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BRIEF

August 2019

Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations

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Many states contract with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) to provide Medicare services to their dually eligible populations, but they do not require these D-SNPs to provide coverage of Medicaid long-term services and supports (LTSS) or behavioral health benefits. Providers of these Medicaid services may not be aware of important Medicare services received by D-SNP enrollees that impact the Medicaid services these individuals receive. Starting in 2021, under a new rule recently released by the Centers for Medicare & Medicaid Services (CMS), these D-SNPs will be required to notify the state or the state's designee when their enrollees experience Medicare-covered hospital or skilled nursing facility (SNF) admissions.[1, 2] (For more information on the new CMS rule and the impact on state D-SNP contracts, see the call out box **New Requirements for D-SNP Information Sharing**.)

The goal of the new rule is to ensure timely initiation of care management activities around transitions of care, and, in turn, help lower readmission rates and more effectively support D-SNP enrollees. The CMS-funded Community-based Care Transitions Program (2011-2015) showed that timely data sharing and targeted transition services could significantly lower readmission rates and reduce Medicare Part A and Part B expenditures for high-risk Medicare beneficiaries.[3] Providing more support for individuals around transitions in care may also facilitate their return to the community.

Some states, including **Oregon**, **Pennsylvania**, and **Tennessee**, already require D-SNPs to share information on their enrollees' hospital and SNF admissions. This brief examines the approaches of these three states used to develop and implement information-sharing processes to support care transitions. It includes examples of contract language and strategies to encourage plan collaboration and problem solving around information sharing. Regardless of each state's approach to information sharing with D-SNPs, their common goal is to create an actionable processes that promote seamless care transitions for similar populations.

This brief will help states, D-SNPs, and other stakeholders assess how to meet the new D-SNP contracting requirements and improve the care of dually eligible individuals. **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.**

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.[4,5] For calendar year 2021, D-SNPs must have either:

- A state contract to provide Medicaid 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 managed care organization or Medicaid care manager), on hospital and SNF admissions of high-risk individuals who are enrolled in the D-SNP.[6]

Approaches to Information Sharing

States have broad flexibility to define the parameters for D-SNP information sharing on hospital and SNF admissions. They can define one or more groups of high-risk full benefit dually eligible (FBDE) beneficiaries for whom the information-sharing requirement would apply. These groups could include home- and community-based services waiver participants, Medicaid health home program participants, or a group defined through the state Medicaid agency's use of claims or encounter data to target high utilizers of acute care or other services. States also have considerable latitude to establish information sharing notification protocols, including:

- Which entities should receive hospital or SNF admission notifications;
- What timeframes will be required for information transmission; and
- How information should be transmitted (e.g., through an automated or manual process, leveraging Health Information Exchange (HIE) or other state-driven technology platforms, etc.).

In addition, states can define their own role in information sharing, including being directly involved in or delegating responsibility for collection and exchange of data to D-SNPs and providers. The role that states, D-SNPs, and other parties play in obtaining and sharing data on hospital and SNF admissions may vary, both by the specific admission data being transmitted and also by the state's use of Medicaid managed care for D-SNP enrollees, the extent of health information exchange infrastructure and participation, and other factors.

This section describes three approaches to information sharing: (1) event notification solutions that can be leveraged by D-SNPs, states, Medicaid plans and providers; (2) a state portal for collecting and disseminating information; and (3) plan- and provider-developed processes for sharing information. The latter two use defined care coordination reports and focus on sharing information for D-SNP enrollees who are in unaffiliated Medicaid managed care organizations (MCOs). These three approaches require different levels of state resources and engagement and can be broadly focused on all D-SNP enrollees or tailored to focus on particular subsets of a state's dually eligible population enrolled in D-SNPs. In all cases, states can establish their own scope and specific requirements for information sharing via their contracts with D-SNPs. States can also apply considerations and lessons from the approaches highlighted here to establish information-sharing requirements with D-SNPs regardless of the state's Medicaid managed care landscape. **Appendix A** includes examples of relevant contract language from Oregon, Tennessee, and Pennsylvania that can be modified for use by other states.

Information Sharing With D-SNPs in States with Dually Eligible Populations in Medicaid FFS Programs

States that do not have Medicaid managed care programs, or that have Medicaid managed care, but allow some or all dually eligible beneficiaries to remain in FFS Medicaid, will need to consider which providers or entities in the FFS system should receive inpatient and SNF admission information. In some states, the state itself could be the initial recipient of this information, and could then pass it on to the appropriate FFS providers or entities. Other states may want to arrange for D-SNPs to share this information directly with FFS providers or entities who would benefit from receiving admission data and can establish care management processes to use it effectively. This could include LTSS and behavioral health providers or care managers, such as Area Agencies on Aging, Aging and Disability Resource Centers, Centers for Independent Living, or targeted mental health case managers, as well as providers of housing services and supports.

