Division of Health Care Finance & Administration

STATE OF TENNESSEE

Tennessee Health Link: Practice Transformation Training

12/14/2016

Agenda

- Overview of Tennessee Health Link
- Partnership between HCFA, MCOs, Navigant and Practices
- Introduction to Navigant
- Philosophy and Approach to Health Link Assessments and Practice Transformation Coaching
- Key Milestones and Schedule
- Questions and Answers

2

Tennessee Health Link

Tennessee Health Link Went Live on December 1, 2016

Tennessee Health Link will coordinate health care services for TennCare members with the highest behavioral health needs. Health Link is meant to produce improved member outcomes, greater provider accountability and flexibility when it comes to the delivery of appropriate care for each individual, and improved cost control for the state.

Health Link providers are encouraged to ensure the best care setting for each member, offer expanded access to care, improve treatment adherence, and reduce hospital admissions. The program is built to encourage the integration of physical and behavioral health, as well as, mental health recovery, giving every member a chance to reach his or her full potential for living a rewarding and increasingly independent life in the community.

TN

3

Primary Care Transformation: Tennessee Health Link Overview

Members in this program	▪ Designed for TennCare members with the highest behavioral health needs (estimated 90,000 people)
Participating providers	▪ Providers able to treat members with the highest behavioral health needs (including Community Mental Health Centers, FQHCs, and others) ▪ 21 practices statewide, additional practices may be added each year ▪ Launched December 1, 2016
Payment to providers	▪ **Activity payment**: Transition rate of $200 as a monthly activity payment per member to support care and staffing for the first 7 months. Stabilization rate of $139 as a monthly activity payment per member begins 7/1/17 for additional 12 months. Recurring rate TBD will begin in 2018. ▪ **Outcome payment**: Annual bonus payment available to high performing Health Links based on quality and efficiency outcomes.
Other resources to providers	▪ **Navigant** will provide training and technical assistance for each site while also facilitating collaboration between providers. They will create custom curriculum and offer on-site training sessions. ▪ **Quarterly provider reports** will include cost and quality data aggregated at the practice level. Each MCO will send reports to participating providers. ▪ **Care Coordination Tool** will help Health Link practices to provide better care coordination. The tool is designed to offer gap in care alerts, ER and inpatient admission hospital alerts, and prospective risk scores for a provider's attributed members.

TN

4

Key differences between current Level 2 Case Management and new Tennessee Health Link reimbursement model

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

TN

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

5

Health Link Identification Criteria

	Identification criteria
Category 1: Diagnostic criteria only	**A new or existing diagnosis or code of:** • Attempted suicide or self-injury • Bipolar disorder • Homicidal ideation • Schizophrenia
or	
Category 2: Diagnostic and utilization criteria	**One or more behavioral health-related (a) inpatient admissions or (b) crisis stabilization unit admissions (18 or over), ED admissions (under 18), or residential treatment facility admissions; WITH a diagnosis of:** • 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 • PTSD • Somatoform disorders • Substance use • Other / unspecified
or	
Category 3: Functional need	**Up to 12/1/16: Receipt of 2 or more Level 2 Case Management (L2CM) services** **After 12/1/16: Provider documentation of functional need, to be attested to by the provider.[1]**

TN

[1]Note: Functional need is defined as aligning with what the State of Tennessee has set out as the new Level 2 Case Management medical necessity criteria, effective March 1, 2016 for adults and April 1, 2016 for children. The look-back period for Category 1 and Category 3 identification criteria is April 1, 2016. The look-back period for Category 2 identification criteria is July 1, 2016.

6

Overview of support available to providers

Unchanged mechanism
Redesigned mechanism
New mechanism

		Objective	Support	Categories of support
Existing payments	Fee for Service Payment	• No change to existing reimbursement process	• Payments tied to discrete care services rendered	The following services remain paid through Fee for Service: • Evaluation & management services • Medication management • Therapy services • Psychiatric & psychosocial rehabilitation services • Level 1 Case Management
Health Link payments	Activity Payment	• Compensate for clinical activities performed by Health Link providers	• Monthly activity payment	• The 6 billable service areas consist of: ▫ Comprehensive care management ▫ Care coordination ▫ Referral to social supports ▫ Patient and family support ▫ Transitional care ▫ Health promotion
	Outcome Payment	• Encourage improvements in quality and efficiency	• Incentive payment based on outcome measures	• Performance measured against a combination of quality and efficiency metrics to determine the amount of the outcome payment
Support	Practice Transfor-mation Support	• Support initial investment in provider changes including infrastructure and personnel	• Support delivered by Navigant	• Includes in-person coaching, webinars, and learning collaboratives

