face-to-face contact or documented attempts at least once per quarter, reinforcing the importance of relationship-building and real-time assessment of member needs.
- Show evidence of closing quality gaps and addressing barriers to care, including efforts to connect members with preventive services, support medication adherence, and resolve social determinants of health such as housing, food insecurity, or transportation.

Together, these elements demonstrate a provider's commitment to delivering high-quality, coordinated, and person-centered care and are critical for both compliance and improved member outcomes.

5.1.2 Best Practices for Aligning Care Coordination with Smart Goals and Person-Centered Care

To ensure Health Link activities are meaningful, measurable, and aligned with person-centered care principles, consider the following best practice reminders when delivering and documenting care coordination services:

- **Establish SMART Goals:** All care plan goals must be Specific, Measurable, Attainable, Relevant, and Time-bound. Goals should be clearly written and directly tied to the member's identified needs and functional impairments.
- **Use Functional Assessments to Drive Planning:** Tools such as the DLA-20 should be used to identify areas of functional need. These findings should inform the development of individualized care plan goals and interventions.
- **Incorporate the Member's Voice:** Members should be actively engaged in the care planning process. Their preferences, values, and language should be reflected in the care plan. Providers should document member input and ensure that care plans are signed by the member (or guardian), the care coordinator, and a licensed clinician.

- **Tie Activities to Goals:** Each care coordination activity should be explicitly linked to a goal in the care plan. Documentation should clearly state how the activity supports goal achievement.
- **Update Goals Based on Progress or Barriers:** If a goal is not being met, providers should document the barriers and revise the goal or interventions accordingly. Updated care plans should reflect the members' evolving needs and include new strategies as appropriate.
- **Demonstrate Person-Centered Engagement:** Providers should document efforts to engage the member in care planning and service delivery. This includes outreach, follow-up, and coordination with family or natural supports.
- **Coordinate Across Systems:** Providers must facilitate communication with primary care providers, specialists, and community-based organizations. Transitions of care should be supported with timely follow-up and updated care plans.
- **Self-Audit for Quality Assurance:** Providers are encouraged to use the engagement evaluation checklist, located in the appendix in section 12.3, as a self-audit tool to review documentation to ensure that all activities are tied to care plan goals, goals are SMART and updated regularly, and member engagement is clearly documented.

5.2 Health Link Service Delivery

In the Health Link model, care coordination activities are designed to be flexible and responsive to each member's unique needs. These activities may involve direct interaction with the member or engagement with collateral contacts such as caregivers, educators, or other professionals involved in the member's care.

To ensure accurate documentation and billing, each Health Link activity must include two types of qualifiers:

1. UA or UB to indicate who the activity involved:
    - UA (Member Contact): The activity involved direct engagement with the TennCare member.

- UB (Collateral Contact): The activity involved a collateral individual who supports the member's care (e.g., caregiver, teacher, case manager).

2. UC or UD to indicate how the activity occurred:
   - UC (Face-to-Face Contact): The interaction was conducted in person or through real-time virtual communication (e.g., video call).
   - UD (Indirect Contact): The interaction occurred through non-face-to-face means, such as a phone call or other synchronous communication.

Each Health Link activity must include one modifier from each category, either UA or UB and either UC or UD, to fully describe the nature of the contact.

For example: a phone call with a caregiver would be coded as UB + UD, while an in-person meeting with the member would be UA + UC.

Understanding and applying these qualifiers correctly is essential for ensuring that activities are meaningful, appropriately documented, and aligned with the member's care plan. Additional information regarding billing codes can be found in section 9.2.5. The following sections provide detailed guidance on each contact type, including what qualifies as a valid Health Link activity and what does not.

5.2.1 Member Contact (UA)

Member contact refers to a face-to-face or telephonic interaction between a healthcare provider and the TennCare member. These contacts are central to the Health Link model and are intended to directly support the member's treatment goals, reinforce engagement, and advance the objectives outlined in the individualized care plan. Member contacts should be purposeful, clinically relevant, and clearly tied to one of the six Health Link activities.

To qualify as a valid Health Link activity, the interaction must demonstrate meaningful engagement with the member and contribute to their overall care coordination. Contacts that are brief, administrative, or lack therapeutic intent do not meet this standard.

Examples of inappropriate member contacts include, but are not limited to:

- **Group Sessions Not Focused on Individual Goals:** Group activities that do not address the specific treatment goals of the member or are not documented accordingly.

- **Brief Check-ins Without Clinical Relevance:** Contacts that do not address a care plan goal or do not result in any meaningful update or intervention.
- **Billing During Other Services:** Attempting to bill a Health Link activity during another reimbursable service (e.g., therapy, medication management) unless the Health Link activity is clearly separate, distinct, and documented as such.

5.2.2 Collateral Contact (UB)

Collateral contact refers to a face-to-face or telephonic interaction between a healthcare provider and an individual who plays a supportive role in the member's care. These contacts are intended to reinforce or advance the treatment objectives outlined in the member's care plan. Collateral participants may include caregivers, educators, primary care providers, guidance counselors, or staff from social service agencies, or anyone significantly involved in the member's well-being. To qualify as a valid Health Link activity, the interaction must be purposeful, clinically relevant, and aligned with the member's treatment goals. Brief or administrative communications, such as simple information requests, do not meet this standard

Examples of inappropriate collateral contacts include, but are not limited to:

- **Brief Information Requests:** Contacts made solely to obtain or verify basic information, such as confirming an appointment, insurance verification, or checking on the status of a referral.
- **Internal Communication:** Interactions between providers within the same agency or organization, as these are considered part of routine internal operations. Providers cannot bill staffing a member's case in treatment team as a collateral contact.
- **Non-Treatment Related Discussions**: Conversations that do not directly support or reinforce the treatment objectives outlined in the beneficiary's care plan.
- **Administrative Tasks:** Communications focused on administrative tasks, such as scheduling, billing inquiries, appointment reminders, or general office management.

5.2.3 Direct Contact (UC)

Also referred to as direct contact is an in-person or synchronous virtual interactions between a member (UA) or collateral contact (UB). These interactions are essential components of care delivery and are intended to directly address the member's health needs, reinforce treatment goals, and support the implementation of the individualized care plan.

Examples of inappropriate face-to-face or direct contacts include:

- **Non-Interactive Encounters:** Dropping off materials or leaving messages without direct interaction with the member or collateral contact.
- **Administrative-Only Visits:** Encounters focused solely on paperwork, billing, or scheduling without therapeutic engagement.
- **Social Visits:** Interactions that are primarily social in nature and not tied to the member's care plan or treatment objectives.

5.2.4 Indirect Contact (UD)

Indirect contact refers to non-face-to-face, non-synchronous communication methods used to support care coordination activities. These contacts may include voicemails, emails, text messages, or faxes. While these methods can facilitate communication and information sharing, they cannot be the only activity code billed in conjunction with the trigger code for the month. They do not qualify as standalone billable Health Link activities.

Indirect contacts may be used to supplement direct or collateral interactions, coordinate logistics, or follow up on previously discussed care plan items. However, they must be clearly tied to a member's care coordination needs and documented appropriately to demonstrate their relevance.

Examples of appropriate uses of indirect contact include:

- **Engaging in an email exchange with a caregiver to clarify next steps in the member's care plan.** For example, the provider emails the caregiver to confirm understanding of a new medication schedule discussed during a recent phone call. The caregiver replies with questions about side effects, and the provider responds with guidance and offers to coordinate with the prescribing clinician. This interactive exchange is documented in the

member's record, including how it supports the care plan and which Health Link activity it aligns with.