Oregon: Leveraging Event Notification Systems to Promote Information Sharing

A growing number of states have event notification systems (ENS) that require hospitals to share emergency department (ED) and inpatient admission data with other parties via an existing HIE platform or another web-based portal. These ENS may be funded and launched by hospitals, health plans, or other parties, and, once established, states have an opportunity to leverage the available data to inform care management for Medicaid beneficiaries, including those who are dually eligible for Medicare and Medicaid. The level of sophistication, rate of provider participation, and the use of ENS varies by state, but some of these systems have achieved high rates of hospital participation.[7] ENS participation can also be expanded to include SNF providers that are working with hospitals and other providers to meet readmission reduction goals by improving transitions in care.

State Background

Oregon has leveraged a statewide subscription for hospital ENS to promote information sharing and improve care transitions for dually eligible beneficiaries. In Oregon, dually eligible beneficiaries have the option to either receive Medicaid services via the FFS system or opt into managed care by enrolling in regional Coordinated Care Organizations (CCOs).[8] In both cases, LTSS services continue to be delivered via FFS providers as required by state law. To better coordinate care for dually eligible beneficiaries, the Oregon Health Authority (OHA) requires that each CCO have a formal agreement with either a D-SNP or a Medicare Advantage plan. As a result of this requirement and state efforts to promote aligned enrollment across Medicaid and Medicare managed care options, a growing subset of dually eligible CCO enrollees are in an aligned D-SNP and CCO arrangement.[9]

Oregon's D-SNP contracts still require plans to share key information about their enrollees to all relevant providers, including FFS LTSS providers (e.g., local case management agencies serving aging and disabled populations including Area Agencies on Aging and Aging and Disability Resource Centers) and CCOs, to enhance coordination (See **Appendix A: State Information Sharing Requirements**). D-SNP contract provisions require "timely notification" to relevant Medicaid CCO or FFS providers of the following: (1) planned or unplanned inpatient admissions; (2) high-priority health concerns; and (3) key provisions of discharge planning documents. Beginning in 2020, Oregon will require D-SNPs to also share information on SNF admissions with relevant parties. Additionally, both CCOs and D-SNPs are required to make reasonable efforts to coordinate with the existing LTSS service delivery system for all CCO enrollees.

Approach to Information Sharing

In recent years, Oregon has made significant investments in the use of health information technology (HIT) to share and analyze patient data as part of the state's overarching care coordination model for Medicaid beneficiaries.[10] The state's HIT investments include launching, in partnership with the private sector, a statewide hospital admission, discharge, and transfer ENS, called Emergency Department Information Exchange (EDie),[11] and support for adoption and spread of a companion web portal, Collective Platform, that alerts subscribers to admission events in real-time. Adoption of the Collective Platform web portal and use of ENS alerts has spread across a broad array of health care organizations in Oregon, including all 60 hospitals, more than 300 primary care practices and 60 behavioral health organizations, LTSS care management agencies, and all CCOs and D-SNPs. These solutions can be leveraged by the state and D-SNPs to meet admission notification requirements set out in the state D-SNP contract.

Although D-SNPs operating in Oregon have not previously been specifically required to use EDie, they have been expected to ensure timely notifications of admissions. OHA's 2020 D-SNP contracts require annual performance reporting on notifications including the proportion of contracted physical, behavioral, and oral health providers who have access to and use hospital event notifications and SNF event notifications. Oregon's D-SNPs participate in EDie and as a result, have secured access to EDie alerts for their enrollees. The state anticipates all D-SNPs will meet the new CMS hospital and SNF admission notification requirements through their ongoing participation in this system.

The initial launch and on-going operation of the EDie event notification system has been funded via a utility model – health plans, hospitals, and the state all contribute to provide hospital ED and inpatient admission, discharge, and transfer alerts to Oregon users of the platform, which results in a reasonable cost per organization.[12] For the Collective Platform web portal, Oregon elected to fund a statewide Medicaid subscription to encourage a broad mix of plans, providers, and care managers involved in care transitions to participate and receive event notifications and related data for their Medicaid enrollees or patients at no cost. In Oregon, all CCOs are using the state subscription, as are several state programs, including Area Agency on Aging, Aging and People with Disabilities, and DHS Office of Intellectual and Developmental Disabilities. CCOs are able to extend, at their own cost, their subscription to their contracted physical, behavioral, and oral health providers and almost all CCOs have done this. D-SNPs in Oregon are required to pay their own costs for access to Collective Platform. Other states with established similar systems, including Florida and Virginia, have also used a utility model and elected to have contracted health plans pay the subscription cost for ENS services directly to the state's vendor.

EDie is increasingly being used to track SNF admissions as well. About 70 SNFs that represent the three largest SNF providers in the state are voluntarily using the system currently, and the state expects all SNFs to participate by the end of 2019. To encourage broader SNF participation, the participating SNF providers are working to convene the smaller SNFs to share why this information sharing is necessary and how it helps them meet federal requirements.[13] SNF representation has also been added to a statewide EDie/Collective Platform Steering Committee, which is convened through a public-private partnership co-sponsored by OHA.