TN

7

Health Link Quality Metrics

1. **7- and 30-day psychiatric hospital / RTF readmission rate**
   - 7-day
   - 30-day
2. **Antidepressant medication management**
   - Acute phase treatment
   - Continuation phase treatment
3. **Follow-up after hospitalization for mental illness within 7 and 30 days**
   - 7-days
   - 30-days
4. **Initiation/engagement of alcohol and drug dependence treatment**
   - Initiation
   - Engagement
5. **Use of multiple concurrent antipsychotics in children/adolescents**
6. **BMI and weight composite metric**
   - Adult BMI screening
   - BMI percentile (children and adolescents only)
   - Counseling for nutrition (children and adolescents only)
7. **Comprehensive diabetes care (Composite 1)**
   - Diabetes eye exam
   - Diabetes BP < 140/90
   - Diabetes nephropathy
8. **Comprehensive diabetes care (Composite 2)**
   - Diabetes HbA1c testing
   - Diabetes HbA1c poor control (> 9%)
9. **EPSDT: Well-child visits ages 7-11 years**
10. **EPSDT: Adolescent well-care visits age 12-21**

Health Link Efficiency Metrics

1. All-cause hospital readmissions rate
2. Ambulatory care - ED visits
3. Inpatient admissions– Total inpatient
4. Mental health utilization- Inpatient
5. Rate of inpatient psychiatric admissions

TN

8

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 member'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 member and his/her family
   - Example: educating the member and his/her family on independent living skills

4) **Transitional care:** Provide additional high touch 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) **Member and family support:** Provide high-touch in-person support, provider caregiver counseling or training, identify resources to assist individuals and family supporters, and check-ins with member
   - Example: supporting adherence to behavioral and physical health treatment

6) **Referral to social supports:** Identify and facilitate access to community supports, communicate member needs to community partners, and provide information and assistance in accessing services
   - Example: facilitating access to community supports including scheduling and follow through

TN

9

Tennessee Health Link Organizations

- **21 provider groups are participating in Health Link**

Alliance Healthcare Services
Camelot Care Centers
CareMore Medical Group of Tennessee
Carey Counseling Center
Case Management
Centerstone
Cherokee Health Systems
Frontier Health
Generations Health Association
Health Connect America
Helen Ross McNabb Center
LifeCare Family Services
Mental Health Cooperative
Omni Community Health
Pathways of Tennessee
Peninsula
Professional Care Services of West TN
Quinco Community Mental Health Center
Ridgeview Behavioral Health Services
Unity Management Services
Volunteer Behavioral Health Care System

TN

10

TN

11

Navigant's Team

NAVIGANT

Community Care of North Carolina

Unity Physician Partners, Inc.

- Multi-Payer Medical Homes
- Health Homes
- Healthcare Delivery Transformation
- Stakeholder Engagement
- Tennessee's Healthcare Environment

TN

12

Navigant's Team

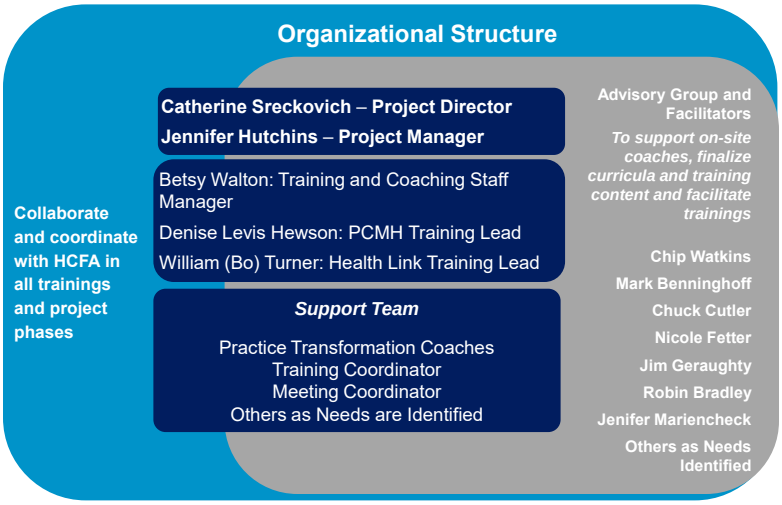
Our team members have supported a variety of states, federal agencies and other entities with design, development and implementation of medical homes, health homes and other physical and behavioral health initiatives.

