ICRC | Integrated Care Resource Center

Key Questions and Considerations for States Implementing New D-SNP Information-Sharing Requirements

December 16, 2019

2:30-3:30 pm Eastern

The Integrated Care Resource Center, an initiative of the Centers for Medicare & Medicaid Services' Medicare-Medicaid Coordination Office, provides technical assistance for states coordinated by Mathematica Policy Research and the Center for Health Care Strategies.

Speakers

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Agenda

- **Introduction**
  - Background on new D-SNP information-sharing requirements
- **Implementing New Requirements**
  - State approaches to information-sharing around hospital and SNF admissions
  - Questions to consider regarding modifying state contracts
- **Plan-to-Plan Information Sharing**
  - View through state lens
  - View from plan perspective
- **Early Insights from Information-Sharing Development**
- **Questions and Discussion**

Introduction

Bipartisan Budget Act of 2018

- The Act includes several provisions that impact D-SNPs and Medicare-Medicaid alignment
  - Permanently authorizes MA SNPs, including D-SNPs, Chronic Condition SNPs (C-SNPs), and Institutional SNPs (I-SNPs)
  - Requires increased integration of D-SNP benefits and appeals and grievance processes
  - Requires that CMS establish new minimum integration standards
  - Designates MMCO as the dedicated state point of contact to address D-SNP integration misalignments

Source: Bipartisan Budget Act of 2018 (P.L. 115-123). Section 50311: Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations. Available at: https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

New Integration Criteria for D-SNPs

- D-SNPs must meet at least one of the following criteria effective CY 2021
  1) Cover Medicaid behavioral health services and/or LTSS to qualify as either:
     - A Fully Integrated Dual Eligible (FIDE) SNP, or
     - A Highly Integrated Dual Eligible (HIDE) SNP
  2) Notify state and/or its designee(s) of Medicare hospital and skilled nursing facility (SNF) admissions for group of high-risk enrollees to improve coordination during transitions of care
- States will need to work with D-SNPs on new contract provisions ahead of the July 1, 2020 state contract submission deadline

Source: CMS. "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021." *Federal Register*, April 16, 2019, pp.15710-15718 and *42 CFR 422.107(d))* p. 15828. Available at: https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf

Implementing New Information Sharing Requirements

Hospital and SNF Admission Notification Requirement

- **Goal:** Improve coordination of Medicare and Medicaid services between settings of care for at least one group of high-risk full-benefit dual eligible individuals
  - D-SNPs (or a designated entity) must notify the state (and/or individuals/entities designated by the state)
  - State determines:
    - Who is "high risk"
    - Who will be notified
    - The timeframe for the notification
    - The notification method
- Requirement does not apply if D-SNP is a HIDE or FIDE SNP

Source: 42 CFR §422.107(d), as amended by the Final Rule entitled "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021," published at 84 FR 15828.

State Information Sharing Examples

Parameter	Tennessee	Pennsylvania	Oregon
Target Population	D-SNP FBDE enrollees, in both affiliated and unaffiliated D-SNPs		
Entity Notified	TennCare MCO	Community Health Choices-MCO service coordination staff	Medicaid MCO or state care management (CM) staff and providers
Timeframe for Notification	Within 2 business day of the "anchor date"[1]	Within 48 hours of specified events	Timely
Notification Method	Daily reports via state-developed portal	D-SNP to Medicaid MCOs/MLTSS plans	Event notification system (ENS) and web portal
Linkage to LTSS Goals or HCBS Waiver Operations	MCOs work with D-SNP to facilitate timely HCBS, and ensure services are provided in the preferred and least restrictive setting	Linked to MLTSS requirements for timely post-discharge re-assessment/care plan updates and NF transitions	State pays subscription for HCBS waiver care management agencies alerts and populates web portal with HCBS contacts

Additional details on state approaches can be found in, "Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations." ICRC, August 2019.