Oregon's implementation of the EDie system began in 2014. Within 15 months, all the hospitals had signed contracts with OHA agreeing to participate and were using EDie. As EDie was being launched, the vendor also released its Collective Platform product, which became available to Medicaid providers and health plans in 2016. Since then, other health plans have also become subscribers, and in 2019 SNFs began to contribute data to both EDie and the Collective Platform. (Note that more information on EDie, the Collective Platform, and the subscription model can be found in Oregon's Strategic Plan for Health Information Technology and Health Information Exchange and on the Oregon Health Leadership Council's website.)[14]

Impact to Date

Organizations using the EDie and Collective Platform systems report that they allow for faster follow up with patients after hospital discharge, potentially reducing readmissions. After utilizing the notification system, one organization that previously had difficulty getting timely notification when mental health clients were discharged from the hospital was able to successfully implement a workflow that resulted in 99 percent of patients receiving follow up within seven days of discharge. OHA staff reported that EDie is being used regularly for virtual "stand ups" where primary care, behavioral health providers, the hospital, and the health plan can jointly discuss patient follow ups and update care guidelines after recent admissions or ahead of discharges or transfers. A 2017 evaluation of the EDie system found that hospitals that were active users of EDie showed a marked decrease in visits by high utilizers compared to other hospitals in the state.[15]

Overview of How Oregon's Emergency Department Information Exchange (EDie) and Collective Platform Systems Support Coordination of Care for High-Risk Individuals

The EDie system alerts ED physicians in real time when a patient who is a frequent user of ED and hospital services (i.e., 5 ED visits in 12 months, 3 ED visits to different facilities within 90 days, or recent care guideline created due to complex care needs) registers in their ED. Alerts include the patient's previous ED and inpatient data from any hospital in Oregon, Washington, or parts of California and Idaho, as well as a small number of other key data elements, including demographics, chief complaint, primary diagnosis, admission, discharge, and transfer times, and care guidelines entered by the patient's primary care medical home, and contact information for case managers. EDie functions as a query system for hospitals, and it has a care team section where users can see all the providers who are providing services for the individual.

EDie links to a companion system developed by the same vendor called Collective Platform (formerly PreManage), which is a web portal that expands access to EDie hospital, ED, and SNF event notifications and the other key data elements to D-SNPs, CCOs, providers (primary, behavioral, and oral health), and LTSS care management agencies. The onboarding process for new Collective Platform users may take several weeks and generally includes establishing legal agreements between the organization and the vendor, configuring the organization's web portal access to meet the needs of its users, and developing a user-specific eligibility file including the specific patients for which alerts will be provided. The vendor also provides user training, the length of which varies depending on the organization's needs. Established users of the Collective Platform web portal then submit an eligibility file on a routine basis to the vendor to demonstrate they have a HIPPA treatment payment or operations (TPO) relationship with a panel of enrollees or patients. Once an outside TPO entity is linked to a patient record in the system, the system will send ED or hospital admission alerts. Each TPO entity can also add to the care guidelines in the system.

OHA provides data to the Collective Platform vendor to ensure that all subscribers can identify current LTSS care management agencies that can work with hospitals, SNFs, CCOs and D-SNPs to manage transitions. The expanded access to Collective Platform data supports care coordination for enrollees that are served by a CCO or D-SNP and the state's LTSS system. Multiple organizations are able to see the same notifications on enrollees and can develop reports unique to their care coordination team's need to monitor a high-risk or high-need population. In some cases, these organizations are working together to share care guidelines across agencies through the system, or in others it can trigger an interdisciplinary care conference with agency partners and relevant providers.

Considerations for Leveraging Event Notification Systems

This approach to information sharing is broadly applicable to states and D-SNPs that may be looking for a real-time admission notification option to support care transitions and meet new D-SNP information sharing requirements. It is also particularly relevant to states that do not use Medicaid managed care plans to serve dually eligible beneficiaries, but could still require that D-SNPs subscribe to ENS alerts and share data with relevant internal and external parties (e.g., Medicaid case management agencies or health home providers) for high-risk D-SNP enrollees. In states that use managed care for providing LTSS or behavioral health, states can work with D-SNPs and existing Medicaid case management providers to ensure assigned Medicaid care managers receive ENS alerts along with access to related data to support care transitions (i.e., discharge plans, care guidelines, high-priority conditions). Multiple avenues exist for funding an ENS or related HIE platform which may allow states to draw from a mix of public and private resources to establish systems and fund ongoing access.

Although there are high rates of hospital participation in notification systems once established, states and providers are still developing linkages between these systems and SNF providers. As a result, states that leverage an ENS solution to meet the D-SNP requirement for notifications around hospital systems may need to either: (1) work to expand these systems to include SNF admission notifications; or (2) work with D-SNPs to establish a separate process for the collection and sharing of SNF admission data. The utility model of funding ENS participation can be used to spread ENS costs across the health plans and providers that will receive notifications (i.e., states could require D-SNPs to pay subscription costs for ENS alerts for all or a portion of their enrollees).