- Alabama
- Hawaii
- Illinois
- Iowa
- North Carolina
- Tennessee
- CMS Multi-payer Advanced Primary Care Practice
- CMS Comprehensive Primary Care Initiative
- Payers
- Providers

TN

13

Navigant's Team



TN

14

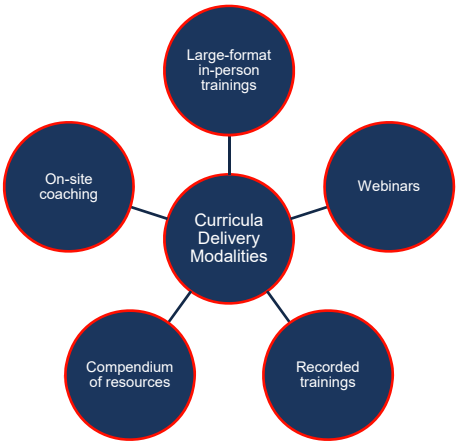
Transformation, Technical Assistance and Training

- Contracted through January 2020 to provide technical assistance and training to practices participating in Health Link.
- Will conduct the following activities:
  - Practice outreach
  - Initial and semi-annual assessments
  - Trainings using various modalities

TN

15

Training and Technical Assistance Modalities



TN

16

Anticipated Timeline and Events: Initial Assessments

TN

17

Philosophy and Approach: Initial Assessments

- Contact practice's Health Link Administrator
  - Discuss assessment intent and approach and schedule onsite assessment
  - Discuss need for multiple meetings for practices with large number of sites
- Recommend all "Core Assessment Team" members attend full meeting
- "Core Assessment Team" comprised of the following practice staff:
  - Medical Director
  - Practice Manager
  - Health Link Administrator
  - Quality Improvement Director
  - Finance Manager
  - IT Support Lead
  - Care Coordinator/Care Manager
  - Office Staff Representative
  - Site Representatives
- One to two Navigant team members will attend the onsite assessment
- HCFA team members will attend as schedules allow
- Use an Assessment Tool to facilitate discussion with Core Assessment Team

TN

18

Philosophy and Approach: Initial Assessments

- Estimate each onsite assessment will require 2-3 hours
- Conduct at the practice level to determine current capabilities
- Some practices and sites are further along in transformation than others
- Use findings as baseline to determine level and frequency of recommended support
  - Generate information on topics for:
    - Individual practice needs for coaching and support
    - Webinars
    - Collaboratives
    - Topics for large conferences
  - Form the baseline for monitoring performance improvement and progress at the practice, region and state levels

TN

19

Assessment Report Example

Health Link Initial Assessment Report

Scoring
Low
Medium
High
Perfect

Access

	Your Answer	Region Answer Totals
Is the practice able to provide same-day appointments?		15 / 15 / 18 / 2
Does the practice support scheduling and reducing barriers to adherence for medical and behavioral health appointments?		15 / 25 / 8 / 2
Is the practice able to provide routine and urgent care appointments outside regular business hours?		15 / 20 / 10 / 5

Health Promotion and Self-Management

	Your Answer	Region Answer Totals
Does the practice educate the patient and his/her family on independent living skills with attainable and increasingly aspirational goals?		3 / 32 / 10 / 5
Does the practice provide educational resources, tracking tools and decision-making aids for self-management support?		10 / 20 / 15 / 5

TN

20

Philosophy and Approach: Coaching

- Each practice site is eligible for up to one two-hour onsite coaching session per month for two years
- Frequency to be determined based on initial assessment and agreement with practice leaders
- Individualized curricula to be developed to focus on practice site needs
- One coach will be assigned to support designated sites

TN

21

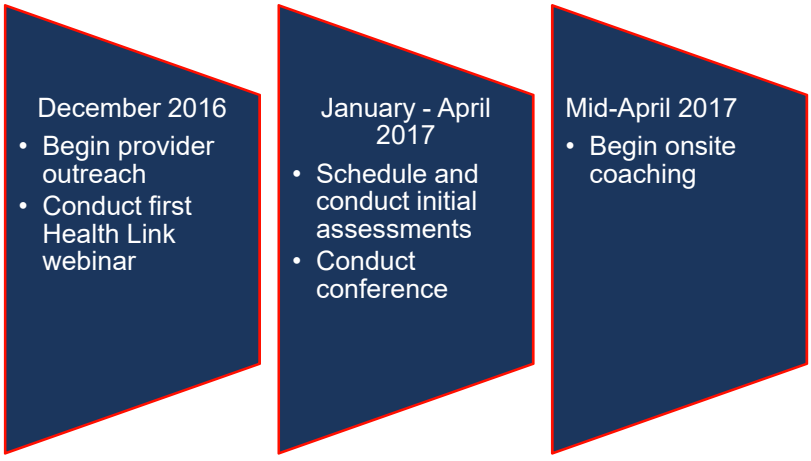
Philosophy and Approach: Semi-Annual Assessments

- Conduct semi-annual assessments as more formal checkpoints than ongoing coaching sessions
- Use results to determine progress to date
- Based on progress, evaluate need for any changes to coaching or for corrective actions
- Develop findings reports

TN

22

Upcoming Milestones



TN

23

TN Division of Health Care Finance & Administration

THANK YOU