D-SNP Performance Monitoring and Oversight: State Experiences and CMS Resources

April 18, 2019
3:00-4:00 pm Eastern
Welcome and Introductions

• Danielle Chelminsky, Integrated Care Resource Center
• Jennifer Valentine, Oregon Health Authority
• Patti Killingsworth, TennCare
• Jamie O’Neal, TennCare
• Elizabeth Wood, Integrated Care Resource Center
Agenda

• **D-SNP Oversight:** Introduction and overview

• **State Experiences:** How three states with different program structures have designed and implemented oversight of D-SNPs
  - Oregon – D-SNPs but no Medicaid managed LTSS plans
  - Tennessee – A mix of D-SNPs and FIDE SNPs
  - New Jersey – All FIDE SNPs

• **Monitoring and Performance Resources:** Overview of publicly available CMS resources on D-SNP performance

• **Facilitated Discussion & Audience Q&A**
State Example: Oregon’s Experience with D-SNP Reporting Requirements

Jennifer Valentine  
Oregon Health Authority
Oregon: D-SNP Reporting Overview

History of OR D-SNPs:
• Began offering D-SNPs in 2007. 8 initial plans, 3 departed and 1 new.
• 6 D-SNP contracts with 21,560 enrollees as of Feb 2019. OR Medicaid does not include LTSS in capitated managed care.
• Established Coordinated Care Organizations (CCOs) in 2012, focusing on coordinating care between providers.

Began adding New Reporting Elements into 2016-2017 D-SNP COBA contracts:
• Purpose: Gain a better understanding of the quality of care, health outcomes, and care coordination processes for dual eligible beneficiaries enrolled in Oregon D-SNPs.
• Goals:
  – Develop a picture of how the Oregon D-SNPs uniquely impact care processes, identify health risks for vulnerable subpopulations of dual eligible beneficiaries, share successes of D-SNP work to address care coordination and care transitions, and highlight impacts on health care quality and outcomes.
  – Create a statewide look at benefits of Oregon D-SNPs with all plans submitting comparable report data.
Oregon: Required Reporting Elements*

Reports due AFTER Star metric data review i.e., completed 2017 -- report due Nov 2018.

1. Demographics on D-SNP Population Served: Summary demographics of D-SNP beneficiaries served by plan and total number of chronic/behavioral health conditions and stratify by: original reason for Medicare, gender, race/ethnicity, age.

2. Narrative Reporting:
   - Summary narrative of unique benefits and care coordination through the D-SNP (we enhanced care coordination expectations & aligned with updated MCE rules in contract).
   - Care Coordination: Notifications Policy Narrative Submission (for new requirements added in 2016-17 regarding notifications).
   - Written Description of Coordination with LTSS.

3. Measures to Report Quality and Care Outcomes: D-SNP Measure Metrics, MA Measure Metrics (stratified by DSNP population only), CCO and State Performance Metrics (stratified by DSNP population in each CCO)

* There is more detail on these reporting requirements in the appendix.

HEALTH SYSTEMS DIVISION
State Example:

Tennessee Experience with D-SNP Monitoring and Oversight

Patti Killingsworth and Jamie O’Neal

TennCare
Tennessee:

- History of TN D-SNPs:
  - Began offering D-SNPs in 2006
  - MIPPA contracts began in 2010
  - Statewide Medicaid MCOs (including mandatory MLTSS) required to offer aligned D-SNPs since 2015
    - No new MIPPA contracting for unaligned plans
  - As of 2019, 3 aligned D-SNP contracts and 3 “legacy” unaligned D-SNP contracts with 106,851 enrollees (67,051 FBDEs) as of Feb 2019—1 contract includes a FIDE SNP and a FIDE-“Like” SNP
  - All 3 aligned D-SNPs approved for default enrollment beginning in 2015, 2016, 2017
    - 66% increase in FBDE enrollment in D-SNPs since Dec 2013
    - 77% increase in FBDE enrollment in aligned D-SNPs
Tennessee (cont):

- **Performance Monitoring and Reporting Overview:**
  - Evolved over time
  - “Real Time”/Ongoing
    - Care Coordination Reports to Medicaid MCOs
      - Within 2 business days
      - Inpatient admissions (planned and unplanned, hospital or SNF), observation days, ED visits
    - Electronic Crossover Claims Files and Comprehensive Encounter Reporting
      - At least weekly or within 2 business days of completion of payment cycle
      - Meets state and federal data quality standards
    - Provider agreement templates, unique provider agreements, provider manuals/handbooks and amendments to the Tennessee Department of Commerce and Insurance (TDCI) TennCare Oversight Division
Tennessee (cont):

- **Performance Monitoring and Reporting Overview:**
  - Quarterly Monitoring Reports
    - MIPPA Coordination Report
      - Inpatient admissions, disposition of the admission, readmissions, discharge notifications, BH/Psychiatric Hospital stays, and referrals both received and sent to all DSNP plans
  - Provider Enrollment File
  - Appeals
    - Total # of appeals (medical and pharmacy), # fully or partially favorable, withdrawn, dismissed, and revised decisions for any reason
  - Grievances
    - Total # of grievances by program, timely notification, expedited review, timely decisions, dismissed grievances, and type of grievance (medical and pharmacy)
  - Default Enrollment (aligned plans only)
    - Individual identified by the plan through state file and identified as eligible by CMS, # noticed at least 60 days prior to enrollment, # enrolled outside of default process, opt outs prior and post enrollment, complaints, and continuity of providers at transition
Tennessee (cont):