[1] TennCare defines the anchor date as, "The date of receipt of notification by the Contractor of upcoming (i.e., planned) or current inpatient admissions and current or recently completed observation days or emergency department visits. The anchor date is not included in the calculation of days within which the Contractor is required to take action."

Key Questions for States

Parameter	Key Questions
D-SNP Landscape	• Which D-SNPs are operating in the state and will they all be required to share admissions data with the state effective January 2021? • Which high-risk Medicaid beneficiaries are enrolled in D-SNPs?
High-Risk Population and Receiving Entities	• Which group(s) of high-risk FBDE beneficiaries would benefit? • What entity(ies) will receive the admission notifications to support care coordination? • Can Medicaid care management (CM) resources (i.e., HCBS waiver care managers, local CM agencies, or MCOs) act on data received for this group? • What mechanism will be used by D-SNPs to identify target enrollees in the high risk group?
Timeframe for Notification	• What are reasonable timeliness standards, given the selected notification method(s) and information technology capacities of the state's D-SNPs, hospitals, and SNF industry?
Notification Method	• What mechanisms are available in the state for notification? Are there notification systems, portals, or file exchange processes already in place that can be leveraged? • What can the state and/or D-SNPs do to support real-time, HIE based alerts and hospital and SNF participation?
Contracting and Oversight	• What contract language needs to be added to the state D-SNP contracts? • How will the state work with D-SNPs and receiving entities to establish new processes? • How can the state monitor any impacts of admission data sharing on Medicaid and D-SNP care transition efforts?

For details see: "Information Sharing to Improve Care Coordination for High-Risk Dual Eligible Special Needs Plan Enrollees: Key Questions for State Implementation."

Recent ICRC Resources for States

- **WEBINAR** (July 2019) – *Update on State Contracting with D-SNPs: The Basics and Meeting New Federal Requirements for 2021:* https://www.integratedcareresourcecenter.com/webinar/update-state-contracting-d-snps-basics-and-meeting-new-federal-requirements-2021
  - See slides 20 and 29-40 for content on data sharing and new requirements
- **TA TOOL** (September 2019) – *Information Sharing to Improve Care Coordination for High-Risk Dual Eligible Special Needs Plan Enrollees: Key Questions for State Implementation*: https://www.integratedcareresourcecenter.com/resource/information-sharing-improve-care-coordination-high-risk-dual-eligible-special-needs-plan
- **ISSUE BRIEF** (August 2019) – *Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations:* https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_InfoSharing_HospitalSNF.pdf
- **TA TOOL** (November 2019) – *Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans:* https://www.integratedcareresourcecenter.com/resource/sample-language-state-medicaid-agency-contracts-dual-eligible-special-needs-plans
- **TA TOOL** (December 2019) – *State Options and Considerations for Sharing Medicaid Enrollment and Service Use Information with D-SNPs: https://www.integratedcareresourcecenter.com/resource/state-options-and-considerations-sharing-medicaid-enrollment-and-service-use-information-d*