- **Texting a caregiver to coordinate a future appointment after a direct conversation, where the caregiver responds with availability and additional questions about transportation.** The provider replies with options and confirms arrangements, documenting the full exchange and its relevance to the member's care plan.
- **Coordinating a referral to a community agency through interactive communication**. For example, the provider contacts a housing support agency by phone to discuss a member's eligibility and service needs. The agency representative requests additional documentation which the provider faxes. The agency then confirms receipt and outlines next steps. The provider responds with clarification and updates the member's care plan to reflect the referral and follow-up plan, and how it supports the member's housing stability goal

Examples of inappropriate indirect contacts include, but are not limited to:

- **Standalone Voicemails, Emails, or Faxes:** Leaving a message or sending an email without any follow-up or interaction does not constitute a billable activity.
- **Administrative Communications:** Messages related solely to scheduling, billing, or insurance verification.
- **One-Way Notifications:** Sending reminders or updates without any opportunity for interaction or engagement.
- **Internal Messaging:** Communications between staff within the same agency that are part of routine operations and not tied to a specific member intervention.
- **Group Messages:** Mass communications not tailored to the individual member's care plan or treatment goals.

NOTE: All member contacts must be clearly documented in the member's record, including the purpose of the contact, the content of the interaction, and how it supports the member's care plan. These contacts should be interactive in nature and generally last at least 15 minutes to be considered meaningful and billable.

6. Quality & Efficiency Metrics

6.1 Quality Metrics Overview

Quality metrics are tracked to ensure that Health Links are meeting specified quality performance levels and to provide them with information they can use to improve the quality of care they provide.

The majority of quality measures are defined by HEDIS specifications. The most up to date HEDIS specifications will guide the inclusion of members and codes used to calculate these measures.

6.1.1 Core Quality Metrics

Measuring physical health HEDIS metrics alongside behavioral health HEDIS metrics is crucial for providing quality holistic care to individuals with Serious Persistent Mental Illness (SPMI). These individuals often face complex health challenges that intertwine physical and mental well-being. By integrating these metrics, healthcare providers can gain a comprehensive view of a patient's overall health, allowing for more effective treatment plans that address both physical and behavioral health needs. This approach not only improves health outcomes but also fosters a more person-centered care experience, ultimately enhancing quality of life. In a system that recognizes the interconnectedness of physical and mental health, providers can better identify gaps in care, reduce health disparities, and support recovery and resilience for those living with SPMI.

Core quality metrics for Health Link that will be used to determine outcome payments. Certain metrics are calculated for a specific age group only, e.g., adults only or children only. Some measures are grouped into composites. Each composite is worth one quality star. All sub-measures within a composite must meet or outperform the threshold in order for an organization to earn that star.

Table 5: Core Quality Metrics

Core Quality Metrics	Description	Threshold
1. Metric Monitoring for Children and Adolescents on Antipsychotics **(HEDIS APM-E)**	The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing	≥ 38.00%
2. Controlling High Blood Pressure **(HEDIS CBP)**	Percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year	≥ 58.00%
3. Eye Exam for Patients with Diabetes **(HEDIS EED)**	Percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed	≥ 51.00%
4. Follow-Up after Substance-Use Visit Within 30 Days **(HEDIS FUA)** • 30-day	The percentage of emergency department (ED) visits among persons age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within 30 days of the ED visit.	≥ 35.00%
5. Follow-Up After Hospitalization for Mental Illness Within 7 Days **(HEDIS FUH)** • 7-day	The percentage of discharges for persons 6 years of age and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service.	≥ 53.00%
6a. 7-day Psychiatric Hospital Readmission Rate **(TennCare Custom RTF)** • 7-day	Rate of psychiatric hospital or RTF readmissions within 7 days	≤ 5.00%

Core Quality Metrics	Description	Threshold
6b. 30-day Psychiatric Hospital Readmission Rate (TennCare Custom RTF) • 30-day	Rate of psychiatric hospital or RTF readmissions within 30 days	≤ 13.00%
7. Adherence to Antipsychotic Medications for Individuals with Schizophrenia **(HEDIS SAA)**	The percentage of members 18 years of age or older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period	≥ 65.00%
8. Diabetes Screening for People With Schizophrenia or Bipolar Disorder **(HEDIS SSD)**	The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year	≥ 86.00%
9a. Child & Adolescent Well-Care Visits 7-11 years **(HEDIS WCV)** • Ages 7 – 11 years	Percentage of enrolled members 7-11 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year	≥ 65.00%
9b. Child & Adolescent Well-Care Visits 12-17 years (HEDIS WCV) • Ages 12 – 17 years	Percentage of enrolled members 12-17 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year	≥ 57.00%
9c. Child & Adolescent Well-Care Visits 18-21 years (HEDIS WCV) • Ages 18 – 21 years	Percentage of enrolled members 18-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year	≥ 39.00%

6.1.2 Core Efficiency Metrics

Efficiency metrics are monitored to ensure Health Links meet designated performance standards and to supply actionable insights for improving care quality. Table 6 lists the core efficiency metrics used to determine outcome payment levels. These metrics are reported per 1,000 member months, with a ±20.00% cap applied to each measure. Additionally, all dual members, whether aligned or non-aligned, are excluded from efficiency targets.

Table 6: Core Efficiency Metrics

Efficiency Metric	Source	Description	Threshold
Ambulatory care - ED visits per 1,000 member months	HEDIS (AMB)	Number of ED visits per 1,000 member months	≤82
Inpatient discharges per 1,000 member months – Total inpatient	HEDIS (IPU)	Number of inpatient discharges per 1,000 member months	≤9.8

6.3 Reporting-Only Metrics Overview

A reporting-only metric is a type of performance or operational metric tracked for informational purposes but not tied to specific targets, incentives, or direct performance evaluations. These metrics are used primarily to monitor, analyze, and report data trends over time, providing insights without necessarily driving specific actions or accountability. Reporting-only metrics can help identify areas for potential improvement or reveal patterns without the pressure of meeting predefined goals.

Table 7: Reporting-Only Quality Metrics

Reporting Only Quality Metric	Description
1. Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics **(HEDIS APP)**	The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.
2a. Depression Remission or Response for Adolescents & Adults (HEDIS DRR-E) • Follow-Up PHQ-9	The percentage of members who have a follow-up PHQ-9 score documented within 120−240 days (4–8 months) after the initial elevated PHQ-9 score.
2b. Depression Remission or Response for Adolescents & Adults (HEDIS DRR-E) • Depression Remission	The percentage of members who achieved remission within 120−240 days (4–8 months) after the initial elevated PHQ-9 score.
2c. Depression Remission or Response for Adolescents & Adults (HEDIS DRR-E) • Depression Response	The percentage of members who showed response within 120−240 days (4–8 months) after the initial elevated PHQ-9 score.
3a. Depression Screening and Follow-up for Adolescents and Adults **(HEDIS DSF-E)** • Depression Screening	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care
3b. Depression Screening and Follow-up for Adolescents and Adults **(HEDIS DSF-E)** • Follow-Up on Positive Screen	The percentage of members 12 years of age and older who received follow-up care within 30 days of a positive depression screen finding.

Reporting Only Quality Metric	Description
4a. Follow-Up After Emergency Department Visit for Mental Illness Within 30 Days **(HEDIS FUM)** • 30-day	This measure assesses the percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days of the ED visit.
4b. Follow-Up After Emergency Department Visit for Mental Illness Within 7 Days **(HEDIS FUM)** • 7-day	This measure assesses the percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 days of the ED visit.
5. Use of Opioids at High Dosage **(HEDIS HDO)**	This measure assesses the proportion of members 18 years and older who received prescription opioids at a high dosage (average milligram morphine dose [MME ≥90 mg]) for ≥15 days during the measurement year. A lower rate indicates better performance.
6a. Initiation & Engagement of Substance Use Disorder Treatment **(HEDIS IET)** • Initiation of SUD Treatment • Total Age Ranges ("13-17," "18-64," "65+") • Total SUDs ("Alcohol," "Opioid," "Other")	The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days.

