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

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Starting January 1, 2021, under a new rule recently released by the Centers for Medicare & Medicaid Services (CMS), many Dual Eligible Special Needs Plans (D-SNPs) will be required to notify the state Medicaid agencies they contract with (or the state's designee) when their enrollees are admitted to a hospital or skilled nursing facility (SNF).[1,2] This requirement applies to any D-SNP that is not contracted, either directly or through an affiliated Medicaid managed care organization (MCO), to cover either Medicaid behavioral health or long-term care benefits. The goal of the new rule is to ensure timely initiation of Medicaid care management activities around care transitions for at least one group of high-risk beneficiaries. This may, in turn, help lower readmission rates and more effectively support enrollees' return to the community.[3] The new rule provides states with more opportunities to help ensure that beneficiaries receive care in the right settings at the right time.[4]

To implement the new rule, states will need to work with D-SNPs subject to the notification requirement to develop a process for sharing and using admissions data. States will need to determine a high-risk population for which the data should be shared and to whom admission notifications should go. To determine the latter, states should consider which entities will be in a position to act on the data to support the state-defined group of high-risk D-SNP enrollees. For example, the entities receiving notifications could be fee-for-service (FFS) providers or Medicaid care managers for the high-risk D-SNP enrollees, or they could be MCOs that serve dually eligible beneficiaries.

New Requirements for D-SNP Information Sharing

In April 2019, CMS published a final rule for Medicare Advantage and Medicare Part D that established information-sharing requirements for D-SNPs.[5,6] For calendar year 2021, D-SNPs must have either:

- A state contract to provide Medicaid long-term services and supports (LTSS) and/or Medicaid behavioral health benefits either directly with the legal entity providing the D-SNP, with the parent organization of the D-SNP, or with a subsidiary owned and controlled by the parent organization of the D-SNP; or
- A contract with the state Medicaid agency specifying a process to share information with the state, or the state's designee (such as a Medicaid MCO), on hospital and SNF admissions of high-risk individuals who are enrolled in the D-SNP.[7]

This technical assistance tool offers key questions and considerations that states can review as they begin working with D-SNPs and other parties to design and implement information-sharing requirements. **Because D-SNPs must submit their 2021 contracts to CMS by early July 2020, all states should begin to consider the new information sharing requirements now in order to have sufficient time to develop new contract language and processes for 2021.**

Key Questions for States Designing Information-Sharing Approaches

The questions that follow are designed to help states design the scope, process, and requirements for D-SNPs to collect and share hospital and SNF admission data and enable recipients of that data to use it effectively. The considerations included here can help states assess ways to operationalize the new information-sharing requirements to best support all or a subset of D-SNP enrollees. States have broad latitude to develop either large- or small-scale approaches to sharing hospital and SNF admissions data.

D-SNP Landscape

States should first determine whether any D-SNPs in their state are exempt from notification requirements and identify which segments of the state's full benefit dually eligible (FBDE) population are enrolled in D-SNPs.

- **Which D-SNPs are operating in the state and will they all be required to share admissions data with the state effective January 2021?** The level of Medicaid benefit integration in place as of January 2021 will determine whether or not the D-SNP is required to begin notifying the state of hospital and SNF admissions. D-SNPs that are designated by CMS as either a highly integrated dual eligible SNP (HIDE SNP) or fully integrated dual eligible SNP (FIDE SNP) will be exempt from the new notification requirements.[8] However, states can still require D-SNPs designated as HIDE or FIDE SNPs to share data on hospital and SNF admissions.[9] States need to identify all D-SNPs to which the notification requirements will apply well in advance of the January 2021 notification start date.
- **Which high-risk Medicaid beneficiaries are enrolled in D-SNPs?** States will want to determine which of their FBDE beneficiaries are enrolled in D-SNPs in order to identify one or more high-risk population(s) for which D-SNP admission notifications would apply. States can determine which Medicaid populations are enrolled in D-SNPs in a number of ways. For example, states can ask D-SNPs for ad hoc or routine enrollment files that the state can then match against Medicaid eligibility data. States can also use information in files exchanged with CMS, such as the MMA response file,[10] to match Medicare plan enrollment information with Medicaid eligibility data. Since FBDE beneficiaries make up a significant portion of Medicaid LTSS users, a state interested in improving care transitions for LTSS beneficiaries enrolled in home- and community-based service (HCBS) waivers could use the data obtained from D-SNP enrollment files or MMA files, aligned with Medicaid eligibility data, to determine how many and which Medicaid beneficiaries, including HCBS waiver participants are currently enrolled in a D-SNP.

High-Risk Population and Receiving Entities

States will need to define one or more groups of high-risk FBDE beneficiaries that would benefit from targeted support after hospital or SNF admissions and determine which entities actually have care coordination resources in place to help manage transitions for the state's selected group(s).