- **Performance Monitoring and Reporting Overview:**
  - Annual Monitoring Reports
    - HEDIS
    - CAHPS
  - Upon Request
    - Medicare Advantage Star Quality ratings, including poor performing icons, notices of non-compliance, audit findings and corrective action plans
  - DNPs must conduct quality improvement activities as requested by TennCare based on performance or opportunities for improved quality and cost efficiency
  - All reports subject to audit
  - Readmission Audit twice per calendar year
    - Appropriate discharge planning, contacts, education, referral, follow up
**Tennessee (cont):**

- **Performance Monitoring and Reporting Overview:**
  - Additional Requirements for FIDE SNP
    - Quality outcomes measures including:
      - Reduction in avoidable inpatient (hospital/SNF) admissions/readmissions
      - Reduction in Emergency Department utilization
      - Reduction in inappropriate use of antipsychotic medications
      - Increased use of primary and preventive care
      - Increased use of Medicaid HCBS (versus institutional care)
      - Improved performance in specified HEDIS measures and in beneficiary satisfaction and quality of life
    - Additional baseline measures for I/DD FIDE-“Like” Plan, including competitive integrated employment, behavioral health utilization, psychiatric inpatient admissions/readmissions
  - Opportunities for national consensus around standard baseline measure reporting to demonstrate the value of alignment
Operational Oversight of D-SNPs by State Medicaid Agencies: Some Lessons from New Jersey

Elizabeth Wood, Integrated Care Resource Center
D-SNP Oversight is Different

- Oversight of D-SNPs is a shared, but largely uncoordinated function, between federal oversight of Medicare managed care (Medicare Advantage (MA) and Part D health plans) and state oversight of Medicaid managed care.

- The Medicare-Medicaid intersection is a distinct regulatory landscape that is related to, but different than, Medicare or Medicaid.
Getting Started

• Strong oversight requires a sustainable structure and organizational buy-in

• Viable oversight starts with a self-assessment
  • What are our goals?
    • Are program goals and oversight activities aligned for progress?
    • How can we make a positive and sustainable impact on our program through oversight?
  • What do we need or want to know, and how can we get that information?
    • How much of our oversight requires manual record checking?
    • What reporting requirements can we draw on or develop?
  • What resources are available for oversight?
    • Human
      • Subject matter expertise
      • Legal (legal and regulatory)
      • Institutional knowledge
    • Data
    • Relationships and partnerships
    • Institutional protocols, procedures, and systems
Getting started with D-SNP oversight...

• Request a meet-and-greet meeting with contracting D-SNPs. They are likely to be very receptive to your outreach!

• Share program goals and invite health plan input on solutions to issues facing your program. Cooperation does not invite non-compliance. It helps compliance through mutual understanding of expectations!

• Learn from health plan experience managing Medicare services.

• Sharing knowledge and learning from health plans is one of the fastest and most effective ways to “study up” on Medicare-Medicaid integration for busy public officials. It works!

• Get to know all of the parts of your Medicaid program. Where does Medicaid need to integrate within itself before it can integrate with Medicare?
# Essential Resources for D-SNP Oversight

Bookmark in browser these foundational resources:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Oversight purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Internet Only Manuals, including the Medicare Managed Care Manual</td>
<td>Where CMS interprets regulation into policy for MA plans and D-SNPs</td>
</tr>
<tr>
<td>Chapter 16-B of 100-16 (Dual Eligible Special Needs Plans)</td>
<td>Specific policy on D-SNPs</td>
</tr>
<tr>
<td>Chapter 2 of 100-16 (MA Enrollment &amp; Disenrollment Guidance)</td>
<td>Specific policy on D-SNP enrollment matters</td>
</tr>
<tr>
<td>Medicare Learning Network</td>
<td>Practical guidance for lay people and physicians – great for coverage and payment policy questions</td>
</tr>
<tr>
<td>Medicaid and CHIP Managed Care Final Rule (CMS-2390-F)</td>
<td>Regulation affecting Medicaid managed care oversight of capitated D-SNP plans, including quality</td>
</tr>
<tr>
<td>MA Annual Application</td>
<td>See State Medicaid Agency Contract Upload Matrix and FIDE SNP Upload Matrix Documents Helps with oversight of annual MIPPA contract filings by July 1</td>
</tr>
<tr>
<td>Integrated Denial Notice &amp; Instructions</td>
<td>Guidance on uses of and requirements for integrated beneficiary notice of denial used in D-SNPs</td>
</tr>
<tr>
<td>NCQA Model of Care Guidance</td>
<td>Guidance on MA framework for D-SNP needs assessments, care plan development, interdisciplinary team formation, and other quality-relevant matters</td>
</tr>
</tbody>
</table>
## Build Your Regulatory Support Base

<table>
<thead>
<tr>
<th>Entity</th>
<th>D-SNP Oversight Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>State-level</td>
<td>Your team. D-SNP oversight is inherently interdisciplinary and needs a broad-based team.</td>
</tr>
<tr>
<td>Plan-level</td>
<td>Mirror image of the state-side team, but involves the local plan and a corporate parent, both of which will make decisions affecting Medicaid-facing D-SNP operations.</td>
</tr>
<tr>
<td>CMS Regional Office - Medicaid</td>
<td>May be involved in review of certain MIPPA contracts, associated EQR reporting, and rates. Fields Medicaid contract and rate setting compliance questions (when MIPPA involves capitation).</td>
</tr>
<tr>
<td>CMS Regional Office - Medicare</td>
<td>Has first line oversight of D-SNPs and all Medicare Advantage plans for compliance with Medicare; Account Managers oversee all plans under the parent company.</td>
</tr>
<tr>
<td>Medicare-Medicaid Coordination Office</td>
<td>Tasked by Congress as the point of contact for states on D-SNP policy and Medicare/Medicaid integration. You can also use the new mailbox <a href="mailto:MMCO_DSNPOPERations@cms.hhs.gov">MMCO_DSNPOPERations@cms.hhs.gov</a></td>
</tr>
<tr>
<td>Integrated Care Resource Center (ICRC)</td>
<td>Technical assistance clearinghouse and support resource for states pursuing Medicare-Medicaid alignment models, including financial alignment demonstrations and special needs plans.</td>
</tr>
</tbody>
</table>
The MIPPA Contract