Reporting Only Quality Metric	Description
6b. Initiation & Engagement of Substance Use Disorder Treatment **(HEDIS IET)** • Engagement of SUD Treatment • Total Age Ranges ("13-17," "18-64," "65+") • Total SUDs ("Alcohol," "Opioid," "Other")	The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.
7. Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia **(HEDIS SMC)**	This measure assesses the percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.
8a. Social Need Screening and Intervention **(HEDIS SNS-E)** • Food Screening	The percentage of members who were screened for food insecurity.
8b. Social Need Screening and Intervention **(HEDIS SNS-E)** • Food Intervention	The percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for food insecurity.
8c. Social Need Screening and Intervention **(HEDIS SNS-E)** • Housing Screening	The percentage of members who were screened for housing instability, homelessness, or housing inadequacy.

Reporting Only Quality Metric	Description
8d. Social Need Screening and Intervention **(HEDIS SNS-E)** • Housing Intervention	The percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for housing instability, homelessness, or housing inadequacy.
8e. Social Need Screening and Intervention **(HEDIS SNS-E)** • Transportation Screening	The percentage of members who were screened for transportation insecurity.
8f. Social Need Screening and Intervention **(HEDIS SNS-E)** • Transportation Intervention	The percentage of members who received a corresponding intervention within 1 month of screening positive for transportation insecurity.
9a. Tobacco Use Screening and Cessation Intervention **(HEDIS TSC-E)** • Tobacco Use Screening	The percentage of persons 12 years of age and older who were screened for commercial tobacco product use at least once during the measurement period.
9b. Tobacco Use Screening and Cessation Intervention **(HEDIS TSC-E)** • Cessation Intervention	The percentage of persons 12 years of age and older who received tobacco cessation intervention if identified as a tobacco user.

Table 8: Reporting-Only Efficiency Metrics

Reporting-Only Efficiency Metric	Description
1. Diagnosed Mental Health Disorders (HEDIS DMH)	The percentage of members 1 year of age and older who were diagnosed with a mental health disorder during the measurement year.
2. Plan All-Cause Readmissions (HEDIS PCR)	For persons 18 years of age and older, the risk-adjusted ratio of observed-to-expected unplanned acute readmissions (inpatient and observation stays) for any diagnosis within 30 days of an acute hospitalization (inpatient and observation stays).
3. Panel enrollment rate (TennCare Custom)	The % of members that enrolled in the Health Link program
4. Panel opt-out rate (TennCare Custom)	The % of members that opted out of the Health Link program
5. Psychiatric inpatient days (TennCare Custom)	The total number of days per 1,000 member months for all inpatient psychiatric hospital stays with a discharge date within the measurement timeframe
6. Rate of inpatient psychiatric admissions (TennCare Custom)	The rate of inpatient psychiatric hospital discharges per 1,000 member months.
7. Rate of residential treatment facility admissions (TennCare Custom)	The rate of residential treatment facility discharges per 1,000 member months

6.4 Measuring Quality & Efficiency

Health Link organizations earn up to 11 stars based on performance in core quality and efficiency metrics, as outlined below:

- **Quality Stars (9 Stars):** Each quality metric or composite that meets or exceeds the threshold earns 1 quality star.
- **Efficiency Stars (2 Stars):** Each efficiency metric that meets or exceeds the threshold earns 1 efficiency star.

6.4.1 Star Eligibility & Criteria

To earn a star for any metric, the organization must:

1. Meet the threshold for the metric or all its sub-measures if it's a composite measure.
2. Meet the observation minimum of 30 members in the metric denominator: For example, "adherence to antipsychotic medications for individuals with schizophrenia" is measured only if at least 30 eligible members are in the metric's denominator.
    a. Exception: The RTF (Readmission to Facility) metric will use a minimum denominator of 10. This adjustment reflects the important work of Tennessee Health Links in reducing hospitalizations through proactive transitions of care.

6.4.2 Outcome Payment Eligibility

At the year-end, organizations must meet the following minimums to qualify for an outcome payment:

1. Quality: 4 quality stars.
2. Efficiency: 1 efficiency star or improvement over the previous year.

NOTE: Each quality star holds a weighted value of 5.5556% for the current program year.

6.4.3 Star Redistribution

Some adjustments may occur if an organization is ineligible for certain metrics due to a lack of data (fewer than 30 observations). Under these conditions, the value of any ineligible stars may be redistributed as follows:

a) **Redistribution of Ineligible Stars:** If a metric lacks sufficient observations (under 30), its star's value is evenly distributed among the remaining eligible metrics.
b) **Composite Measures:** If an organization does not meet the minimum denominator across all sub-measures of a composite, the star's value is redistributed. If the organization has sufficient observations for at least one sub-measure, it may still earn a star if thresholds are met for all eligible sub-measures.

Organizations must still meet the quality threshold (4 stars) to remain eligible for outcome payments, regardless of redistributed star values. The table below outlines the value of each star based on redistribution and eligible stars earned:

Table 9: Star Redistribution

Stars Earned	Eligible for 1 star	Eligible for 2 stars	Eligible for 3 stars	Eligible for 4 stars	Eligible for 5 stars	Eligible for 6 stars	Eligible for 7 stars	Eligible for 8 stars	Eligible for 9 stars
1	0%	0%	0%	0%	0%	0%	0%	0%	0%
2	-	0%	0%	0%	0%	0%	0%	0%	0%
3	-	-	0%	0%	0%	0%	0%	0%	0%
4	-	-	-	33.33%	33.33%	33.33%	28.57%	25.00%	22.22%
5	-	-	-	-	41.67%	41.67%	35.71%	31.25%	27.78%
6	-	-	-	-	-	50.00%	42.86%	37.50%	33.33%
7	-	-	-	-	-	-	50.00%	43.75%	38.89%
8	-	-	-	-	-	-	-	50.00%	44.44%
9	-	-	-	-	-	-	-	-	50.00%

7. Reporting

7.1 Performance Reports

Each quarter, Health Link providers will receive detailed performance reports from each MCO, which include metrics on quality and efficiency stars, total cost of care (TCOC), and potential payments relevant to the performance period. These reports provide a regular, interim view of the member panels for which providers are accountable during the program year. There are two types of quarterly reports:

- **Preview Performance Reports** are preliminary performance reports provided to Health Link providers, containing early data to offer insights into current performance levels and identify areas needing improvement. This report serves as an initial assessment, helping providers understand their standings on key metrics, including quality and efficiency, before official performance measurement begins. It is intended to guide providers in making adjustments to enhance their outcomes ahead of the finalized performance evaluation.

- **Performance Outcome Report** is released each August, the Annual Health Link Performance Report is a comprehensive summary of a provider's outcomes for the full program year. It includes finalized data on quality and efficiency metrics, total cost of care, and any earned outcome payments. The report reflects official results, incorporating all relevant claims data and necessary run-out periods to ensure accuracy. It serves as the basis for determining final payments and offers a complete assessment of provider performance, highlighting both areas of achievement and opportunities for future improvement.

7.1.1 Performance Report Details

The reports will contain the following sections:

- **Health Link Membership:** This section will list the percentage of attributed Health Link members that are enrolled with the given Health Link as of the end of the quarter. This percentage allows providers to assess potential for increasing enrollment. The section will also include the activity payments earned, based on activity claims, year to date.
- **Quality Performance:** This section summarizes the quality stars achieved by the provider as of the end of the given quarter. The redistribution of quality values may be applied under certain circumstances. Most of the quality metrics are defined by HEDIS. HEDIS requires that an organization have at least 30 observations in the denominator of any metric for it to be measured accurately. If an organization does not have at least 30 observations during a calendar year for a given HEDIS metric, that organization is ineligible for that particular quality star. The potential value of each ineligible quality star will be redistributed.
- **Efficiency Performance:** This section summarizes the efficiency stars and efficiency improvement score, an input of the outcome payment calculation. Performance must meet or exceed the threshold in order to earn an efficiency star. Each efficiency star earned contributes 15.00% to the efficiency performance. For the efficiency improvement score, the provider's current performance (year to date) on the two-efficiency metrics is compared to their performance from the prior year to

determine the Health Link's improvement. The improvement percentages for each metric are averaged together to generate the total efficiency score.