State Driven Information Sharing – Tennessee's Defined Care Coordination Reports and State Portal

States can take a lead role working with D-SNPs to facilitate the sharing of inpatient admission data between plans, including developing specific reports and hosting an online portal through which plans can both submit and obtain relevant data for their enrollees. As an example of this approach, Tennessee developed daily and quarterly care coordination reports that include hospital and SNF admission data, a care coordination request form, and a data portal plans can use to submit and access this information, which are intended to improve care transitions and reduce readmissions over time.

State Background

Tennessee operates two MLTSS programs: (1) TennCare CHOICES serving beneficiaries over the age of 65 or age 21-64 with physical disabilities, and (2) Employment and Community First CHOICES serving beneficiaries with intellectual and developmental disabilities. The state contracts with D-SNPs to provide an integrated option for dually eligible CHOICES and Employment and Community First CHOICES enrollees where they can receive integrated care by enrolling in the same health plan for Medicare and Medicaid benefits.[16] Tennessee's D-SNP contracts specify information-sharing requirements and strong coordination requirements for D-SNPs intended to establish timely information exchange between the state and plans and improve care transitions.[17] The state tailors its D-SNP contracts to help improve coordination of care for both aligned CHOICES and Employment and Community First CHOICES enrollees receiving Medicare benefits from an affiliated D-SNP as well as for CHOICES and Employment and Community First CHOICES enrollees being served by an unaffiliated D-SNP.[18]

Approach to Information Sharing

In 2013, Tennessee began working with TennCare managed care organizations (MCOs) and contracted D-SNPs to establish routine information exchange, including notification of hospital and SNF admissions occurring as beneficiaries moved between acute, post-acute, and community or other long-term care settings. Today, the state requires all D-SNPs operating in Tennessee to maintain and exchange daily inpatient census data on both hospital and SNF admissions and discharges as well as other less frequent reports that also include admission, discharge, and transfer information. The state defined information exchange around hospitalizations and SNF stays broadly to include hospital observation stays as well as Medicare rehabilitative SNF stays that are converting to a Medicaid nursing facility stay.

D-SNPs in Tennessee serving individuals for whom they do not also manage the Medicaid benefit alert TennCare MCOs about admissions the MCOs otherwise might not be aware of.[19] For dually eligible beneficiaries enrolled in unaligned Medicare-Medicaid arrangements, this is the primary way meaningful coordination of benefits can occur across the two programs and two health plans. Particularly for LTSS beneficiaries (or *potential* LTSS beneficiaries), the MCO can partner with the D-SNP in discharge planning to facilitate timely access to HCBS, and ensure services are provided in the preferred and least restrictive setting. Importantly, it enables the development of an integrated person-centered support plan, reflecting the Medicare, as well as Medicaid, benefits that the beneficiary needs. It

also alerts the MCO to the reasons that HCBS visits will not be provided (during the inpatient stay), and triggers a post-discharge reassessment of needs (per the MLTSS contract) to determine whether additional supports or interventions are needed to sustain community living and optimize health and quality-of-life outcomes. D-SNPs also make use of this information to coordinate enrollee's immediate acute care needs and support discharge planning—particularly when a person is already enrolled in MLTSS or when such enrollment might be needed to facilitate safe and appropriate discharge.

To help facilitate timely information exchange and subsequent discharge planning, the state requires D-SNPs to submit data on all FBDEs' admissions within two business days via the *Inpatient Census Report*. See **Appendix B** for a list of data fields included in the state's *Inpatient Census Report*. This report is submitted every business day by all D-SNPs to the appropriate Medicaid plan or D-SNP via a state-administered file-transfer-protocol (FTP) site.[20] The state also uses this FTP site for purposes of other secure data exchange with and between MCOs and D-SNPs. D-SNPs determine the method and frequency with which they will obtain hospital and SNF admission data to meet the state's two business day notification requirement. D-SNPs may establish more stringent reporting timeframes (e.g., within 24 hours) for enrollees with higher risk levels, as long as they comply with the two business day reporting requirements for all enrollees. In parallel to the plan-to-plan information sharing efforts, TennCare also partnered with the Tennessee Hospital Association to conduct trainings for hospital social workers and discharge planners on the D-SNP coordination requirements in each region of the state, including, importantly, the availability of Medicaid HCBS, and the importance of coordination for purposes of Medicare skilled nursing facility diversion.

To improve care transitions and support state goals to reduce readmissions for enrollees of CHOICES and Employment and Community First CHOICES, Tennessee also requires D-SNPs to submit a *Quarterly Dual Coordination Report* that TennCare reviews and uses for discussion with D-SNPs and as a method for tracking and trending coordination efforts.[21] The D-SNPs also use a *Care Coordination Request* form to request coordination assistance from TennCare MCOs and information from these plans on non-aligned beneficiaries. In addition, TennCare LTSS staff conduct a clinical audit of a sample of enrollees with multiple re-admissions listed on the quarterly dual coordination report, up to two times per year, to determine whether adequate coordination occurred to reduce preventable readmissions and appropriate discharge planning, referrals, and education to beneficiaries and their families was provided by plans. The *Quarterly Dual Coordination Report* and clinical audits provide TennCare with continued opportunities for oversight and improvement of D-SNP coordination activities.