- **What group(s) of high-risk dually eligible beneficiaries will the state include in hospital and SNF admission notification requirements?** The state has broad flexibility to define one or more high-risk groups to target. States can include all D-SNP enrollees or a subset such as participants in one or more HCBS waivers, Medicaid health home program participants, or another group – perhaps identified through claims or encounter data – as high utilizers of acute care or other services. States can start with a small group of high-risk beneficiaries in 2021, and consider broadening notifications to add additional groups once an effective process for notifications and use of admissions data is in place.
- **What entity(ies) will receive the hospital and SNF admission notifications to support care coordination?** The appropriate recipients of the admission data will depend on which high-risk population(s) the state is targeting for transition support as well as the Medicaid delivery system for these populations. Potential designees for receiving admission data include Medicaid MCOs (MLTSS

plans, behavioral health organizations, or other Medicaid plans) or FFS HCBS case management agencies (e.g., Area Agencies on Aging or Centers for Independent Living). Medicaid officials and D-SNPs should consult with potential receiving entities in the early design stages of an information-sharing process to help define parameters for data sharing and assess readiness to act on admissions data.

- **Can Medicaid care management resources (i.e., HCBS waiver care managers, local care management agencies, or MCOs) act on data received for the selected group of high-risk dually eligible beneficiaries?** A key aspect of determining which group(s) to target and who will receive notifications includes evaluating whether existing care managers and other care coordination resources can effectively act on admissions data in a timely manner. Potential designees that may have resources to act on admission notifications include, but are not limited to, FFS HCBS provider and care management agencies (e.g., Area Agencies on Aging or Centers for Independent Living), or Medicaid MCOs (managed long-term services and supports [MLTSS] plans, behavioral health organizations, or other Medicaid plans) where applicable. States and plans will need to work together and with any designated receiving entities to ensure processes are in place to act on the data ahead of the January 1, 2021 start date.
- **Does the state have a mechanism by which D-SNPs can identify enrollees in the high risk group and the entity(ies) to direct the hospital and SNF admission notifications to**? Since dually eligible beneficiaries could have their Medicaid benefits delivered by different Medicaid programs or provider types including one of several Medicaid MCOs/MLTSS plans that are not affiliated with the D-SNPs, or through a Medicaid FFS system, D-SNPs will need to be able to identify which entity should receive the notification for which member. Potential mechanisms include, but are not limited to, states sharing Medicaid enrollment information with D-SNPs in eligibility files, developing and sharing lists of key points of contact at recipient entities, or a state providing access to a beneficiary eligibility portal that provides this information. States will need to work with D-SNPs to establish a reliable, and timely process to identify the group of high risk beneficiaries who are enrolled in the D-SNP to facilitate on-going information sharing.

Notification Method

States and D-SNPs can use a variety of methods for SNF and hospital admission notifications. States can either leverage existing mechanisms and resources to share admissions data, or work with plans and providers to develop new information-sharing pathways. Understanding current data sharing methods at state, plan, or provider levels may help to guide the selection of a 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 by the state and/or D-SNPs to share admissions data?** States should work with D-SNPs, as well as hospitals and SNFs, to understand how they currently obtain and share admission data. Using existing portals or other file or data exchange processes can limit state or plan investments needed to support data sharing around hospital and SNF admissions. The availability of event notification systems (ENS) as a method for data exchange should also be considered and could be applied in either Medicaid FFS or managed care delivery systems. ENS use by hospitals and SNFs has increased in recent years, and CMS proposals to require hospitals to send electronic notifications of patient admissions, discharges, and transfers to another health care facility, community provider, or an intermediary by 2020[11] may further adoption of ENS. This makes ENS data exchange an important vehicle for states to consider.
- **Will existing or planned mechanisms result in effective support of care transitions?** States and D-SNPs may need to examine multiple options for sharing admission data before deciding on a method that will maximize delivery of effective care transition supports. In some cases, low-technology solutions, such as direct outreach to a Medicaid care manager, daily email exchanges using a pre-designed

template form, or hosting a site for secure file transmission, may be the most effective way of sharing information with providers or care managers. In states without automated notification systems, it may be more feasible to use low-technology, but potentially labor-intensive mechanisms (e.g., calls to care coordinators) if the focus is on a small group of high-risk FBDE beneficiaries.

Regardless of the specific mechanism chosen for data sharing, states should work with D-SNPs and the entities that will be receiving admission notifications to ensure that those entities have appropriate systems in place to respond to the data received. For example, this may include verifying that MCOs or HCBS care management agencies have a process in place to transfer data into care management systems or to the appropriate care management staff in a timely manner.