- **Outcome Payments:** This section provides information on potential (or actual, if it is the annual report) outcome payments. It lists the amount of the potential payment, and details of the calculation of that amount. The outcome payment is calculated as detailed in section 9.3
- **Total Cost of Care (for reporting only):** This section offers provider total cost of care information, calculated as explained in section 9.3.1, by care category. The provider TCOC figures are compared to a provider average and are provided on a non-risk adjusted basis for both total cost of care and BH-specific cost of care.
- **Appendix:** This section contains more detail on the quality metrics. The section includes a short description of each quality metric and a visual depiction of the provider performance on each metric as compared to other providers and as compared to the metric threshold for earning a star.

7.1.2 Performance Report Timelines

This table displays the timeframe for data included in each quarterly report for the 2026 reporting year, detailing the type of report, total cost of care (TCOC) data range, and quality and efficiency data range.

Table 10: Performance Report Timelines

Release Date	Q1 February	Q2 May	Q3 August	Q3 August	Q4 November
Performance Year	PY2025 Report 3	PY2025 Report 4*	PY2025 Final Report 5*	PY2026 Report 1	PY2026 Report 2
TCOC Data	Jan 1 – Sep 30, 2025	Jan 1 – Dec 31, 2025 + Runout	Jan 1 – Dec 31, 2025 + Runout	Jan 1 – Mar 31, 2026	Jan 1 – Jun 30, 2026
Quality & Efficiency Data	Jan 1 – Dec 31, 2025	Jan 1 – Dec 31, 2025	Jan 1 – Dec 31, 2025	Jan 1 – Jun 30 2026	Jan 1 – Sep 30, 2026

NOTE: *Preview Report 4 and Performance Outcome Report 5 have 9-month attribution rules applied.

7.2 Care Coordination Reports

TennCare and our MCOs have partnered to create standardized reports for the PCMH & THL programs in areas that are critical for program management and care coordination. MCOs will be uploading provider reports to their respective portals on a scheduled cadence and in a standardized layout for Member Attribution, Gap-in-Care reports, and admission/discharge/transfer (ADT) reports.

7.2.1 Data in the Care Coordination Reports

- **Admission/discharge/transfer Reports:** These reports are provided daily (Monday-Friday) and are populated by ADT feeds from hospitals across the state. They contain data such as basic member information, provider information, hospital event details, and data load details.
- **Member Attribution List:** This report is provided once per week and contains a full list of your attributed members by the respective MCO. The report contains attributed provider information and basic and detailed member information.
- **Gap-in-Care/Performance Report:** This report is produced twice per month and contains detailed information regarding each attributed member's associated measures, whether status is Met or Not, and if Met how it was closed. Additionally, the Practice Performance tab provides information on each metric's numerator, denominator, performance percentage and target, report period, and run date.

7.2.2 Delivery Cadence of Care Coordination Reports

The delivery cadence varies by report, however, each MCO follows the same cadence listed below to ensure you can expect the same report to be available in each of the MCO's respective portal on the same day.

Table 11: Care Coordination Reports Delivery Cadence

Report	Delivery Cadence
ADT (Admission, Discharge, Transfer)	Daily (Monday-Friday) by 12:00 pm CT
Member Attribution	Weekly (Fridays) by 5:00 pm CT
Gaps-in-Care & Practice Performance	Bi-weekly (2nd & last Friday of each month) by 5:00 pm CT

Please note: All reports will be delayed until the next business day if the delivery date is a holiday.

7.2.3 Care Coordination Report Training Materials

A recording and slide deck of the webinar reviewing the contents and delivery cadence of the ADT, Member Attribution, and Gap-in-Care reports are available on the PCMH & THL Learning and Training webpage. Additionally, an Excel data dictionary is available, if you are interested in receiving this, please reach out to TennCare.CCT@tn.gov.

7.2.4 Troubleshooting and Access Issues

If you have questions or need assistance accessing reports in an MCO's portal, please contact your representative at the respective MCO. Each MCO has different training materials and assistance available to individuals trying to access these reports in their respective portal. If you have tried to resolve an issue with MCO and have been unsuccessful after multiple attempts, please notify us for further assistance at TennCare.CCT@tn.gov.

8. Practice Transformation Support

8.1 Practice Transformation Overview

On-site and virtual coaching, along with practice transformation support for Health Links, will be provided by the contracted Managed Care Organizations (MCOs). These MCOs are dedicated to enhancing the effectiveness of Health Link organizations through structured support systems, which include:

- **Engagement Evaluation** is a systematic assessment conducted semi-annually by contracted Managed Care Organizations (MCOs) to evaluate the performance and effectiveness of Health Link organizations in delivering

integrated care. This process analyzes key metrics and practices to identify strengths, areas for improvement, and opportunities for practice transformation, offering a framework for tailored support and development.

- **Joint Operations Committee (JOC)** meetings are collaborative gatherings involving representatives from Health Link organizations and their contracted Managed Care Organizations (MCOs). These meetings typically occur on a quarterly basis and serve as a platform to discuss critical aspects of program implementation and operational performance. Key topics addressed during JOC meetings may include billing practices, provider relations, compliance with program requirements, performance metrics, and strategies for enhancing service delivery. The primary goal of these meetings is to foster effective communication, alignment, and partnership between Health Links and MCOs, ultimately driving improvements in care coordination and outcomes for the populations served.
- **Coaching** refers to regular, structured sessions held between Health Link organizations and their contracted Managed Care Organizations (MCOs) providing ongoing support, guidance, and performance improvement strategies. These sessions can take place in person or via teleconference and are designed to facilitate discussions on various topics, including integrated care practices, best practices, quality improvement initiatives, and follow-up on previous Engagement Evaluations. The primary purpose of monthly coaching is to help Health Link providers enhance their operational effectiveness, improve patient outcomes, and navigate challenges in delivering integrated care. Attendance by key personnel, such as those with clinical oversight, is typically required to ensure accountability and promote successful practice transformation.

The table below outlines the purpose, goals, and expectations of the transformation meetings

Table 12: Transformation Meeting Requirements

Meeting Type	Cadence	Audience	Required Attendees	Purpose

Engagement Evaluation	Semi-Annual	Leadership, Care Coordinators	Clinical Lead	Assess performance, identify strengths and improvement areas
Joint Operations Committee (JOC) Meetings	Quarterly	Administration, Leadership	THL Leadership (Clinical Directors/Program Managers)	Discuss program implementation, billing, and provider relations
Coaching	At a minimum quarterly or more frequently, depending on performance/ need	Agreed upon collaboratively by THL & Coach based on topic of session.	THL Clinical Leadership	Discuss integrated care, best practices, and performance improvement

NOTE: While this table identifies required attendance, it is left at the discretion of the practice and each MCO to determine who they feel is appropriate for attendance at each meeting. While the required parties must be present, additional THL staff may and are encouraged to attend if it is beneficial to the organization and success of the program.

8.2 Engagement Evaluation

The Engagement Evaluation is a selection of charts to evaluate the performance and effectiveness of Health Link organizations in delivering integrated care and meeting program goals. Conducted semi-annually by contracted Managed Care Organizations (MCOs), this evaluation analyzes key metrics, practices, and outcomes related to quality and efficiency. The primary purpose is to identify strengths, areas for improvement, and opportunities for practice transformation, providing a framework for continuous support and development tailored to each Health Link organization's needs. In-depth chart reviews will assess effort as well as outcome. A clear indication that the provider has identified needs, incorporated them into the individualized plan and is actively attempting to address those needs would be considered in assessing whether the enrollee is benefiting from the Health Link program.