The intended outcomes of these reporting and coordination requirements include: more effective hospital discharge planning that takes into account all of the potential services and settings in which they could be provided rather than defaulting to SNF admission; a reduction in avoidable hospital and SNF admissions/readmissions; increase in appropriate follow-up care upon discharge; increased use of Medicaid HCBS (versus institutional care); and improved performance in specified HEDIS measures and in beneficiary satisfaction and quality of life. TennCare is currently participating in a study funded by the CMS Office of the Assistant Secretary for Planning and Evaluation and conducted by Vanderbilt University Medical Center that is assessing whether these outcomes are occurring, using claims-based measures.

Lessons Learned

An important takeaway from the initial implementation of these requirements in Tennessee is that the state found value in being prescriptive and "hands-on" in helping D-SNPs think through how the data would be collected, shared with one another, reported to the state, and used to improve coordination of care. Tennessee engaged in pre-implementation readiness review processes with each D-SNP to review policies, procedures, and training materials that relate to the D-SNP's role in exchanging data and using it to support care transitions. The state also required D-SNPs to engage in onsite demonstrations of key operational processes and IT systems and data exchange processes.

Once implementation was underway, TennCare staff also held weekly calls with each D-SNP to ensure that data was being collected, shared, and used as expected. TennCare staff also developed a coordination protocol to elaborate on contract requirements, and conducted numerous implementation meetings as well as trainings with affiliated and unaffiliated D-SNPs. The opportunity to ask questions of staff from other health plans, identify barriers and concerns, and address challenges together fostered relationships and a collaborative spirit that carried forward into the coordination of care for beneficiaries. The implementation of TennCare's information sharing requirements began with establishing contract requirements in July 2012 and completing all implementation activities by May 2013 for all but one D-SNP.

Plan-Driven Information Sharing – Pennsylvania's D-SNP Information Sharing to Improve Care Transitions for Unaligned Enrollees

A third approach is for states to require D-SNPs to work with Medicaid MCOs or designated Medicaid providers to develop and implement their own process and data elements for information sharing. This plan- and provider-driven approach can be used to share information on a broad group of D-SNP enrollees or a subset depending upon state goals and program design (e.g., D-SNP enrollees being served by MLTSS MCOs, D-SNP enrollees enrolled in an HCBS waiver program). Plans and providers can be asked to agree on data elements and create a template and process for information sharing.

State Background

In 2018, the Pennsylvania Department of Human Services (DHS) launched its mandatory MLTSS program, Community HealthChoices (CHC), contracting with three health plans to deliver Medicaid LTSS and coordinate medical care for dually eligible individuals and individuals with physical disabilities. The state requires all three CHC MLTSS plans to operate a D-SNP, creating opportunities for aligned Medicare and Medicaid enrollment. However, the state also elected to continue contracting with seven other D-SNPs that do not participate in CHC. Given this contracting strategy, Pennsylvania's contract with D-SNPs specifically requires that the plans share information on enrollee hospital and SNF admissions within 48 hours of specified events to support care coordination for both aligned and unaligned enrollees.

Approach to Information Sharing

In the fall of 2017, just prior to the launch of CHC, DHS representatives began a series of face-to-face meetings with all D-SNPs and CHC plans to establish lines of communication with the goal of improving care coordination. Over time, these meetings expanded to include the state's Medicaid comprehensive managed care and behavioral health managed care plans. In establishing information sharing between D-SNPs and CHC plans to support care coordination efforts, the state took a delegated approach, asking these plans to work together to develop the information-sharing approach and periodically convening plans to discuss their progress.

In addition to plan-to-plan information sharing, D-SNPs and CHC plans in Pennsylvania are also sharing relevant admission information on hospital and SNF stays with CHC contracted Medicaid case management agencies operated by aging network community-based organizations coordinating community-based LTSS and by managed behavioral health organizations that deliver Medicaid covered behavioral health services to D-SNP enrollees. This data sharing between plans and external care managers helps meet state MLTSS care management expectations for timely patient outreach and post-discharge re-assessment and care plan updates. The state's MLTSS program and D-SNP contracts also require that CHC MCOs and the D-SNPs work together to reconcile medications and care plans, so CHC plans are also sharing admission data with other key external care team members including primary care physicians.

Along the way, the state also required that plans work together on new data-sharing agreements that would enable unaffiliated DSNPs to share enrollee-level data with CHC plans. Initially, some plans were concerned about whether

they were legally prohibited from sharing their enrollees' health information. However, Pennsylvania D-SNPs and CHC plans worked through potential options, established data sharing agreements, and identified a secure file exchange process for information sharing between plans. In addition to convening plans to discuss and problem solve around information-sharing efforts, DHS is helping the D-SNPs identify which entity covers their enrollees' Medicaid benefits (CHC plan, behavioral health organization, etc.) by providing D-SNPs with access to the state's electronic verification system which identifies specific programs a beneficiary is eligible for as well as which CHC MCO is covering a recipient. The state also makes Minimum Data Set data available to D-SNPs to help them understand the care needs of enrollees in nursing facilities.