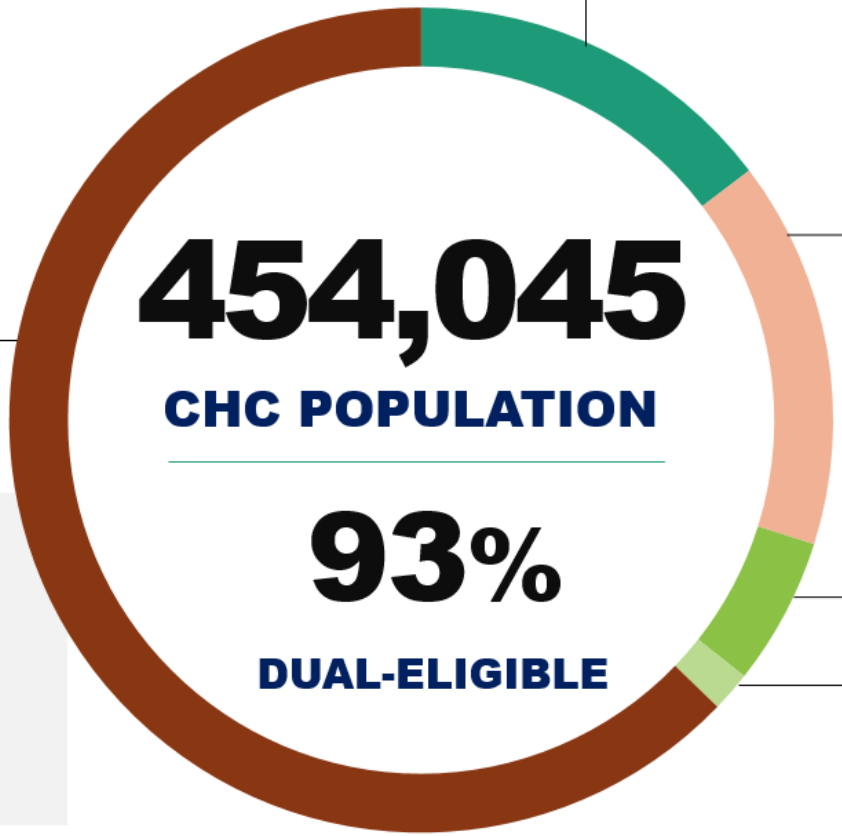
Key Implementation Dates

- **November 2019:** Notice of intent to apply (NOIA) from new or expanding D-SNP applicants due to CMS for CY 2021
  - States can ask D-SNPs for copies of these
- **June 2020:** MA organizations submit bid and plan benefit package for the upcoming year
- **July 1, 2020:** MA organizations submit signed state Medicaid agency D-SNP contracts to CMS
  - D-SNP contracts must either document Medicaid benefit integration that meets HIDE or FIDE bar, or a hospital and SNF admission notification process for a group of high-risk D-SNP enrollees that will be in place for CY 2021
- **January 1, 2021:** New integration standards must be in place

Plan-to-Plan Information Sharing: View through the State Lens

Wilmarie Gonzalez and Dr. Larry Appel,
Office of Long Term Living,
Pennsylvania Department of Human Services