8.2.1 Engagement Evaluation Record Selection

MCOs will use claims data to identify 12 enrollees', active or discharged, charts for evaluation. Additional files could be requested; especially if results showing potential patterns of concern with services being rendered. While the MCOs will randomly select charts for review they will meet the following selection criteria:

- Three (3) charts with open Gaps in Care
- Three (3) charts with three (3) consecutive months without face-to-face Care Coordination
- Three (3) charts with three (3) consecutive months without a non-care coordination service (no claims for any OP services)
- Three (3) charts with more than two (2) ED visits in three (3) consecutive months

All selected charts must have a THL billed activity code within two years from the time of the chart review to ensure evaluation of current practice operations and performance.

A total of twelve charts should be reviewed; however, if the practice does not have enough records that meet the selection criteria, only the charts meeting the criteria should be reviewed, with at least ten charts required overall.

For example, if only two members meet the criteria of two or more ED visits within three months, the MCO may review eleven charts. If, in another instance, there is only one member with two ED visits and only two charts with open care gaps (totaling nine eligible charts), the MCO will need to select an additional chart with a THL billed activity code within the last two years, at their discretion, to reach the minimum of ten charts for evaluation.

The evaluating MCO will provide Health Link providers with a list of selected charts at least two weeks in advance. **Any documentation** made in the file after date of notice for chart review will be **excluded** from the Engagement Evaluation process. Additionally, at the time of evaluation an MCO may request physician or nurse notes in order to support evidence of integrated care coordination.

8.2.2 Engagement Evaluation Scoring

Each evaluation tool item is scored individually, and all questions have the same value. Providers not meeting the minimum performance threshold of 85% on any one item are required to submit a corrective action plan.

If a provider receives a total score of less than 85%, they are subject to the remediation as outlined in Section 3.3.

Engagement Evaluation tools can be located in the appendix in section 12.3.

8.2.3 Engagement Evaluation Participants

The person who has clinical oversight of the Health Link program should be available for MCO staff to consult. This can include but is not limited to the Health Link Lead staff.

At a minimum, the person who has clinical oversight of the Health Link program should meet with the Engagement Evaluation staff in order to receive the results of the chart reviews.

9. Payments & Billing

9.1 Payment Overview

There are two main types of payments for providers under the Health Link Payment Structure:

1. **Activity Payment**: A per-member-per-month (PMPM) payment that is not risk-adjusted. This payment supports THL providers in maintaining ongoing activities such as care coordination, increasing member access, and creating care plans, to promote sustained commitment to transformational efforts.
2. **Outcome Payment**: An annual bonus payment available to THL providers who demonstrate high performance. This incentive aims to reward providers for improving efficiency and clinical outcomes, fostering higher standards of care.

NOTE: Current professional fee-for-service delivery model remains unchanged under Health Link for non-Health Link services.

9.2 Activity Payments

Tennessee Health Link providers play a vital role in transforming care for TennCare members. To support this work, Activity Payments are issued to providers who deliver key services that improve care coordination and outcomes. These payments are tied to specific, qualifying activities that reflect meaningful engagement with enrolled members.

Activity Payments are intended to support providers as they deliver the following core services:

- Comprehensive care management
- Care coordination
- Referrals to social support services
- Support for patients and their families
- Transitional care
- Health promotion

These services are essential to the THL model and are expected to be delivered consistently to enrolled members. For more information on Health Link services, refer to section 5 of this manual.

9.2.1 Activity Payment Duration and Eligibility

Providers are eligible to receive one Activity Payment per enrolled member each month, but only if the member participates in at least one qualifying Health Link activity during that month. To trigger the payment, providers must submit the designated Billing Code (also referred to as the trigger code). This code can only be submitted once per member per month.

NOTE: Submitting it more than once will result in a denied claim.

Even though the Billing Code is limited to a single submission, providers should continue submitting Activity Encounter Codes with the applicable modifiers (see Table 14) throughout the month as services are delivered. These codes help track the full scope of care coordination efforts and ensure accurate reporting.

While additional patient support activities are encouraged and accounted for in the case rate, they do not result in additional Activity Payments for the month.

However, they may still contribute to outcome-based payments by improving the quality and efficiency of care.

It's important to note that outreach activities such as contacting members who are attributed but not yet enrolled (ANE) are not billable on a per-activity basis. However, the time spent on outreach is accounted for in the THL model and is built into the overall payment structure. Providers are expected to perform outreach to ANE members as a core component of THL services.

9.2.2 Lookback Claims

The Look Back Claims policy supports provider flexibility by allowing retroactive billing for qualifying Health Link activities delivered in a prior month. This ensures providers can still receive payment for eligible services despite administrative delays in claim submission, provided all eligibility and documentation requirements are met.

A look-back claim is valid if:

- The member was enrolled and/or attested to via MCO specific methods within 30 days of member consent.
- At a minimum, attestations are submitted 14 days prior to filing the claim.
- Providers follow MCO specific process related to member switches, as outlined in section 4.5.1.
- A qualifying activity was performed and documented (see section 5).
- The claim is submitted within the MCO's timely filing window.

Any claims submitted without a switch submission and enrollment, if required by the MCO, will deny appropriately. MCOs will not be required to pay or reprocess claims where the MCO switch process was not followed.

9.2.3 Activity Payment Rates

Each Managed Care Organization (MCO) contracted with TennCare—Wellpoint, BlueCare, and UnitedHealthcare is responsible for:

- Negotiating payment rates
- Managing contracts for Health Link services

Providers should work directly with their contracted MCO to understand the specific rates and terms.

9.2.4 Billing & Activity Encounter Codes

To ensure timely payments and accurate tracking, providers should follow these guidelines:

- Submit the Billing Code once per month, along with all applicable Activity Encounter Codes to trigger the monthly case rate.
- Additional Activity Encounter Codes submitted after the Billing Code do not require the Billing Code again.
- Each Activity Encounter Code should include a minimum charge of $0.01 on the TennCare 1500 professional claim form.
- Submit all codes on a professional claim using the TennCare 1500 form at the entity level. Leave field 24j blank.

Table 13: Billing Code

Billing Code (Trigger Code)
S0280

Table 14: Activity Encounter Codes

Code	Activity	Member or Collateral	Face-to-face or Indirect
G9004	Comprehensive care management *Initiate, complete, update, or monitor the progress of a comprehensive person-centered care plan*	UA: Member UB: Collateral	UC: Face-to-face UD: Indirect
G9005	Care coordination	UA: Member UB: Collateral	UC: Face-to-face UD: Indirect
G9006	Health Promotion	UA: Member UB: Collateral	UC: Face-to-face UD: Indirect
G9007	Transitional care	UA: Member UB: Collateral	UC: Face-to-face UD: Indirect
G9010	Patient and Family Support	UA: Member UB: Collateral	UC: Face-to-Face UD: Indirect
G9011	Referral to Social Supports	UA: Member UB Collateral	UC: Face-to-Face UD: Indirect

9.2.5 MCO Activity Payment Monitoring Requirements

To maintain consistency and avoid duplicate payments, MCOs are required to enforce the following:

- Only one Health Link provider may be paid per member per month.
- Only one Billing Code may be paid per member per month.

- If a member is enrolled in Health Link, a claim that includes both the Billing Code and an Activity Encounter Code will trigger the monthly payment.

9.3 Outcome Payments

Outcome payments are designed to reward Health Links annually for providing high-quality care while effectively managing overall spending. Outcome payments for each Health Link are based on performance on the core quality and efficiency metrics described in section 6.

Health Link organizations are eligible for outcome payments only if the organization earns:

- 4 quality stars; **AND**
- 1 efficiency star **OR** efficiency improvement over the previous year.