• Place expectations for program in MIPPA or extra-contractual guidance; if it isn’t in the contract it may be hard to enforce

• MIPPA contract forms part of official policy within Medicare Advantage for health plans and D-SNPs

• Provides state leverage in Medicare Advantage operations not otherwise available

• Tip: Keep D-SNP representatives informed of program changes and help plan staff when possible to understand what to include on annual State Medicaid Agency Contract matrix and FIDE SNP matrix upload documents.
  • New Jersey invites its FIDE SNPs to an annual meeting and provides pre-populated upload matrix forms to its FIDE SNPs to help with the tight turnaround for filing. Standardization ensures that key points of the FIDE SNP MIPPA will receive consideration from CMS reviewers.

• **Note:** MIPPA contract requirements will change as a result of CMS-4185-F, the final rule implementing new definitions and requirements for D-SNPs as of January 2021 within Section 50311(b) the Bipartisan Budget Act of 2018.
Overview of Functional Areas within D-SNP Operations

- Contracting
- Marketing
- Enrollment
- Benefit determination
- Business systems
- External and internal relations
- Rate setting
- Encounter data monitoring
- Cost sharing
- Savings expectations
- Prior approval of supplemental benefit bids

- Care delivery
- Network
- Member relations
- Provider relations
- Medicare program audits
- External Quality Review (Medicaid)

- Oversight of integrated systems requires human coordination of system components
- Meetings
- Specialized communications
Create Infrastructure for Operational Awareness

- Develop state-health plan relations for low-friction issue resolution; encourages trust and early self-reporting of issues by health plans
- Incorporate oversight across administrative, quality, and financial domains
- Incorporate D-SNP operations and oversight awareness into state Medicaid agency (and sister agency) awareness
- Develop home-grown reports, if necessary, that go beyond public reporting CMS or other state agencies
- Build D-SNP oversight into other routine Medicaid agency activities.
  - Example: New Jersey uses a combination of formal Medicaid External Quality Review Organization activities (PIPs, performance measure validation, and annual assessments), home-grown reports, readiness reviews, and regular conversations with health plans and other stakeholders to assess performance. In addition, New Jersey monitors audit findings from Medicare and compares reports to its own EQRO audit findings to identify areas of opportunity for program improvement.
Benefits of Proactive and Cooperative Oversight

• Increases and democratizes institutional program knowledge by involving local expertise beyond traditional compliance teams (quality, program integrity, legal).

• Promotes transparency, increases trust, and enhances public-private partnerships with managed care plans.

• **Responsive to urgent and specialized problems outside the realm of off-the-shelf instruments or traditional approaches.**

• Generates insight into, and complements well, Medicare audit findings and nationally validated instruments (HEDIS, CAHPS, etc.) for program improvement.

• Creates a broad and deep evidence base for program evolution.

• **Creates window into Medicare Part C utilization and state leverage over MA operations not otherwise available.**
D-SNP Monitoring and Performance: CMS Public Resources

Danielle Chelminsky, Integrated Care Resource Center
Monitoring Enrollment: SNP Comprehensive Report

- Contains monthly SNP enrollment data
- Use the data to:
  - Monitor D-SNP enrollment in each state by plan
  - Compare enrollment to other states and/or nationally
  - Track enrollment over time
  - Data lag: 2 weeks

Monitoring Enrollment: SNP Comprehensive Report

- Example of D-SNP enrollment in a state by contract, April 2019

<table>
<thead>
<tr>
<th>Contract Num</th>
<th>Contract Name</th>
<th>Organization Type</th>
<th>Plan ID</th>
<th>Segment</th>
<th>Plan Name</th>
<th>Plan Geographic Name</th>
<th>State(s)</th>
<th>Plan Enrolmer</th>
<th>Special Needs Plan Type</th>
<th>Specialty Disease</th>
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</thead>
<tbody>
<tr>
<td>H0913</td>
<td>WELLCARE HEALTH PLANS OF NEW JERSEY, INC.</td>
<td>Local CCP</td>
<td>013</td>
<td>0</td>
<td>WellCare Liberty (HMO SNP)</td>
<td>Select Counties in NJ</td>
<td>NJ</td>
<td>3,429</td>
<td>Dual-Eligible</td>
<td>FIDE SNP</td>
</tr>
<tr>
<td>H3113</td>
<td>OXFORD HEALTH PLANS (NJ), INC.</td>
<td>Local CCP</td>
<td>005</td>
<td>0</td>
<td>UnitedHealth care Dual Complete</td>
<td>Select counties in New Jersey</td>
<td>NJ</td>
<td>23,045</td>
<td>Dual-Eligible</td>
<td>FIDE SNP</td>
</tr>
<tr>
<td>H3240</td>
<td>AMERIGROUP HEALTH PLAN OF NEW JERSEY, INC.</td>
<td>Local CCP</td>
<td>013</td>
<td>0</td>
<td>Ameriadvantag e Dual</td>
<td>Eastern and Central New Jersey</td>
<td>NJ</td>
<td>8,390</td>
<td>Dual-Eligible</td>
<td>FIDE SNP</td>
</tr>
<tr>
<td>H3240</td>
<td>AMERIGROUP NEW JERSEY, INC.</td>
<td>Local CCP</td>
<td>016</td>
<td>0</td>
<td>Ameriadvantag e Dual</td>
<td>Select Counties in New Jersey</td>
<td>NJ</td>
<td>802</td>
<td>Dual-Eligible</td>
<td>FIDE SNP</td>
</tr>
<tr>
<td>H8298</td>
<td>HORIZON HEALTHCARE OF NEW JERSEY, INC.</td>
<td>Local CCP</td>
<td>001</td>
<td>0</td>
<td>Horizon NJ TotalCare (HMO SNP)</td>
<td>New Jersey</td>
<td>NJ</td>
<td>10,244</td>
<td>Dual-Eligible</td>
<td>FIDE SNP</td>
</tr>
</tbody>
</table>