- **What can the state and/or D-SNPs do to support ENS development and hospital and SNF participation?** For an ENS to become the platform for D-SNP admission, discharge, and transfer alerts, both hospitals and SNFs would need to participate—with a goal to achieve universal participation among these providers over time. States or D-SNPs might consider whether incentives or contractual requirements for plans or providers could increase participation rates. ENS systems can be funded with either private or public investments or some combination of both. States can assess whether plans or providers can fund ENS costs through a utility model. States can also consider funding up-front IT costs or specific subscriptions to ENS alerts. For example, states with dually eligible beneficiaries receiving services via Medicaid FFS could fund ENS subscriptions for FFS LTSS care managers and care managers for other high-risk segments of their dually eligible population. States could also require that Medicaid plans or D-SNPs fund subscription costs for ENS alerts from existing resources.

Timeframe for Notifications

States have flexibility to define the timeframes that will be required for the transmission of admission data between D-SNPs and other entities.

- **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?** Timeliness standards for sharing of admissions data, along with any related notifications of discharges and transfers should be established in partnership with D-SNPs and the entities designated to receive the data. The notification timeframe may need to be different for hospital vs. SNF settings, or vary depending on the method of data collection and notification (e.g., ENS alerts allow for real-time notifications, while states would have to work with D-SNPs to assess how rapidly notifications could otherwise occur). States without ENS systems to leverage can create important linkages between existing care managers for high-risk populations by requiring D-SNPs to obtain inpatient admission data directly from contracted providers and in turn report that data in a timely fashion to either the state or the state's designee.

Contracting and Oversight

States will need to work with D-SNPs to incorporate information-sharing requirements into Medicaid agency D-SNP contracts and develop a process for overseeing notifications as well as any impact on care transitions.

- **What language needs to be added to the state Medicaid agency's contracts with D-SNPs?**[12] All D-SNPs subject to the information-sharing requirement will need to include provisions in their state contract no later than July 1, 2020, specifying a process to share information with the state, or the state's designee, on hospital and SNF admissions. The contract language must address: (1) the "high risk" population(s) subject to information sharing; (2) who will be notified; (3) the timeframe for the notification; and (4) the notification method. States have broad latitude to work with D-SNPs to define these parameters for information sharing.

- **Is model contract language available?** The following is an example of contract language that addresses required elements including population, receiving entities, timeframes, and notification methods:

  > "For all plan enrollees enrolled in [**Medicaid health home/HCBS waiver/behavioral health MCO/MLTSS plan**—*Use state specific terms, include all that apply*], [**D-SNP name**] shall provide timely notification of all admissions to a hospital or skilled nursing facility to the enrollee's [**Medicaid health home/HCBS waiver case manager/behavioral health MCO/MLTSS plan**—*Use state-specific terms, include all that apply*] as applicable to the member. Timely notification is defined as any real-time notification provided by the D-SNP or its contracted hospitals and skilled nursing facilities via Health Information Technology (HIT) or Health Insurance Exchange (HIE) or, where notification via HIT or HIE is not provided, via direct communication from [**D-SNP name**] within [**x hours/days**] of [**D-SNP name**] receiving information of such admission.[**State Medicaid Agency**] will provide [**D-SNP name**] information on plan enrollees enrolled in [**Medicaid health home/HCBS waiver/behavioral health MCO/MLTSS plan**—*Use state specific terms, include all that apply*] via [**daily file exchange/access to Medicaid eligibility portal/other specified exchange**—*Use state specific terms, include all that apply*]."

- **How should the state work with D-SNPs and other entities to establish new processes and monitor the data exchange between D-SNPs and receiving entities?** States that established information-sharing requirements between D-SNPs and Medicaid MCOs, providers, or care management agencies have found significant value in having on-going, face-to-face meetings with all D-SNPs and the entities receiving admission notifications to think through how data would be collected, shared, used, and reported to the state. Early on, states can use these sessions to convey state goals for care transitions, identify data elements to exchange, and systematically work through new processes, roles, and challenges as they arise. After information-sharing processes are launched, these meetings, along with direct reporting from D-SNPs and receiving entities to the state, can help states monitor the exchange and use of admissions data. States may also want to engage in pre-implementation readiness review processes with each D-SNP to review policies and procedures and system testing related to the D-SNP's role in exchanging data and using it to support care transitions.
- **How can the state monitor the transmission and use of admission data to support care transitions and any impact on Medicaid and D-SNP care transition efforts?** States with D-SNPs subject to new information-sharing requirements should consider how they will monitor whether D-SNP admission notifications around hospital and SNF admissions are being provided timely and used to support care transitions as intended. States can work with D-SNPs to develop periodic reports that track and trend admission notifications and with care coordinators to track the response to such notifications.