For Health Link organizations who qualify for an outcome payment, the outcome payment amount is calculated as follows:

Table 15: Outcome Payment Formula

Average Cost of Care (PMPM)		Efficiency Improvement Percentage + Efficiency Stars		Maximum Share of Savings		Quality Stars		Member Months		Outcome Payment
Average	✖	%	✖	15%	✖	%	✖	# Attributed	=	Calculated

9.3.1 Average Total Cost of Care (TCOC) Per Member Per Month (PMPM)

This is the average total cost of care per member per month for members in Health Links across all of TennCare. The statewide average TCOC amount to be used is $801.The total cost of care is meant to capture the total cost of an average member in a Health Link's organization, adjusted for the member months during which the member was eligible for TennCare. Using this, the MCOs can calculate the savings an organization has generated and share those savings with organizations. At the end of each quarter, the TCOC is generated for the provider report, based on each Health Link's member panel for performance. TCOC amounts will be displayed for informational purposes only.

For purposes of the Health Link program, certain spending is excluded from the TCOC calculation:

- Dental
- Transportation
- NICU and nursery
- Any spending during the first month of life
- Gain-sharing payments made to the Health Link as a Principle Accountable Provider (i.e. Quarterback) of episode-based payment models
- Mobile Crisis Capitation payments
- Medication therapy management (MTM) payments
- Payments made to Department of Children's Services (DCS) directly billed to MCO

Health Link activity payments are considered a cost associated with delivering care. Health Link payments during the reporting period are included in the TCOC calculation. Each Health Link organization will receive a breakdown of their TCOC by category in each quarterly report for reporting-only.

Table 16: Total Cost of Care (For Reporting-Only)

Category	Description
Inpatient Facility	All services provided during an inpatient facility stay including room and board, recovery room, operating room, and other services.
Emergency Department or Observation	All services delivered in an Emergency Department or Observation Room setting including facility and professional services.
Outpatient Facility	All services delivered by a facility during an outpatient surgical encounter, including operating and recovery room and other services.
Inpatient professional	Services delivered by a professional provider during an inpatient hospital stay, including patient visits and consultations, surgery, and diagnostic tests.
Outpatient Laboratory	All laboratory services in an inpatient, outpatient, or professional setting.

Category	Description
Outpatient Radiology	All radiology services such as MRI, X-Ray, CT and PET scan performed in an inpatient, outpatient, or professional setting.
Outpatient Professional	Uncategorized professional claims such as evaluation and management, health screenings, and specialists' visits.
Pharmacy	Any pharmacy claims that are billed under the pharmacy or medical benefit with a valid National Drug Code.
Other	DME, home health and any remaining uncategorized claims.

Actual Total Cost of Care: Actual total cost of care for a Health Link is calculated as a per-member-per-month metric, on a separate basis for each MCO with which the Health Link contracts.

Non-risk-adjusted TCOC is defined as the sum of spend included in TCOC divided by the sum of the number of enrollment months with the MCO, for all the members in the Health Link's panel. In other words, across all members of the Health Link's panel within an MCO:

Table 17: Non-risk Adjusted TCOC

$$Non\ risk\ adjusted\ TCOC = \frac{\sum Included\ Spend}{\sum Member\ months\ with\ MCO}$$

Non-risk-adjusted TCOC for behavioral health is defined analogously with the non-risk-adjusted TCOC above but taking into account only the BH spend. For non-risk-adjusted TCOC for behavioral health, spend included is spend that meets the BH spend definition as well as the TCOC definition.

Each Health Link organization will receive a breakdown of their TCOC Behavioral Health Spend by category in each quarterly report for reporting-only.

Table 18: Total Cost of Care- Behavioral Health Spend (For Reporting-Only)

Category	Description
Inpatient/Residential	Hospital inpatient care, Mental health residential
Emergency	ED care, Crisis services
Outpatient and Other Treatment	Therapy, Assessment & testing, Substance use treatment, Medication management, Counseling/Intervention, Detox, Rehab, Other E&M, Other BH treatment
Pharmacy	Medication/Pharmacy
Case management	Case management, level 1, Case management, level 2, Case management, integrated care team, Other case management, Health Link activities
Supportive Services	Psychiatric rehab, Supportive services, Ancillary services
Other Care	Radiology, lab and DME, PT/OT/ST, Other types of care

9.3.2 Efficiency Performance

Efficiency performance is determined by combining percentages earned from both efficiency improvement and efficiency stars, with a maximum possible score of 50.00%.

9.3.3 Efficiency Improvement Percentage

The efficiency improvement percentage is designed to reward Health Links for increased efficiency year-over-year. Improvement is calculated by averaging the change in each efficiency metric from the prior calendar year. For instance, if CY2026 is the performance period, CY2025 values are used as the baseline. Each efficiency metric is rounded to the nearest hundredth decimal place.

The formula for calculating improvement in a metric is:

Table 19: Efficiency Improvement Percentage Calculation

$$\begin{pmatrix} Efficiency \\ Improvement \\ Percentage \end{pmatrix} = \frac{\begin{pmatrix} Efficiency\ metric\ 1 \\ Prior\ year\ value \end{pmatrix} - \begin{pmatrix} Efficiency\ Metric\ 1 \\ Current\ value \end{pmatrix}}{\begin{pmatrix} Efficiency\ metric\ 1 \\ Prior\ year\ value \end{pmatrix}}$$

If a prior year's metric value cannot be calculated, that metric's improvement is set to zero. The improvement for each metric is then capped at ±20.00%. For example, if a decrease in efficiency is 31.25%, it will be capped at -20.00%, and if an increase in efficiency is 31.25%, it will be capped at +20.00%.

Table 20: Illustrative Example of Efficiency Improvement Percentage

Metric	Baseline (CY2025)	Since 1/1/26	Improvement (%)
ED Visits	78.10	76.00	2.69%
Inpatient Discharges	3.00	2.80	6.67%
Total Improvement	-	-	4.68%

Note: Efficiency metrics are displayed to the hundredth decimal place. When averaging, the result is rounded to the nearest hundredth. If the average of the efficiency improvement percentages is negative, it will be set to 0%, and if it exceeds 20%, it will be capped at that value.

9.3.4 Efficiency Stars

To earn an efficiency star, performance must meet or exceed a set threshold. Each efficiency star contributes 15.00% to the total efficiency performance. For additional information regarding efficiency metrics please reference section 6.1.2.

9.3.5 Maximum Shared Savings

Health Link organizations may earn up to 15% of the total savings achieved during a year unless a THL is in remediation in which the THL is subject to a reduction in shared savings as outlined in Section 3.3.

9.3.6 Quality Stars

To earn a quality star, a Health Link organization's performance must meet or exceed the defined threshold **AND** have a minimum of 30 observations for each metric (see section 6.4.1 for exception). Each quality star earned contributes to the organization's overall quality performance, with a maximum possible quality performance score of 50.00%. For additional information regarding quality metrics please reference section 6.1.

9.3.7 Member Months

Member Months refers to the cumulative total of months during which all members in a Health Link's panel (meaning "Active" members and "Attributed Not Enrolled" members) are eligible with the Managed Care Organization (MCO). For each member, one "member month" is counted for every month they are enrolled with the MCO under the Health Link program. If a member is enrolled for only part of a month, the member month is calculated proportionately based on the number of days the member was active during that month.

Key Points:

- **Calculation**: Member months are calculated by tallying each month of active enrollment for all members in the Health Link's panel over a specific performance period.
- **Panel Inclusion**: To be included in the Health Link's panel for outcome-based payments, a member must be attributed to that Health Link for **at least nine months** of the performance period. This ensures consistency and sufficient engagement to measure outcomes accurately.

In essence, member months serve as a metric to quantify sustained member engagement, essential for assessing both the scope of the Health Link's impact and performance in outcome payment calculations. This framework incentivizes providers to focus on long-term member support.