Pennsylvania's MLTSS Program—Population



15%
66,561
Duals in Waivers

63%
285,018
Nursing Facility Ineligible Duals

20%
IN WAIVERS
17%
IN NURSING FACILITIES

15%
69,036
Duals in Nursing Facilities

6%
26,293
Non-duals in Waivers

2%
7,137
Non-duals in Nursing Facilities

Community HealthChoices

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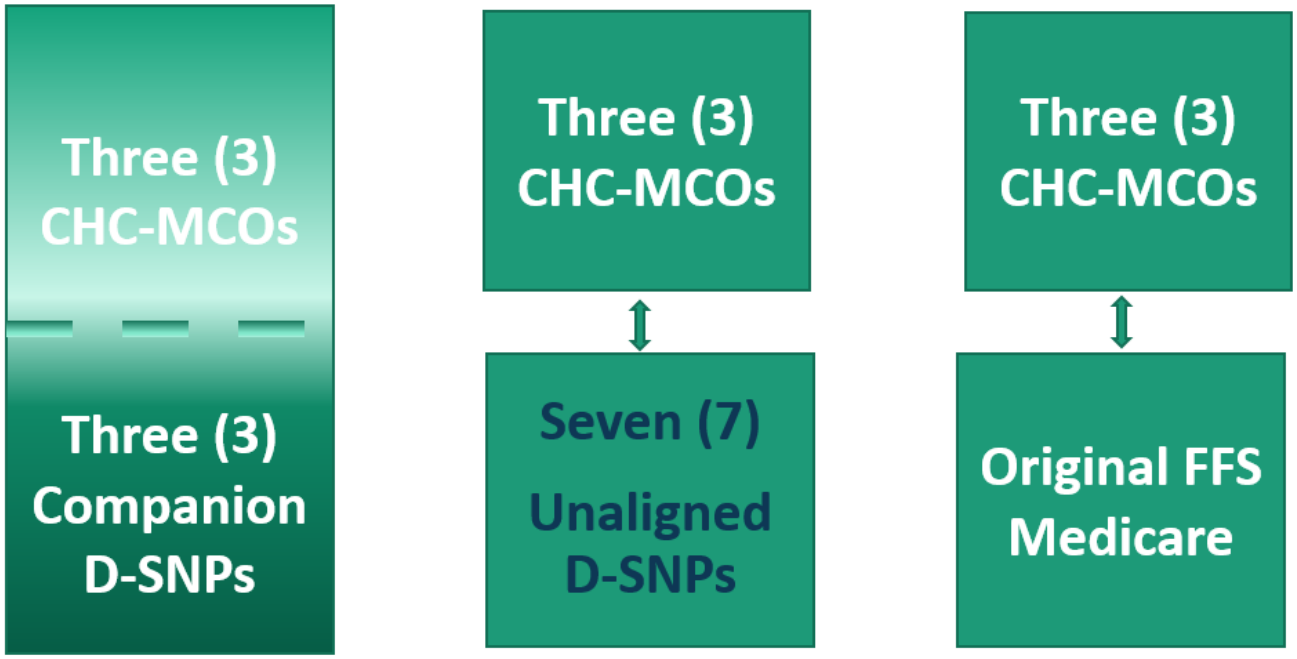
Pennsylvania's Approach to MLTSS and D-SNP Contracting



Community HealthChoices

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Data Sharing and Care Transition Requirements

MIPPA Agreement (D-SNPs)

- Must coordinate with CHC & BH-MCOs and notify within 48-hrs of hospitalization
- Notify CHC-MCOs and BH-MCOs within 48-hrs of hospitalization
- Mandatory Health Information Organization (HIO)*

CHC Agreement (CHC-MCOs)

- Must coordinate with Medicare plans and providers and BH-MCOs
- Must conduct coordinated PIPs: 1) transitioning enrollees in SNF to the community and (2) strengthening care coordination
- Mandatory HIO

Coordinated Care

Data Integration

- Plans develop data sharing agreements
- HIO Utilization
- Medicaid encounters (CHC and BH-MCOs)
- TRC Transition of care measure

Oversight

- CHC-MCO & MIPPA Monitoring Teams
- Established Quarterly Meetings between CHC-MCOs, D-SNPs (10 plans), and BH-MCOs Plans are required

Community HealthChoices

*Health Information Organization (HIO) is a Pennsylvania term for regional health information exchange entities.

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Working with Plans to Implement Data Sharing

Establishing D-SNP Meetings to Promote Collaboration	
Goal	Enhance care coordination and SNF transition
State Role	Facilitate discussions between the plans to develop elements for data exchange (MLTSS, BHs, D-SNPs)
Considerations or Lessons	• Empower plans to work together to establish mutually agreed data elements. • Allow plans to present case studies and lessons learned at meetings. • Acknowledge and work with state regulatory barriers that were present.

Working with Plans to Implement Data Sharing

Establishing Data Sharing Agreements	
Goal	Uniform and rapid information exchange between the plans
State Role	• Leverage both the MLTSS Agreement and MIPPA Contract • Outline data sharing vision and approach
Considerations or Lessons	• Recognize that plans are competitors and may have reluctancy to share information. • Not all plans are the same with regards to technology. • Level the field by allowing plans to share challenges and/or barriers with the state and work together to solve issues.