Monitoring Enrollment: SNP Comprehensive Report

• Example of national D-SNP enrollment growth over time

Note: Service areas of some TN D-SNPs span multiple states. For this graph, enrollment was split evenly across states.
Monitoring Enrollment: Monthly Enrollment by Contract/Plan/State/County

• Contains county-level enrollment data for all plans

• Use the data to:
  • Monitor D-SNP enrollment in each county in a state by plan
  • Compare enrollment to other counties in a state
  • Track enrollment over time
  • Data lag: 2 weeks

Monitoring Enrollment: Monthly Enrollment by Contract/Plan/State/County

• Example of D-SNP enrollment by county in a state

Samaritan Health Plan D-SNP (H3811) Enrollment in OR by County, April 2019

Monitoring Quality:
SNP HEDIS Measures

- Contains the Healthcare Effectiveness Data and Information Set (HEDIS) measures for SNPs

- Use the data to:
  - Identify how each D-SNP in a state scored on the 15 quality measures (e.g., follow up after hospitalization for mental illness, care for older adults, plan all-cause readmissions)
  - Compare D-SNP performance to other D-SNPs in the state
  - Track D-SNP performance over time
  - Most recent 2018 HEDIS measures are from the 2017 calendar year

## Monitoring Quality: SNP HEDIS Measures

- Example of D-SNP contract rates by the Follow up After Hospitalization for Mental Illness (EOC010) Measure
- Compare to National Rate (listed in “National Rates” tab)

### New Jersey D-SNP Contracts: EOC010 – Follow up after Hospitalization for Mental Illness (FUH) 2018

<table>
<thead>
<tr>
<th>Contract #</th>
<th>Contract Name</th>
<th>Rate - 7 Days EOC010-0011</th>
<th>Rate - 30 Days EOC010-0012</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0913</td>
<td>WELLCARE HEALTH PLANS OF NEW JERSEY, INC.</td>
<td>20.00</td>
<td>42.50</td>
</tr>
<tr>
<td>H3113</td>
<td>OXFORD HEALTH PLANS (NJ), INC.</td>
<td>16.53</td>
<td>33.06</td>
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<tr>
<td>H3240</td>
<td>AMERIGROUP NEW JERSEY, INC. (Plan 13)</td>
<td>11.54</td>
<td>29.49</td>
</tr>
<tr>
<td>H3240</td>
<td>AMERIGROUP NEW JERSEY, INC. (Plan 16)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>H8298</td>
<td>HORIZON HEALTHCARE OF NEW JERSEY, INC.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>National Rate</td>
<td></td>
<td><strong>32.86</strong></td>
<td><strong>53.76</strong></td>
</tr>
</tbody>
</table>

Monitoring Quality: Part C and D Medicare Star Ratings

- Contains Medicare Star Ratings for Medicare Advantage Contracts (including D-SNPs)
  - Star Ratings range from 1 (Poor) to 5 (excellent)

- Use the data to:
  - Identify how contracts that include D-SNPs in a state scored on the Star Ratings. (Data applies exclusively to D-SNPs only when a contract has 100% D-SNP enrollment.)
  - Compare contract performance in a state to other contracts
  - Track contract performance over time.
  - Most recent 2019 Star Ratings are from the 2017 Calendar Year

# Monitoring Quality: Part C and D Medicare Star Ratings

- Examples of measures and Star Ratings for D-SNPs in states in 2019
  - For average star ratings, see the Star Ratings Fact Sheet

<table>
<thead>
<tr>
<th>Contract #</th>
<th>Organization Name</th>
<th>SNP Care Management % (C08)</th>
<th>SNP Care Management Star Rating (C08)</th>
<th>Diabetes Care – Blood Sugar Controlled % (C15)</th>
<th>Diabetes Care – Blood Sugar Controlled Star Rating (C15)</th>
<th>Members Choosing to Leave Plan % (C30)</th>
<th>Members Choosing to Leave Plan Star Rating (C30)</th>
<th>Overall Star Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0251</td>
<td>United HealthCare (TN)</td>
<td>51%</td>
<td>2</td>
<td>74%</td>
<td>3</td>
<td>5%</td>
<td>5</td>
<td>3.5</td>
</tr>
<tr>
<td>H2174</td>
<td>Trillium (OR)</td>
<td>51%</td>
<td>2</td>
<td>72%</td>
<td>3</td>
<td>3%</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>H3259</td>
<td>Volunteer State Health (TN)</td>
<td>53%</td>
<td>2</td>
<td>71%</td>
<td>3</td>
<td>12%</td>
<td>3</td>
<td>3.5</td>
</tr>
<tr>
<td>H8298</td>
<td>Horizon BCBS (NJ)</td>
<td>73%</td>
<td>4</td>
<td>41%</td>
<td>2</td>
<td>20%</td>
<td>2</td>
<td>2.5</td>
</tr>
<tr>
<td>National Average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**National Average**