10. THL Reconsiderations and Complaints

10.1 Outcome Payment Reconsiderations

A provider may file a Reconsideration for the following reasons:

- Quality Metric Performance
- Efficiency Metric Performance
- Efficiency Improvement Percentage
- Calculation of the Outcome Payment amount

10.1.1 Reconsideration Process

1. Providers must submit the reconsideration request using the MCO specific THL Reconsideration form within 30 calendar days of receiving the Final Performance Report.
2. The MCO is required to respond to the reconsideration request within 30 calendar days of receipt.
3. If no reconsideration is filed, the outcome payment must be issued within 30 calendar days of the report distribution. All outcome payments should be made by the MCO no later than December 1 of the year in which the final performance report was issued.

10.1.2 Reconsideration Resources

The following details are each of the Reconsideration Resources by MCO:

Wellpoint :

- Wellpoint THL Reconsideration Forms
- Email TNHealthlink@wellpoint.com ; Attn: Tennessee Health Link Program Manager,

BlueCare:

- BlueCare THL Reconsideration Process
- BlueCare THL Reconsideration Form

- BlueCare THL Appeal Form

UnitedHealthcare:

- UnitedHealthcare THL Reconsideration Forms
- Email bh_payment_reform@uhc.com; Attn Tennessee Health Link Manager

10.1.3 TDCI Independent Review

If a provider disagrees with the outcome of a reconsideration, they may request an independent review through the Tennessee Department of Commerce and Insurance (TDCI). This review is governed by the TennCare Provider Independent Review of Disputed Claims process (T.C.A. 56-32-126). It is understood that in the event program care providers file such a request with the Commissioner of Commerce and Insurance for Independent Review, such dispute shall be governed by T.C.A. 56-32-126(b).

Sample copies of the Request to Commissioner of Commerce and Insurance for Independent Review of Disputed TennCare Claim form, instructions for completing the form, and frequently asked questions developed by the State of Tennessee Department of Commerce and Insurance can be obtained on the state's website.

For questions about the independent review process, call the State of Tennessee at (615)-741-2677.

10.2 Provider Complaints

This process is a courtesy provided to medical and transportation providers who have a complaint against a TennCare managed care company ("MCC") or a Medicare Advantage Special Needs Plan ("MA-SNP"). Complaints may involve claims payment accuracy and timeliness, credentialing procedures, inability to contact or obtain assistance from the MCC/MA-SNP, miscommunication or confusion around MCC/MA-SNP policy and procedures, etc. This process is also available for disputing annual Episodes of Care Reports. This process is free.

When a provider complaint is received, the TennCare Oversight Division will forward the complaint to the MCC or MA-SNP for investigation. The MCC or MA-SNP is required to respond in writing to both the provider and the TennCare

Oversight Division by a set deadline to avoid assessment of liquidated damages or other appropriate sanctions.

If the provider is not satisfied with a TennCare MCC's response to the complaint, the provider may seek other remedies to resolve the complaint, including but not limited to, requesting a claims payment dispute be sent to an Independent Reviewer for resolution or pursuing other available legal or contractual remedies.

If the provider is not satisfied with an MA-SNP's response to the complaint, the provider may seek other remedies to resolve the complaint, including pursuing other available legal or contractual remedies. However, the Independent Review process is not available for MA-SNP provider disputes.

Provider complaints can be submitted by completing the electronic form for TennCare Provider Complaints and submitting it by email (PREFERRED), fax or mail to the mailing address listed below.

- Email Address: TennCare.Oversight@tn.gov
- Fax Number: (615) 401-6834
- Mailing Address:

  Tennessee Department of Commerce & Insurance

  TennCare Oversight Division

  500 James Robertson Parkway

  Nashville, TN 37243-1169

In you need to speak with us; we can be reached by Telephone at: (615) 741-2677

Please provide as much information as possible, including copies of claims and remittance advices and/or other denial correspondence from the MCC, if applicable.

Always include with your provider complaint:

- Full name of provider contact person
- Mailing address
- Phone #
- Fax number #

- Email address

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12. Appendix

12.1 Department of Children's Services Eligibility

As noted above in Section 4.3, one reason for Health Link eligibility exclusion is patient enrollment in duplicative DCS programs. This section provides further detail regarding this exclusion and explains the services that a Health Link can provide to some patients enrolled in DCS programs.

On entering DCS custody, children are assessed and placed at a level of care appropriate to their needs. Programs within some of these levels of care (level 3 and above) have been judged to be significantly duplicative of the care coordination offered by Health Links. Following thirty continuous days of a child's membership in such a level of DCS custody, they will have their Health Link membership suspended for the duration of their time in this level of care. In extraordinary circumstances, the DCS provider may appeal to the MCO for the continuation of the child's membership (on grounds of capacity, continuity of care coordination, or following an assessment of clear need for services provided through Health Links, such as transitional care arrangements using the Care Coordination Tool and Admission, Discharge, Transfer (ADT) feeds or specialized expertise on mental health care coordination for high needs populations).

For children entering DCS custody at levels of care that do not trigger suspension of Health Link membership, the Health Link will continue to be able to offer services for these children and be paid for these services. The DCS provider and Family Services Worker (FSW) will retain overall responsibility for these children and the coordination of their broader needs (e.g., educational, legal, permanency). These providers are expected to coordinate the health needs of these children but are allowed to incorporate services provided by a Health Link. This pattern also reflects arrangements made under the former Level 2 Case Management program. Working under the auspices of the DCS FSW and provider and their permanency plan for the child, Health Links will be able to provide a range of useful services for the child.

Such interactions might include the following (not intended to be an exhaustive list):

Attending the Child and Family Team meetings and contributing to discussions regarding the child's welfare (an example of communicating patient needs to community supports);

Communicating with the DCS FSW and provider if the child has been admitted or discharged from a hospital (as indicated through the Care Coordination Tool) and formulating a discharge plan. This is an example of developing a systemic protocol to assure timely access to follow-up care post discharge;

Using specialist knowledge of behavioral health services to coordinate behavioral health appointments, or to help with medication management;

Working with the child's potential 'forever family' to educate and help them manage the child's behavioral health needs, complementing the work the DCS FSW and provider will do for other aspects of the child's life;

Supporting the transition in and out of DCS custody, working with the DCS provider in the first instance to update them of the child's behavioral health needs and current care plan (as appropriate). And, in the latter instance working with the DCS provider to reassume full responsibility for the child's care plan as they prepare to transition out of custody; or

Offering extra capacity to the DCS provider during acute spikes in the child's needs, requiring intensive coordination between multiple specialists and facilities.

12.2 Medical Necessity Criteria Resources by MCO

- **Wellpoint**
  - Tennessee Health Link Guidelines: Adults Medical Necessity Criteria
  - Tennessee Health Link Guidelines: Children and Adolescents Medical Necessity Criteria
- **BlueCare**
  - THL-MNC-Adult-Final-BC.pdf (bcbst.com)
  - THL-MNC-CY-FINAL-BC.pdf (bcbst.com)
- **UnitedHealthcare**

- Tennessee Health Link Guidelines: Adults Medical Necessity Criteria
- Tennessee Health Link Guidelines: Children and Adolescents Medical Necessity Criteria

12.3 Engagement Evaluation Tool

	Program Requirements
1	The organization is either a Community Mental Health Center or another qualified organization as outlined in the POM section 3.
2	The organization is committed to adopt the provider reports and demonstrates understanding of the resources available.
3	The organization has established collaborative partners with local primary care providers and documented letters of collaboration.
4	There is a designated Health Link Administrator who serves as the main point of contact for THL related matters and attends all THL MCO/State meetings or sends an appropriate designee with notice.
5	There is a designated lead clinical care coordinator who has an active unrestricted RN license in the state of TN. If lead clinical care coordinator is not an RN there is a clearly documented consulting process.
6	There are clearly defined case managers who act as primary point of contact for member and family relationships and are licensed as an LPN, RN, or have obtained a bachelor's degree.
7	The organization has the ability to provide behavioral health services either with a psychiatrist or primary care physician (MD/DO), a masters-level clinician (possessing a master's degree tied to mental health practice or related subjects, with an active TN license, or a psychologist.
8	The organization has a clear onboarding process that clearly presents the goals and aims of the THL program to new staff
9	The organization has a continuous learning plan enabling employed and affiliated personnel involved with Health Link to continue to grow and refine their skill set and understanding of the program.
10	Organization earned a minimum of four quality stars in the most recent performance year
11	Organization has completed all coaching sessions since last Engagement Evaluation
12	Person assigned to provide clinical oversight to THL program and/or person who provides direct oversight to integrity of treatment plans is present and engaged at Engagement Evaluation
13	Organization attends quarterly Joint Operations Committee meetings and Health Link Administrator is present.
	Enrollment Criteria
1	The reasons for initiation of THL service is clearly documented and identified by a licensed clinician within 30 days of enrollment.