To inform their information sharing approach, DHS staff and their contractors spoke with other states, including Florida, Kansas, and Tennessee, about the varied approaches those states took toward information sharing. DHS staff considered using a state-administered portal, even speaking to one of Tennessee's D-SNPs to get the plan's feedback on the process. However, after reviewing available resources Pennsylvania decided to have the D-SNP and CHC plans work together to create a process for directly sharing inpatient admission data.

Linking Information Sharing on Inpatient Admissions Performance Improvement Strategies

Pennsylvania's efforts to require D-SNP and CHC plans to coordinate around care transitions is part of its broader strategy to improve care coordination overall for dually eligible beneficiaries enrolled in CHC, the state's MLTSS program. This larger effort also includes working with plans and the state's external quality review organization to ensure the MLTSS Performance Improvement Projects (PIPs) that CHC plans must conduct incorporate and report on coordination between CHC plans and D-SNPs.

The 2019 CHC contract requires plans to perform at least two PIPs, one clinical and one non-clinical that both promote coordination between CHC plans and D-SNPs. The clinically focused project is on strengthening care coordination between LTSS and other Medicare and Medicaid services used by dually eligible individuals. The non-clinically focused project is on transitioning enrollees from nursing facilities to the community, including a focus on individuals that have a history of readmissions. Both of these PIP focus areas are particularly important to Pennsylvania's integrated program design where enrollees can be unaligned across Medicare and D-SNPs and barriers to coordination can exist (i.e., enrolled in unaffiliated D-SNPs and CHC plans).

State staff report that plans are structuring these projects to support care transitions and significant opportunities exist to utilize data on hospital admissions, discharges, and transfers as well as SNF admissions in their performance improvement efforts. These projects will run for three years, but the state hopes to begin seeing initial data on the projects in September 2019.

DHS, D-SNPs, and CHC plans are also working together to leverage the HIE platforms operating in the state, which can complement and improve upon D-SNP to CHC plan information-sharing efforts by enabling D-SNPs and CHC plans to receive and respond to data on faster, real-time basis. Pennsylvania's statewide HIE, called P3N, is operated and coordinated by DHS under the Pennsylvania eHealth Partnership Program. There are five certified health information organizations (HIOs) that have access to the statewide P3N and although provider participation may be regional, they can virtually connect providers in any region of the state. The HIOs are in varying stages of pushing out admission, discharge, and transfer data to CHC plans and D-SNPs. CHC plans are currently required to join one of the certified HIOs, and beginning in 2020, D-SNPs will also be required to join one, with DHS expecting all plans to cover the subscription costs.

Early Lessons

Taking a plan or provider driven approach similar to Pennsylvania's may reduce administrative burden for a state, although states would still have an important role to play in establishing information-sharing requirements and overseeing the plan's use of data in line with state goals. DHS strategically linked development of information sharing on admissions between CHC plans and D-SNPs to the broader CHC plan MLTSS care management efforts, especially those related to transition of care from hospitals to the community or nursing facilities. DHS found that establishing clear expectations by requiring CHC plans to participate with at least one HIO is helping drive faster adoption of real-time admission, discharge, and transfer data transmission to first CHC plans and now D-SNPs. Additionally, Pennsylvania required that its Medicaid MCOs, rather than the D-SNPs, submit copies of signed business agreements for data sharing between plans. Having Medicaid MCOs take the lead on specific development steps, including executing business agreements between unaligned plans, was an effective way for Pennsylvania to assure compliance with the new information sharing requirements.

Considerations for Working with Plans to Establish Data Sharing on Admissions and Related Data

Both Pennsylvania and Tennessee established hospital and SNF admission information sharing between health plans (i.e., D-SNPs and Medicaid MCOs). At the start of their efforts, both states found significant value in having on-going, face-to-face meetings with all D-SNPs and Medicaid plans. States can use these sessions strategically to convey state goals around care transitions, identify data elements to exchange, and systematically work through new processes, roles, and challenges as they arise. In Pennsylvania, plans sent representatives to these meetings from several functional areas including medical directors, quality, and information technology, and worked through a number of related areas in the state D-SNP contract. This included having D-SNP and CHC plan staff split into groups to problem solve around obstacles to data sharing.

A plan-driven approach may be most effective when there is a manageable number of D-SNPs and Medicaid MCOs to coordinate across. In states with large numbers of D-SNPs it may take longer to come to agreement on the data elements that will be exchanged or the process for sharing timely admissions data. In all cases, states will need to review D-SNP and Medicaid MCO contracts to determine what types of already established business agreements or trading partner agreements will govern the exchange of personal health information between plans, the state, or other parties.

Conclusion

New federal rules designed to improve care coordination around transitions in care will soon require D-SNPs to share information about their enrollees' hospital and SNF admissions with states or their designees. This will be required in all cases where the D-SNP contract does not integrate LTSS or behavioral health benefits, and state D-SNP contracts will need to specify an information sharing process for hospital and SNF admissions by July 1, 2020. To meet this deadline, states interested in continuing to contract with D-SNPs currently operating in their state will need to answer the following questions as soon as possible:

- Which dually eligible beneficiaries are at "high risk" and what population of these individuals do they want to prioritize for information sharing on hospital and SNF admissions to improve care coordination?
- Which entities should be notified of hospital or SNF admissions?
- What notification method will be used?
- What will be the timeframe for notification?