3.2

3.7

3.9

4.1

**Note:** All example contracts listed include exclusively D-SNP enrollees.

**Source:** CMS Part C and D Medicare Star Ratings Data, 2019: [https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin/performancedata.html](https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin/performancedata.html)
Other Resources

• Program audit results
• Ad hoc Corrective Action Plans (CAPs)
• Past performance outlier results
• Plan-level risk scores and PMPM Medicare payments
• Medical loss ratio data

The Appendix includes additional tables illustrating the use of some of these measures.
ICRC Resources for States

• ICRC is available to help states find their relevant data on dually eligible beneficiaries and can develop tailored state profiles upon request.

• ICRC resources:
  • How States Can Monitor Dual Eligible Special Needs Plan Performance: A Guide to Using CMS Data Resources
  • How States Can Better Understand their Dually Eligible Beneficiaries: A Guide to Using CMS Data Resources
  • How States Can Use Medicare Advantage Star Ratings to Assess D-SNP Quality and Performance
Facilitated Discussion Questions

• What tips or lessons learned do you have for working with D-SNPs to encourage their cooperation and compliance? What have you done to minimize burden on the plans?
• What have been the biggest challenges in developing an oversight process? What steps have you taken to overcome them?
• What would you recommend to other states looking to begin or improve their monitoring and oversight?
• What D-SNP operational areas do you believe require the most oversight and monitoring?
• Which reporting requirements have you found most useful? Do you use any of the CMS data resources, and if so, how?
• What opportunities are there in the future to improve oversight and monitoring?
About ICRC

• Established by CMS to advance integrated care models for dually eligible beneficiaries

• ICRC provides technical assistance (TA) to states, coordinated by Mathematica Policy Research and the Center for Health Care Strategies

• Visit http://www.integratedcareresourcecenter.com to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges

• Send other ICRC questions to: integratedcareresourcecenter@chcs.org
Appendices
Additional Information on Oregon
Oregon

Additional Detail on Oregon DSNP reporting elements:

Demographic Population totals report structure:
A. Overall number served. (If more than one CCO region, breakdown by region)
B. Population by Race/Ethnicity, Disability/Non-Disability, Gender & Age Groupings
C. DSNP Population Served Chronic/Behavioral Health Disease Burden:
   – Please provide DSNP population numbers/percentages served by number of chronic/behavioral conditions
   – Stratify these groups for: original reason for Medicare, gender, race/ethnicity, age groupings

Narrative Reporting:
A. Summary narrative that includes any unique benefits provided to dual eligible members through the SNP to members.
B. Care Coordination: Notifications Policy Narrative Submission to specifically address: timely notification of the full dually eligible member’s Medicaid CCO, MCO, or State Medicaid Agency care coordination staff or contractors of:
   1.) Planned or Unplanned Inpatient Admissions
   2.) High Priority health concerns identified through member health assessments (HRAs)
   3.) Sharing of key provisions of discharge planning documents (i.e. medications)

For 2017 -- implementation successes and challenges for implementation of Care Coordination Notifications policy(ies) adopted 2016.
C. Written Description of Coordination with LTSS
Additional Detail on Oregon DSNP reporting elements:

Measures to Report Quality and Care Outcomes:

Existing DSNP Measure Metrics: Provide metric data (not actual Star rating) for each of the following corresponding to each plan service year.

- Special Needs Plans (SNP) Care Management (Members Whose Plan Did an Assessment of Their Health Needs and Risks) – DSNP Plan Data
- Care for Older Adults – Medication Review—(Yearly Review of All Medications and Supplements Being Taken) --Data set HEDIS Care for Older Adults measure
- Care for Older Adults – Functional Status Assessment (Yearly Assessment of How Well Plan Members Are Able to Do Activities of Daily Living) – data set HEDIS Care for Older Adults measure
- Care for Older Adults – Pain Assessment –(Yearly Pain Screening or Pain Management Plan) data set HEDIS Care for Older Adults measure

Additional MA Measures: Submit DSNP member data segregated from all MA plan data (metric data, not actual Star rating)—i.e. stratified data for DSNP members.

- Measure: Plan All-Cause Readmissions-Plan All-Cause Readmissions (PCR)-- Readmission to a Hospital within 30 Days of Being Discharged – [compare this measure with the State Metric –Plan All Cause Readmission to determine if we keep this one in.]
- Measure: C16 - Controlling Blood Pressure: HEDIS measure Controlling High Blood Pressure (CBP)
- Part D Measures (2016 Trial Run, 2017 Report): Measure MTM Program Completion--Rate for CMR

Note: MA or DSNP metrics follow guidelines from CMS’s released Medicare 2016 Part C & D Star Rating Technical Notes document and any referenced documents from HEDIS maintained by NCQA on measure detail.
Oregon

Additional Detail on Oregon DSNP reporting elements:

Measures to Report Quality and Care Outcomes:

CCO Metrics Inclusion & State Metrics:

- **CCO and State Metrics definitions available at**
  [http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx](http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx)

- **CCO Metric --Ambulatory Care: Outpatient and ED utilization**

- **State Metric - Plan all-cause readmission (NQF 1768)**

- **State Metric: PQI 01: Diabetes, short term complication admission rate (NQF 0272)**

- **State Metrics : PQI 05: Chronic obstructive pulmonary disease admission (NQF 0275)**

- **State Metrics : PQI 08: Congestive heart failure admission rate (NQF 0277)**

Existing CCO metric data stratified by DSNP X CCO {12 member months} OHA to provide plan CCO and State Metrics stratified by DSNP population correlated with metrics timeline).