2	There is evidence of the member's consent to participate in the THL (or evidence of not opting out). Ensure an updated consent is available in the record at least every 12 months or until discharge.
3	There is clear evidence of functional need, based upon the DLA or other equivalent functional need assessment, within 30 days of enrollment.
	Person-Centered Care Plan
4	There is evidence of a completed person-centered care plan within 30 days of THL enrollment.
5	The functional needs assessment is updated at a minimum of every six months.
6	The person-centered care plan is updated every six months or earlier as needed to address the care coordination needs of the member.
7	All person-centered care plans are signed by Coordinator, Licensed Clinician and Member/Guardian within 30 days of completion.
8	Care Plan includes physical health goal(s) if the member has a significant physical condition or a physical health need.
9	All Care Plans include minimally 1 behavioral health goal with specific Care Coordinator interventions.
10	All person-centered care plans are specific, measurable, attainable, relevant, and time-based.
11	The updated care plan(s) have barriers documented for any goals that have not been noted as "met."
12	The updated care plan(s) have modified member objectives or new care coordinator interventions for on-going goals.
	THL Engagement
13	Based on the individualized care plan, the record documentation demonstrates efforts to provide consistent member support, as evidenced by completion of monthly care coordination activities and engagement attempts.
14	Do THL progress notes contain interventions that tie directly to defined THL activities and are related to current care plan goals? (Review most recent 3 months of progress notes)
15	There have been active attempts to facilitate access to community supports, communicate member needs to community partners (e.g. schools, food banks, etc.), and provide information and assistance in accessing services.
16	There is documentation in the record that the THL is supporting health promotion with the member based on member needs identified in the care plan.
17	There is documented evidence in the record that the THL is supporting recovery and resilience through strategies to assist the member with utilizing supports in their natural environment.
	Coordination of Services

18	There is evidence of care coordination with member's primary care provider (PCP) within 30 days of THL enrollment and at least annually. The documentation must demonstrate evidence of outreach, e.g.: a mailed letter, fax, email, or phone call.
19	If member has chronic health condition(s) or ongoing medical needs, there is evidence of care coordination with appropriate specialty providers.
20	If member has received inpatient or ER services, the THL has provided transitional care to include assistance in discharge planning, support in crisis situations, and/or establishing and/or confirming follow-up care post discharge.
21	The record demonstrates care coordination attempts to close THL quality gaps in care and/or verification that gaps are closed for the calendar year
22	For children with DCS involvement, there is evidence that the THL has coordinated with DCS
	Continuation of Services
23	Per the documentation, member demonstrates progress towards targeted goals within the past 6 months or barriers to their progress have been addressed.
24	There is documented evidence in the record that demonstrates the THL provider conducted appropriate and/or varied efforts to engage the member during the most recent 3-6 months (F2F visits, CM reassignment, appropriate incentives, enlisting a Peer Specialist).
25	There is documented evidence of face-to-face contact or attempts at least once every quarter.
26	Member has current BH treatment needs, other specialty care needs, or a demonstrated need for support that require THL Care Coordination Services?

12.4 Adjustments to Outcome Payment Memo- 2023

To: Tennessee Health Link Providers
From: Sara Cox, LPC-MHSP Behavioral Health Services Lead of Operations
Date: October 11, 2023

Subject: Adjustments to Outcome Payment Formula and Quality Thresholds

Tennessee Health Link (THL) outcome payments are intended to reward providers who demonstrate high quality and efficient healthcare for the members they serve. The Division of TennCare has been evaluating the THL outcome payment formula to ensure it is aligned with the value-based goals of the program.

Beginning performance year 2024, we will be modifying the outcome payment formula. Since 2019, outcome payments have been calculated using the lower amount of 10% of the total annual activity payments or the base outcome payment formula. Beginning in performance year 2024, the base formula for shared savings will be used, and the Maximum Share of Savings will be changed from 25% to 15%. The 10% cap will be removed. Please note that this change **will <u>not</u>** impact outcome payments paid in calendar year 2024 for performance year 2023.

Performance Year 2024 Outcome Payment Formula

Note: 10% Cap has been removed

12.5 Adjustments to ANE Status Memo- 2023

Division of TennCare

To: TennCare Managed Care Organizations
From: Sara Cox Program Tennessee Health Link
Date: June 28, 2023

Subject: Adjustment to Attributed Not Enrolled Status

The Division of TennCare is directing the Managed Care Organizations (MCOs) to adjust the logic of the Attributed Not Enrolled (ANE) status within the Tennessee Health Link (THL) program. Beginning August 1, 2023, ANE members will be removed from attribution following a 24-month period without a behavioral health claim. As a reminder, non-aligned dual members are excluded from member panels, regardless of behavioral health claims status.

This change shall be reflected in the Care Coordination Tool beginning August 14, 2023, and shall be reflected in the November 2023 Provider Performance Reports. The implementation of this change is expected to result in a decrease in the number of members included on providers' ANE panels. The goal of introducing this change is to help providers manage their rosters and prioritize outreach to patients with an active behavioral health need.

12.6 Lookback Claims Memo- 2019

Division of TennCare

To: TennCare Managed Care Organizations
From: Mary Shelton, Director, Behavioral Health Operations
Date: June 13, 2019

Subject: Tennessee Health Link re: Look Back- Claims Analysis

The Division of TennCare is directing the Managed Care Organizations (MCOs) to continue with the 'Look Back- Claims Analysis' for Tennessee Health Link (THL). This particular claims analysis is being conducted to address situation where a THL member is attributed to THL A but receives Health Link services at THL B. The analysis shall be conducted 120 days after the end of each month to allow for claims runout.

Tennessee Health Link Provider Requirements

Providers must enroll and/or attest members via MCO-specific methods within 30 days of member consent or risk denial of claims for months of service where enrollment/attestation was not complete. At a minimum, attestations should be submitted at least 14 days prior to filing the claim. Any claims submitted prior to completing the attestation/enrollment process as defined by the MCO will deny appropriately. Effectively 07/01/19, MCOs will not be required to pay or reprocess claims that precede enrollment/attestation per TennCare guidance.

In addition, providers must also follow MCO-specific processes related to member switches. Members will switch to new THL per the current language in the THL Provider Operating Manual (POM). Providers must submit switches and complete enrollment, as required by each MCO, before filing a claim. Any claims submitted without a switch submission and enrollment, if required by the MCO, will deny appropriately. Effective 07/01/19, MCOs will not be required to pay or reprocess claims where the MCO switch process was not followed.

The Division of TennCare will add this language to the THL POM at the next scheduled update. However, the omission of this language in the current version of the THL POM, does not, in any way, restrict the applicability of the 07/01/19 effective date of this guidance.

If you have any questions or concerns regarding this information, please contact Mary Shelton at Mary.C.Shelton@tn.gov or 615-507-6687.