Each of the approaches to information sharing described in this brief can be adapted for use by states or plans and for large or smaller scale efforts. States may want to work directly with D-SNPs to determine what role the state will play in supporting the timely exchange of D-SNP data on hospital and SNF admissions with Medicaid providers or care managers. States will need to be actively involved in overseeing the development of the information exchange process, even if the ultimate responsibility for receipt and use of the data is delegated to other parties, including key Medicaid case managers, specialized health plans, or other providers. States, plans, and other stakeholders have the opportunity to work together to improve the care received by D-SNP enrollees as they navigate transitions in care.

All three states highlighted here are either leveraging or planning to leverage real-time admission notifications from hospital ENS, which can complement required reports that transmit information on admissions, like those used in Tennessee and Pennsylvania. Since systems that provide admission, discharge, and transfer notifications are increasingly in place or under development in a number of states, states designing new processes for sharing admission data with D-SNPs should assess the ENS capacity and participation rates in their state early on to determine how they could support D-SNPs and other entities to improve care transitions. Requiring D-SNPs to share timely admission data with key Medicaid plans, providers, or case managers for a state-defined group of dually eligible beneficiaries will help to ensure that high-risk beneficiaries receive assistance with discharge or transfer processes, and where applicable, are given supports to return to community settings.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

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 Policy Research** and the **Center for Health Care Strategies**. For more information, visit **www.integratedcareresourcecenter.com**.

Appendix A. State Information Sharing Requirements

This table highlights state contract provisions in Oregon, Pennsylvania, and Tennessee that relate to D-SNP admissions notifications, discharge planning, care transition requirements, and, where applicable, participation requirements for state or regional HIE platforms. These contract provisions were found in each state's most recently available state Medicaid agency D-SNP contract.

State (D-SNP Contract Title and Year)	Target D-SNP Population	Entity Notified	Timeframe for Notification	Notification Mechanism	Relevant Contract Language
Oregon Oregon Health Authority 2019 Coordination of Benefits Agreement	D-SNP full benefit dual eligible members, both affiliated and unaffiliated D-SNPs, including notifications for FFS LTSS beneficiaries	Medicaid managed care entity or state Medicaid agency care coordination staff and providers, including FFS LTSS care management agencies	Timely	Via event notification system for all hospital and some SNF admissions, discharges, and transfers; Via direct beneficiary level notifications for remaining SNF admissions.	**Section 6 – Information sharing to improve care coordination and care outcomes** **6.1** The Health Plan shall work to ensure information sharing for Medicaid and Medicare benefits coordination, and work to facilitate communication for care coordination and care transitions with network providers and facilities for all full dually-eligible members. **6.3**. Plans shall have policies and protocols for timely notification of the full dually-eligible member's Medicaid Managed Care Entity (MCE), or State Medicaid Agency care coordination staff and providers serving the member of Health Plan determined relevant 1) planned or unplanned inpatient admissions, 2) high priority health concerns identified through member health assessments, and 3) sharing of key provisions of discharge planning documents. **6.4.** Plans shall coordinate services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays: 6.4a with the services the member receives from any other MCE; 6.4b with the services the member receives in FFS Medicaid; including long-term care and long term services and supports; and 6.4c with the services the member receives from community and social support providers.

State (D-SNP Contract Title and Year)	Target D-SNP Population	Entity Notified	Timeframe for Notification	Notification Mechanism	Relevant Contract Language
Tennessee MIPPA Agreement, 2019	D-SNP full benefit dual eligible enrollees	TennCare MCO	Within 2 business day of the "anchor date" (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.")	Via daily plan-to-plan file exchange currently via state FTP site. The state is also developing a process to make admission, discharge, and transfer files available to TennCare MCOs for coordination purposes.	**Sec. A.2.b.6.a-b** **6.** The Contractor shall coordinate TennCare benefits not covered by the Contractor with the FBDE member's TennCare MCO. The Contractor shall be responsible for the following: (a) Providing notification within (two) business days from the anchor date[1] to a FBDE member's TennCare MCO of all FBDE members' inpatient admissions, including planned and unplanned admissions to the hospital or a SNF, as well as observation days and emergency department visits. The Contractor shall report each inpatient admission, observation day, and emergency department visit separately. The Contractor's implementation of emergency department visit notifications will occur at a later date to be determined by TennCare. (b) Coordinating with a FBDE member's TennCare MCO regarding discharge planning from any inpatient setting when Medicaid LTSS (NF or HCBS) or Medicaid home health or private duty nursing services, may be needed upon discharge in order to ensure that care is provided in the most appropriate, cost effective and integrated setting. The Contractor shall engage in care coordination with a FBDE member and the member's TennCare MCO following observation days and emergency department visits to address member needs and coordinate Medicaid benefits, as appropriate. Discharge planning shall meet minimum requirements as specified by TennCare in policy or protocol. **Attachment F – Fully Integrated Dual Eligible Special Needs Plan** (8) Leverage the Tennessee health information exchange, as it is developed, the TennCare Care Coordination Tool, or an alternative approach approved by TennCare, to facilitate and enhance efficient care coordination processes among Medicare and Medicaid providers, including primary, specialty, behavioral health and LTSS, regardless of payer. This shall include, for members receiving LTSS, ensuring that providers are able to access the member's Person-Centered Support Plan, as appropriate, and that processes are in place for the ongoing exchange of information between LTSS (including Nursing Facility (NF) and HCBS) and primary care and behavioral health providers.