*Next major updates expected for 2021 COBA contracts to align with Oregon CCO 2.0 and new CMS DSNP rules anticipated for release this year regarding 2021.*

[https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0.aspx](https://www.oregon.gov/oha/OHPB/Pages/CCO-2-0.aspx)
Oregon Health Reform – Began @2009

- Transform Oregon’s delivery system to focus on prevention, integration, and coordination of health care across the continuum of care with the goal of improving outcomes, and bending the cost curve.
- Promote the Triple Aim of better health, better health care and lower per capita costs.
- Establish supportive partnerships to implement innovative strategies for providing high-quality, cost-effective, person-centered health care under Medicaid and Medicare.
- Coordinated Care Organizations began in 2012.

Oregon Health Sciences University independent evaluation 2012 -2017 Medicaid waiver.
Additional Information on Tennessee
## Tennessee Study: Impact of Alignment

- Conducted by Vanderbilt University Medical Center
- Funded by ASPE
- FBDEs, 2011-2016

<table>
<thead>
<tr>
<th>Medicaid Benefits</th>
<th>Medicare Benefits</th>
<th>Aligned Benefits</th>
<th>Medicaid-Medicare Coordination</th>
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</thead>
<tbody>
<tr>
<td>Insurer A</td>
<td>Insurer A: D-SNP plan</td>
<td>Yes</td>
<td>Greatest</td>
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<tr>
<td>Insurer A</td>
<td>Insurer A: Medicare Advantage plan</td>
<td>Yes</td>
<td>↓</td>
</tr>
<tr>
<td>Insurer A</td>
<td>Insurer B: D-SNP or Medicare Advantage plan</td>
<td>No</td>
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<tr>
<td>Insurer A</td>
<td>Fee-for-service (traditional Medicare)</td>
<td>No</td>
<td>Least</td>
</tr>
</tbody>
</table>
RESEARCH QUESTIONS

• For all dual-eligible beneficiaries, how did increased availability of aligned benefits affect:
  – Use of inpatient services, emergency room services, and Part D prescription drugs
  – Use of Medicaid-financed long-term services and supports (LTSS), including nursing home care and home and community-based services

• Did dual-eligible beneficiaries who participated in aligned plans experience changes in:
  – Use of inpatient services, emergency room services, and Part D prescription drugs
  – Use of Medicaid-financed LTSS, including nursing home care and home and community-based services
### Tennessee Study (cont):

<table>
<thead>
<tr>
<th>Data Sources</th>
<th>Main Data Elements</th>
<th>FFS</th>
<th>MA Plans</th>
<th>D-SNPs</th>
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<tbody>
<tr>
<td><strong>Tennessee Data</strong></td>
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<tr>
<td>TennCare enrollment files</td>
<td>Medicaid MCO enrollment</td>
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<td>✓</td>
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<td>Tennessee all-payer hospital</td>
<td>Inpatient and emergency room use in Tennessee</td>
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<td>✓</td>
<td>✓</td>
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<td>discharge database</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>TennCare MCO encounter data</td>
<td>Medicaid LTSS services</td>
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<td>✓</td>
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<tr>
<td>TennCare crossover claims</td>
<td>Medicaid copays for Medicare services</td>
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<td>✓</td>
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<tr>
<td><strong>CMS Data</strong></td>
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<tr>
<td>Master Beneficiary Summary File</td>
<td>Medicare/Medicaid enrollment</td>
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<td>✓</td>
<td>✓</td>
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<tr>
<td>Part D claims</td>
<td>Prescription drugs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>HEDIS</td>
<td>MA plan membership</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
Oversight Reporting Examples from NJ FIDE SNP Program
New Jersey approaches oversight of aligned enrollment by monitoring three key functional areas:

- **Business systems (10.3; 10.5.1, et seq.):** Medicare and Medicaid enrollment transaction files and monthly reports used for screening of eligibility for D-SNP enrollment; final monthly enrollment validation used for capitation of Medicaid wraparound services.

- **Marketing (10.5.16.1; Appendix 10.I):** State-driven policies that promote informed, voluntary enrollments, including boilerplate language reminding prospective enrollees to check network participation by physicians and pharmacies they use.

- **Customer service (10.10.10.11):** Monitoring customer service hotlines for signs of an enrollment file problem (e.g., spike in complaints about pharmacy point of sale transactions failing; SHIP hotline complaints about involuntary enrollments by brokers or facilities).

**Source:** Model Contract between State of New Jersey Department of Human Services Division of Medical Assistance and Health Services and MIPPA Contractors. (2018) [https://www.state.nj.us/humanservices/dmahs/info/d-snp_contract.pdf](https://www.state.nj.us/humanservices/dmahs/info/d-snp_contract.pdf)
Monitoring Integrated Medicare-Medicaid Appeals & Grievances

New Jersey uses an “Integrated Operations Report” to monitor quarterly “the natural history of appeals within the integrated program to identify trends in Medicare-Medicaid benefit provision and utilization management that may affect enrollee quality of care or quality of life.”