Working with Plans to Implement Data Sharing

Implementation of Data Sharing Agreements	
Goal	Uniform and rapid information exchange between the plans.
State Role	• Present vision for information sharing involving data sharing agreements as a precedent for HIE utilization. • Foster agreements between the plans by reporting out on progress at quarterly meetings, follow up individual phone calls. • Mandatory HIO* participation.
Considerations or Lessons	• Monitor all plans' progress related to Data Sharing Agreements • Demonstrate the value of HIO participation, data sharing, care coordination. • Engage plans in presenting successful coordination cases.

*Health Information Organization (HIO) is a Pennsylvania term for regional health information exchange entities.

PA HIO Informational Flow

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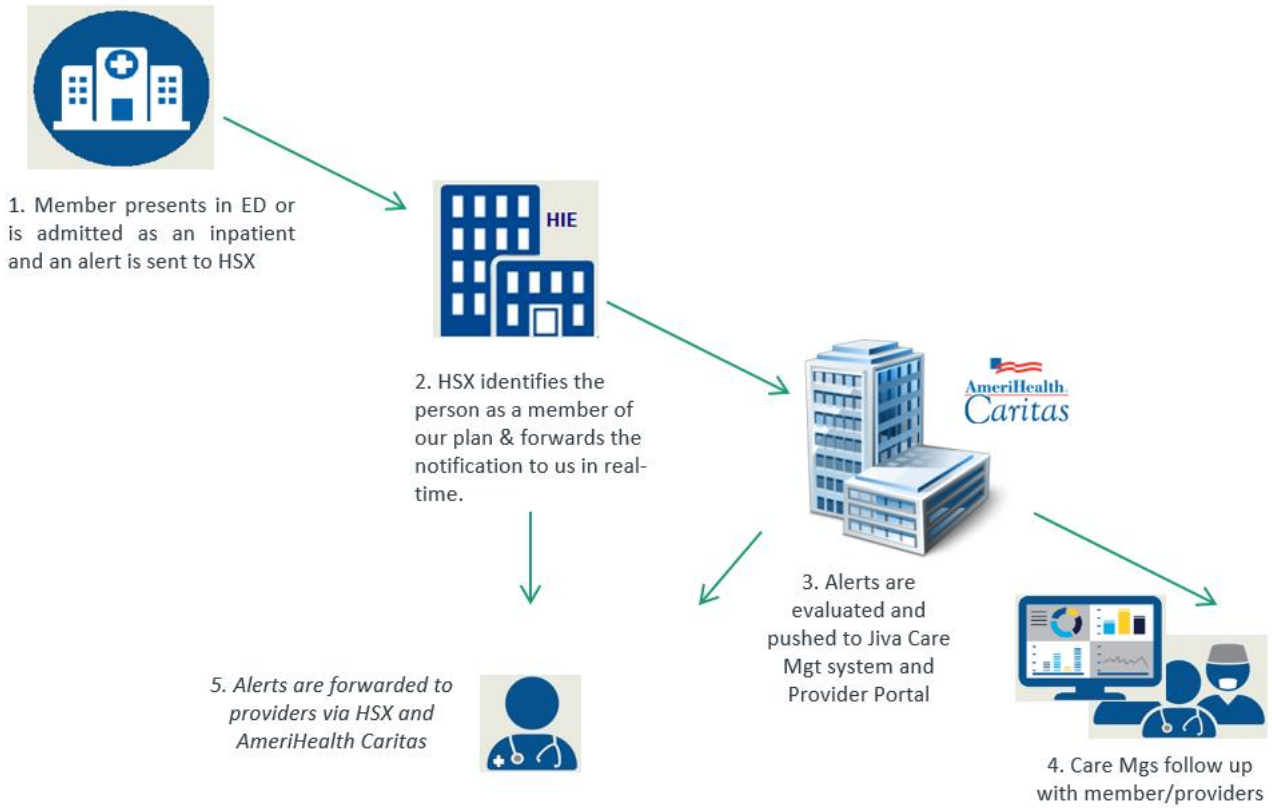
ADT Notification and Coordinated Care Management



