Division of
Health Care
Finance & Administration

Health Care
Innovation Initiative

# Health Link Webinar: What Services Will a Health Link Provide?

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# Key Differences between Level 2 Case Management and Tennessee Health Link

## Broader set of activities[1]

**These activities may be delivered to…**

- The member
- Another provider, family member or someone else who is actively involved in the member's life.

**… and be delivered**

- In person
- or through an indirect contact

**Members with at least 1 activity are eligible for a monthly payment**

## Expanded population

**Maintain access for Level 2 Case Management patients**

- Members actively receiving Level 2 Case Management will be enrolled with a Health Link

**Include patients missed by the current system**

- Members meeting the new Health Link criteria, which includes combination of severe BH conditions and utilization of acute services

## Emphasis on recovery

**Health Links should:**

- Support increased self-sufficiency over time
- Help their patients towards recovery, which means that, on average, Health Link patients will require less support over time

**Some members will be able to exit the Health Link as they meet their treatment goals**

## What does this mean for you?

The **flexibility to provide the right support** at the right time to the right person

1 Health Link activities: Comprehensive care management, Care coordination, Referral to social supports, Patient and family support, Transitional care, Health promotion

# Flexibility with the Health Link Program

- Staffing Ratios
- Types of Contacts
- Number of Visits
- Who may render the service?

# Health Link- Billing/Coding for Quality Metrics

- **EPSDT Well child visits ages 7-11 years**
  - PCP
- **EPSDT Adolescent well-care visits age 12-21 years**
  - PCP or OB/GYN
- **Counseling for nutrition (children)**
  - PCP or OB/GYN
- **Diabetes Eye Exam**
  - Eye exam must be performed by an eye care professional (optometrist or ophthalmologist)

**Health Link providers are encouraged to work with the member and the member's primary care provider (PCP) to close gaps in care for the following physical health metrics**:

- Adult BMI screening
- BMI percentile (children and adolescents only)
- BP control (<140/90 mm Hg)
- Medical attention for nephropathy
- HbA1c testing
- HbA1c poor control (>9.0%)

# Health Link - Clarifications for Modifier Examples

**Effective June 1, 2017**

## Health Link Modifier Examples

This table provides information for Health Link providers regarding definitions and acceptable uses of Health Link billing modifiers.

| UA - Member | UC – Face to Face |
|---|---|
| • Member Contact Only | • Face to Face Contact Only (includes telehealth) |
| **UB - Collateral** | **UD - Indirect** |
| • Provider to Provider<br>• Individuals with a Valid Release of Information on File for the Member | • Telephone Call Only[1] |

[1] The telephone call must be to either the member or a collateral contact and must be associated with one of the six Health Link activities: comprehensive care management, care coordination, health promotion, transitional care, patient and family support or referral to social supports. The call must also be interactive in that the Health Link must be able to successfully reach the member or collateral contact. Voicemails are not considered interactive.

# One Activity a Month is the MINIMUM for Health Link

- The Bureau of TennCare sets the minimum standard for the service, similar to the minimum contacts for Level 2 Case Management
- There is no requirement that Health Link activities are limited to 1 per member per month
- The Health Link provider determines the number of face-to-face or indirect contacts the member or collateral individual receives each month
- This determination is made based on the needs of the member (medical necessity)

# Billing Requirements vs. What is Best for the Member

- All Health Link organizations are paid on a case rate methodology that is prescribed by the state
- Providing the one activity allows for a claim to be billed which then triggers payment
- The case rate methodology contemplates that the member may need multiple visits during the month

# Health Link Services

- The activities encompass care coordination and patient engagement techniques to help members manage their healthcare across the domains of behavioral and physical health
- This is designed to improve the members' quality outcomes

# What Services Will A Health Link Provide?

**There are 6 types of clinical activities that may be performed to receive an activity payment:**

1) **Comprehensive care management:** Initiate, complete, update, and monitor the progress of a comprehensive person-centered care plan as needed
    - Example: creating care coordination and treatment plans
2) **Care coordination:** Participate in patient's physical health treatment plan, support scheduling and reduce barriers to adherence for medical and behavioral health appointments, facilitate and participate in regular interdisciplinary care team meetings, follow up with PCP, proactive outreach with PCP, and follow up with other behavioral health providers or clinical staff
    - Example: proactive outreach and follow up with primary care and behavioral health providers
3) **Health promotion:** Educate the patient and his/her family
    - Example: educating the patient and his/her family on independent living skills
4) **Transitional care:** Provide support in crisis situations, participate in development of discharge plan for each hospitalization, develop a systemic protocol to assure timely access to follow-up care post discharge, establish relationships, and communicate and provide education
    - Example: participating in the development of discharge plans
5) **Patient and family support:** Provide in-person support, provider caregiver counseling or training, identify resources to assist individuals and family supporters, and check-ins with patient
    - Example: supporting adherence to behavioral and physical health treatment
6) **Referral to social supports:** Identify and facilitate access to community supports, communicate patient needs to community partners, and provide information and assistance in accessing services
    - Example: facilitating access to community supports including scheduling and follow through