**Scope:** Includes all Medicare and Medicaid appeals for enrolled FIDE SNP members.

**Frequency:** Quarterly

Summary of fields captured (NJ FIDE SNP MIPPA Contract, 10.H.2.)
- **Beneficiary demographics** – name, ID, program eligibility status codes, county, care management level, waiver participation indicator (MLTSS, I/DD, etc.)
- **Adverse action and appeal type** – reduce, suspend, deny, stop; standard or expedited appeal
- **Service information** - service type, date, service included in transfer package (if new member); prior authorization #, if applicable; ratio of PCA service units requested:denied; Medicare portion denied; Medicaid portion denied; rationale for denial
- **Provider information** – name, type, provider ID, service county, network status at time of service
- **Highest appeal type sought and resolution type** – appealed under Medicare flag; appealed under Medicaid flag; expedited; state fair hearing requested; explanation of partial denials; continuation of services requested; highest level of appeal sought; final disposition; SFH outcome
- **Grievances captured similarly**

**Source:** Model Contract between State of New Jersey Department of Human Services Division of Medical Assistance and Health Services and MIPPA Contractors. (2018) [https://www.state.nj.us/humanservices/dmahs/info/d-snp_contract.pdf](https://www.state.nj.us/humanservices/dmahs/info/d-snp_contract.pdf)
NJ FIDE SNP contains a comprehensive wraparound benefit package under Medicaid, including but not limited to extensive medical, long-term services and supports, outpatient mental health, substance use disorder, dental, vision, and hearing benefits. Extensive detail on the benefit package is provided in an appendix to improve contractor understanding of the scope of benefit (10.D).

**Encounter data (10.3.9.1)**
- Encounter data from contracting FIDE SNPs is used primarily for rate setting purposes.
- All Medicare and Medicaid encounter records submitted, even $0 liability

**Medicare bids and supplemental benefits**
- D-SNPs must submit to Medicare annually bids for covered benefits that will be in the benefit package for the next calendar year. Initial and final bids must be submitted to the state for reference in rate setting.
- To avoid duplication and/or jeopardizing eligibility, supplemental benefit filings must receive prior approval from the state.
- Final stars scores must be submitted (relevant to rebate dollars available)

*Source: Model Contract between State of New Jersey Department of Human Services Division of Medical Assistance and Health Services and MIPPA Contractors. (2018) [https://www.state.nj.us/humanservices/dmahs/info/d-snp_contract.pdf](https://www.state.nj.us/humanservices/dmahs/info/d-snp_contract.pdf)*
D-SNP Document Filings with Medicare – Annual & Ad Hoc

Sharing with the state major filings that go to Medicare is an easy way for a D-SNP to stay in touch with the state on updates to its internal operations.

- NJ FIDE SNP Medicare filings required annually, or at the time of filing with Medicare (10.10.12):
  - November Notice of Intent to Apply as Filed with CMS, including intent to change service area
  - February SMAC attestation as filed with CMS
  - Supplemental benefit package as filed with CMS
  - Part C and Part D bid filings and all revisions
  - Final SMAC Upload Matrix
  - All Medicare Advantage audit findings, reports, and corrective actions, adverse actions taken by the CMS or sanctions
  - Final Star Ratings and Past Performance Methodology Scores
  - HEDIS, CAHPS and HOS Scores
  - Model of Care
  - NCQA Model of Care score (triennially, or with any change)

- Ad hoc
  - Marketing materials
  - Significant changes
  - Certain provider, subcontractor, or vendor contracts
Other CMS Monitoring Resources and Examples
Monitoring Compliance: Program Audit Results

- Contains health plan program audit results
- Use the data to:
  - Identify D-SNP audit results in a state
  - Identify the number and types of Corrective Actions Required (CARs)
  - Most recent audit year is 2017

<table>
<thead>
<tr>
<th>Sponsor Name</th>
<th>Overall Audit Score</th>
<th>Number of CARs</th>
<th>Number of ICARs</th>
<th>Number of Audit Elements Tested</th>
<th>Audit Year</th>
<th>Enforcement Action Issued?</th>
<th>Audit Status</th>
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</thead>
<tbody>
<tr>
<td>Affinity Health Services Holdings, Inc.</td>
<td>1.44</td>
<td>15</td>
<td>4</td>
<td>16</td>
<td>2017</td>
<td>Yes</td>
<td>Validation in Progress</td>
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<tr>
<td>AllCare Health, Inc.</td>
<td>1.06</td>
<td>12</td>
<td>1</td>
<td>13</td>
<td>2017</td>
<td>No</td>
<td>Closed</td>
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<tr>
<td>Anthem Insurance Co., BCBSMA, BCBSRI &amp; BCBSVT</td>
<td>0.00</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td>2017</td>
<td>No</td>
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<td>Anthem, Inc</td>
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<td>8</td>
<td>2</td>
<td>16</td>
<td>2017</td>
<td>No</td>
<td>Validation in Progress</td>
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<tr>
<td>Aware Integrated, Inc.</td>
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<td>8</td>
<td>2</td>
<td>16</td>
<td>2017</td>
<td>No</td>
<td>Closed</td>
</tr>
</tbody>
</table>

Source: CMS Program Audit Results: [https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/ProgramAuditResults.html](https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/ProgramAuditResults.html)
Monitoring Compliance: Ad Hoc Corrective Action Plans (CAPs)

- Contains names of specific health plans with a Corrective Action Plan.
- Use the data to:
  - Identify which sponsors of D-SNP plans in a state were issued an ad hoc CAP for persistent and/or serious plan performance issues
  - Data lag: 2 weeks (see “Date Letter Sent” column for specific dates)