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Plan-to-Plan Information Sharing: Lessons and Opportunities

Anthony Davis and Michael Smith, UPMC Health Plan

UPMC LIFE CHANGING MEDICINE

Data Sharing with D-SNPs

Data Sharing Agreements

- All PA D-SNPs required to share data on Community HealthChoices (CHC) members
- Sharing data requires signed contracts, which was the first hurdle to overcome. As of Dec 2019, UPMC has signed contracts with all other PA D-SNP health plans
- A standardized template for the fields of information to be shared was developed by the health plans
- Next step is implementation of sharing data:
  - Integrating data into current systems
  - Daily automated reporting and notifications

Initial Data Exchange Fields

- MEDICAID_ID
- MBI
- RECIPIENT_ID
- MEMBER LAST NAME
- MEMBER FIRST NAME
- DOB
- STATUS
- FACILITY_NAME
- FACILITY_TAX_ID
- FACILITY_NPI
- MEMBER_PCP_FNAME
- MEMBER_PCP_LNAME
- PCP_NPI
- ADMITTING_MD_FNAME
- ADMITTING_MD_LNAME
- ADMITTING_MD NPI
- ADMIT_TYPE
- DISCHARGE_DISPOSITION
- ADMIT_DT
- DSCHRG_DT
- DISCHRG_DX
- ADMIT_DX
- CHC_PLAN_CD

UPMC LIFE CHANGING MEDICINE

HIE Current State: Benefits and Limitations

- **UPMC will have ADT alerting available from CCHIE in early part of 2020**
  - Ability to have real time 'event based' information supports collaborative care for individuals
  - Allowing all disciplines to be involved in discharge planning increases the success rate
  - Modifying contracts with HIEs to exchange information from various payors and provide admissions, discharges, transfer notifications
- **Some current HIE limitations include:**
  - HIEs do not directly communicate and must pass through the States P3N HIE Connector system for information
  - Plans cannot directly pull data from the P3N (must go through a regional HIE)
  - Nursing Facility Data mostly missing in many data feeds and HIE models

Command Team Approach

Application of the data available leads to improved care coordination:

- Structured care management aligning all disciplines of support: clinical physical, behavioral and functional health needs along with pharmacy and social determinants
- Service coordination assesses and arranges LTSS in the home and provides observations that informs the data review processes and structured care management providing opportunity for timely adjustments to services
- Supported by real time, event based data and historical intelligence to guide decision collaborating specific needs
- Early program evaluation short term of 6 months post intervention demonstrated a 30% decrease in utilization compared to the pre-intervention span

Developing a New Information Sharing Approach: Early Insights

Katherine Rogers, Department of Health Care Finance, District of Columbia Government

District of Columbia

2020 State Medicaid Agency D-SNP Requirement for Data Sharing

Coordination of Health Care Services Agreement, pp. 4-7

- *Section 3.2 – Coordination of Health Care Services*
  (D-SNP) and DHCF shall work in collaboration to develop the following care coordination activities for which (D-SNP) will be responsible for implementation:
  - *3.2.2.3 Utilization Triggers: Providing timely notification to a member's Health Home, EPD waiver case manager, or other primary provider within a designated timeframe for all planned and unplanned inpatient admissions to the hospital, SNF, and emergency department visits, facilitated by health information technology or the DC Health Information Exchange (HIE) as appropriate.*

- *3.2.9 Reporting: D-SNP shall submit to DHCF on a quarterly or annual basis, as indicated below, reports and data regarding the following:*
  - *3.2.9.6. Utilization triggers (for example, hospital admissions or emergency department visits) to include protocols for using and transmitting to providers any utilization trigger data and trends in key triggering evens over time (quarterly).*

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Question & Answer

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About ICRC

- Established by CMS to advance integrated care models for dually eligible beneficiaries
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- Send other ICRC questions to: integratedcareresourcecenter@chcs.org