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# Health Link activity requirements (1/4)

| | Activity requirements for Health Link providers |
|---|---|
| 1 **Comprehensive care management** | **Initiate, complete, update, and monitor the progress of a comprehensive person-centered care plan (as needed)**, following a comprehensive assessment of the patient's behavioral and physical health needs within 30 days of patient enrollment. The plan should address the patient's behavioral health treatment and care coordination needs, including protocols for treatment adherence and crisis management, incorporating input from:<br>• the patient<br>• the patient's social support<br>• the patient's primary and specialty care providers (within 90 days of enrollment with the Health Home) |
| 2 **Care co-ordination** | **Participate in patient's physical health treatment plan** as developed by their primary care provider, as necessary |
| | **Support scheduling and reduce barriers to adherence for medical and behavioral health appointments**, including in-person accompaniment to some appointments |
| | **Facilitate and participate in regular interdisciplinary care team meetings with PCMH / PCP** |
| | **Follow up with PCP** to understand significant changes in medical status and translate into care plan |
| | **Proactive outreach with PCP** regarding specific gaps in care |
| | **Follow up with other behavioral health providers or clinical staff** as needed to understand additional behavioral health needs, and translate into care plan |

# Health Link activity requirements (2/4)

| | Activity requirements for Health Link providers |
|---|---|
| 3 **Referral to social supports** | **Identify and facilitate access to community supports** (food, shelter, clothing, employment, legal, entitlements, and all other resources that would reduce barriers to help individuals in achieving their highest level of function and independence), including by providing referrals, scheduling appointments, and following up with the patient, their relevant caregivers, and these community supports |
| | **Communicate patient needs to community partners** |
| | **Provide information and assistance in accessing services** such as: self-help services, peer support services; and respite services. |
| 4 **Patient and family support** | **Provide in-person support** to ensure treatment and medication adherence (including medication reconciliation, medication management for specialty medications, medication drop-off, help arranging transportation to appointments) |
| | **Provide caregiver counseling or training** to include, skills to provide specific treatment regimens to help the individual improve function, obtain information about the individual's disability or conditions, and navigation of the service system. |
| | **Identify resources to assist individuals and family supporters** in acquiring, retaining, and improving self-help, socialization and adaptive skills. |
| | **Check-ins with patient** to support treatment adherence |

# Health Link activity requirements (3/4)

## Activity requirements for Health Link providers

**5 Transitional care**

**Provide support in crisis situations** when other resources are unavailable, or as an alternative to ED / crisis services

**Participate in development of discharge plan for each hospitalization**, beginning at admission to support patient's transition. This includes emergency rooms, inpatient residential, rehabilitative, and other treatment settings

**Develop a systemic protocol to assure timely access to follow-up care post discharge** that includes at a minimum all of the following:

- Receipt of a summary of care record from the discharging entity
- Medication reconciliation
- Reevaluation of the care plan to include and provide access to needed community support services
- A plan to ensure timely scheduled appointments

**Establish relationships** with hospitals, residential settings, rehabilitation settings, other treatment settings, and long term services and supports providers to promote a smooth transition if the patient is moving between levels of care and back into the community

**Communicate and provide education** to the patient, the patient's supporters, and the providers that are located at the setting from which the person is transitioning, and at the setting to which the individual is transitioning

**6 Health promotion**

**Educate the patient and his/her family** on independent living skills with attainable and increasingly aspirational goals

# Health Home activity requirements (4/4)

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**Population health management**

**Activity requirements for Health Link providers**

**Track and make improvements based on quality outcomes** distributed in reports from MCOs

**Identify highest risk patients on a continuous basis,** supported by the Care Coordination Tool, and align with organization to focus resources and interventions

**Meet CMS e-prescribing requirements**[1]

**Participate in practice transformation training and learning collaboratives** at which best practice on a variety of topics, including health promotion, will be disseminated

**Receive ADT notifications** for the patient and continue ongoing use of the Care Coordination Tool

1 Activity requirement comes into effect in Year 2 of the program

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# THANK YOU

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