<table>
<thead>
<tr>
<th>Contract ID(s) and Names</th>
<th>Parent Organization Name</th>
<th>Organization Contact Name</th>
<th>Organization Contact Phone</th>
<th>Compliance Issue ID</th>
<th>Date Letter Sent</th>
<th>Issue Type</th>
<th>Issue Topic</th>
<th>Issue Summary</th>
<th>Letter Name</th>
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</thead>
<tbody>
<tr>
<td>H2359 - UCARE MINNESOTA</td>
<td>UCare Minnesota</td>
<td>Pauk Vang</td>
<td>6126753185</td>
<td>53704</td>
<td>28-FEB-2019</td>
<td>Drug Benefit</td>
<td>Bid Submission</td>
<td>Failure to comply with CY2019 Part D bid submission requirements.</td>
<td>pdf</td>
</tr>
<tr>
<td>S7694 - ENVISION INSURANCE COMPANY</td>
<td>Rite Aid Corporation</td>
<td>Customer Service</td>
<td>8662502005</td>
<td>53709</td>
<td>28-FEB-2019</td>
<td>Drug Benefit</td>
<td>Formulary Submission and Administration, including Transition</td>
<td>Failure to properly implement the required Transition Policy</td>
<td>pdf</td>
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<tr>
<td>H1904 - CELI-CARE HEALTH INC.</td>
<td>InterSource Health Care, Inc.</td>
<td>Mark Richardson</td>
<td>801424210</td>
<td>53700</td>
<td>28-FEB-2019</td>
<td>Drug Benefit</td>
<td>Formulary Submission and Administration, including Transition</td>
<td>Failure to properly implement the required Transition Policy</td>
<td>Ad-Hoc CAP-letter.pdf</td>
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<td>S4319 - HEALTH ALLIANCE MEDICAL PLANS</td>
<td>The Carle Foundation</td>
<td>Jennifer Marquardt</td>
<td>3170029229</td>
<td>53721</td>
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<td>Drug Benefit</td>
<td>Bid Submission</td>
<td>Failure to comply with CY2019 Part D bid submission requirements.</td>
<td>pdf</td>
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</table>

Monitoring Compliance: Past Performance Outlier Results

• Contains names of specific health plans that were deemed performance outliers

• Use the data to:
  • Identify which sponsors of D-SNP plans performed poorly on quality measures or compliance with Medicare requirements
  • Most recent Spring 2018 review from Jan 2017 – Feb 2018 timeframe

<table>
<thead>
<tr>
<th>Parent Organization</th>
<th>Legal Entity(ies)</th>
<th>Outlier for Part C and/or Part D</th>
<th>Areas of Poor Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affinity Health Services Holdings, Inc.</td>
<td>Affinity Health Plan, Inc.</td>
<td>C</td>
<td>Part C Compliance Letters</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>Part C Star Ratings</td>
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<td>Performance Audit</td>
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<td>Civil Money Penalties</td>
</tr>
<tr>
<td>Anthem</td>
<td>Blue Cross of California</td>
<td>C</td>
<td>Part C Compliance Letters</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>Part C Star Ratings</td>
</tr>
<tr>
<td>Banner Health</td>
<td>The University of Arizona Health Plans – University Care Advantage, Inc.</td>
<td>C</td>
<td>Part C Compliance Letters</td>
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<td>Multiple AdHoc CAPS</td>
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<td></td>
<td>Serious Problem with Beneficiary Impact</td>
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<tr>
<td>Baylor Scott &amp; White Holdings</td>
<td>Insurance Company of Scott and White</td>
<td>C and D</td>
<td>Part C Compliance Letters</td>
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<tr>
<td></td>
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<td>Part D Compliance Letters</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Serious Problem with Beneficiary Impact</td>
</tr>
</tbody>
</table>

Monitoring Payment: Plan-Level Risk Scores and PMPM Medicare Payments

- Contains the CMS payments to D-SNPs for Medicare Part A and B services, average rebates towards supplemental benefits, and average risk scores.

- Use the data to:
  - Identify plan-level (or county-level) average PMPM Medicare Parts A and B payments to each D-SNP in a state, rebate payments and risk scores and compare across plans.
  - Most recent payment data as of 2015 (Part D reconciliation data as of 2017).

Source: CMS Plan Payment Data: https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Plan-Payment-Data.html
Monitoring Payment: Plan-Level Risk Scores and PMPM Medicare Payments

- Average risk score and PMPM payment and rebate payment in an MA plan in OR

<table>
<thead>
<tr>
<th>Contract #</th>
<th>Plan Benefit Package</th>
<th>Contract Name</th>
<th>Average Part C Risk Score</th>
<th>Average A/B PMPM Payment</th>
<th>Average Rebate PMPM Payment</th>
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<tbody>
<tr>
<td>H2174</td>
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<td>TRILLIUM COMMUNITY HEALTH PLAN</td>
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</table>

Source: CMS Plan Payment Data: [https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Plan-Payment-Data.html](https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Plan-Payment-Data.html)
Monitoring Payment: Medical Loss Ratio Data

- Contains contract-level and PMPM revenue, payments, medical loss ratio and other related cost data
- Use the data to:
  - Identify particular costs and payments related to specific D-SNPs in a state and compare across D-SNPs
  - Most recent Public Use File from 2014

Source: CMS Medical Loss Ratio Public Use File: [https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/MedicalLossRatio.html](https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/MedicalLossRatio.html)