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The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the *Integrated Care Resource Center* are coordinated by **Mathematica** and the **Center for Health Care Strategies**. For more information, visit **www.integratedcareresourcecenter.com**.

ENDNOTES

[1] 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. See pp.15710-15718. Available at: https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf

[2] As described in the final rule, D-SNPs can satisfy the new integration standards by either meeting the information-sharing requirement or by being a FIDE SNP or a HIDE SNP. The federal information-sharing requirements do not apply to HIDE or FIDE SNPs. However, states have the discretion to develop information-sharing requirements on hospital or SNF admissions and include those in their state Medicaid agency D-SNP contracts. This may be useful for states where enrollment in the D-SNP and affiliated Medicaid MCOs is not always aligned or where there are other Medicaid providers who could use the information to initiate care coordination activities.

[3] Created by Section 3026 of the Affordable Care Act, the Community-Based Care Transition Program (CCTP) provided funding to test models for improving care transitions for high-risk Medicare patients by using services to manage patients' transitions effectively. Community-based organizations partnered with 448 acute-care hospitals with high readmission rates to deliver care transition services to enrolled high-risk Medicare fee-for-service beneficiaries, with the purpose of reducing readmissions and demonstrating measurable savings to Medicare. CCTP extended sites operating for more than one year showed that targeted transition services which include information sharing on admissions could significantly lower hospital readmission rates and reduce Medicare Part A and Part B expenditures for high-risk Medicare beneficiaries. For more information see: Ruiz, D., McNealy, K., Corey, K., et al. "Final Evaluation Report Evaluation of the Community based Care Transitions Program." Econometrica and Mathematica Policy Research, November 2017. Available at: https://downloads.cms.gov/files/cmmi/cctp-final-eval-rpt.pdf

[4] Some states, including Oregon, Pennsylvania, and Tennessee, already require D-SNPs to share this information on hospital and SNF admission for all D-SNP enrollees. See the ICRC brief "Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations" for details on these state approaches. Available at: https://www.integratedcareresourcecenter.com/resource/promoting-information-sharing-dual-eligible-special-needs-plans-improve-care-transitions

[5] 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. Available at: https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf

[6] In addition to the information-sharing requirements included in the final rule on Medicare Advantage and Medicare Part D, CMS proposed in February 2019 a new rule supporting its MyHealthEData initiative to improve patient access and advance electronic data exchange and care coordination throughout the health care system. While the "Interoperability and Patient Access" proposed rule would broadly improve care coordination by addressing the interoperability and exchange of health care information, two provisions would directly impact D-SNPs' information sharing. The first proposes that hospitals be required to send electronic notifications of a patient's admission, discharge, or transfer to another health care facility or community provider at the patient's request. Hospitals would have to demonstrate that the information was sent directly to the facility or to an intermediary that facilitates the exchange of health information. The second proposes that Medicare, Medicaid, and CHIP managed care plans and Qualified Health Plans in Federally Facilitated Exchanges coordinate care between plans by sending the standardized set of health data classes and constituent data elements contained in the U.S. Core Data for Interoperability (USCDI). These provisions would take effect April 1, 2022 if the rule is finalized as proposed. See: CMS. "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans in the Federally-Facilitated Exchanges and Health Care Providers." Published in the *Federal Register* on March 4, 2019. Available at: https://www.federalregister.gov/documents/2019/03/04/2019-02200/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and

[7] CMS did not include notification of emergency department visits in the final rule, but states may require D-SNPs to share information around these events.

[8] 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. See pp.15710-15718. Available at: https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf

[9] See the ICRC brief "Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations" for details on these state approaches. Available at: https://www.integratedcareresourcecenter.com/resource/promoting-information-sharing-dual-eligible-special-needs-plans-improve-care-transitions

[10] States exchange MMA files at least monthly to identify individuals who are dually eligible for Medicare and Medicaid. The MMA response files that states receive from CMS not only include confirmation of dual eligibility status, but also information about individual beneficiaries' Medicare Advantage plan enrollment. States can use that enrollment data to identify which Medicaid enrollees are enrolled in a D-SNP for their Medicare benefits. For more information about MMA file exchange, see the CMS MMA file webpage: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/StateMMAFile.html.

[11] CMS. "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans in the Federally-Facilitated Exchanges and Health Care Providers." Published in the *Federal Register* on March 4, 2019. Available at: https://www.federalregister.gov/documents/2019/03/04/2019-02200/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and

[12] States developing information-sharing requirements with D-SNPs can find examples of relevant contract language used in Oregon, Pennsylvania, and Tennessee in Appendix A of a recently released ICRC issue brief "Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations." Available at: https://www.integratedcareresourcecenter.com/resource/promoting-information-sharing-dual-eligible-special-needs-plans-improve-care-transitions