State (D-SNP Contract Title and Year)	Target D-SNP Population	Entity Notified	Timeframe for Notification	Notification Mechanism	Relevant Contract Language
Pennsylvania Department of Human Services MIPPA Contract, 2020	D-SNP enrollees	Community HealthChoices-MCO service coordination staff (Affiliated Medicaid MCO)	Within 48 hours of specified events	Plan-to-plan exchange of uniform data elements, and D-SNPs must also join an HIE	**Section C. Provisions for Enhanced Coordination and Health Care Outcomes** **1. Service Coordination** f. To ensure coordination of inpatient discharge planning, the D-SNP shall link clinical management systems across all providers, including written protocols for accountability, referrals, information sharing, and tracking transfers between settings such as from the hospital to the home, from the nursing facility to the home, or from the hospital to the nursing facility. The D-SNP must require that hospitals, nursing facilities, and skilled nursing facilities that contract with the D-SNP notify both the D-SNP and a member's service coordinator within 24 hours of visits and admissions of that member. The service coordinator must follow-up to address any care needs including skilled services covered by Medicare and LTSS services covered by Medicaid. To the extent possible, the Department would like these processes to be electronic and automated but they may include fax, email, telephone and other forms of manual communication and coordination. i. In order to coordinate care for its dual eligible members, the D-SNP shall develop written care coordination policies that will be used by the D-SNP to ensure notification within 48 hours of the dual eligible member's CHC-MCO service coordination staff of the following: 1) planned or unplanned inpatient hospital and skilled nursing facility admissions and discharges, 2) high priority health concerns defined as a cardiac or orthopedic diagnosis requiring a procedure or an oncologic diagnosis requiring chemotherapy identified through the member's health assessment, and 3) sharing of discharge planning documents, and 4) significant medication changes. Significant medication changes include: starting, stopping, reducing, or increasing medications by more than 25% (medication examples include antipsychotics, blood pressure, blood thinners, and diabetic medicines).These policies must be submitted to the Department annually by May 15 and within 15 calendar days of any policy revision for review and approval, and if the Department determines changes are necessary, the D-SNP must revise the policies accordingly. The Department may request other elements be added to the care coordination policies throughout the course of the contract year or subsequent contract extensions. **Section C.5.b Information Technology Systems** b. D-SNPs are required to join a Health Information Exchange within the Commonwealth to enhance their capabilities to coordinate care for their members.

Appendix B. Sample Data Elements to Exchange on Hospital and Skilled Nursing Facility Admissions

The tables below include potential data elements that states can ask D-SNPs to exchange with the state or its designee to support care transitions around hospital or SNF admissions. These draw from well-established data elements in use in Tennessee today as well as draft data elements that have been proposed by D-SNPs and Medicaid MLTSS plans in Pennsylvania as they work together to implement new data sharing processes that address state policies for information sharing related to hospital and SNF admissions.

Tennessee Daily Inpatient Census Report	
Receiving_DSNP_MCO	Admission_Date
Sending_DSNP_MCO	Admission_Type
SSN	Bed_Type
HICN	Admission_Process
CHOICES_Member	Admitting_Primary_Diagnosis
LastName	Additional_Diagnoses
First_Name	ER_Visits_in_12_months
Middle_Initial	Hospital_Admissions_in_12_months
Date_Of_Birth	Anticipated_Dischange_Disposition
Phone_Number	Anticipated_Discharge_Date
Address	Discharge_Date
City	Discharging_Physician
State	Risk_Score
Zip_Code	PCP
Facility_Name	PCP_Phone
Facility_Contact_Name	Med_List
Facility_Contact_Phone	PCP_Specialty_Appt
Anticipated_Admission_Date	NotificationID
Notification_Admission_Date	

Pennsylvania Draft Data Elements	
Policy Description	**Data Element**
Member's planned or unplanned inpatient admissions (Medical and behavioral health related)	Admit date & time
	Admit type
	Admitting facility
	Admitting Diagnosis
	Primary Care Physician
	Referring Physician, if applicable
Notification of SNF admissions	Admit date & time
	Admit type
	Admitting facility
	Admitting diagnosis
	Primary Care Physician
	Referring Physician, if applicable
	Scheduled admit date & time
	Attending Physician for SND
Current or planned future admissions	Admit type
	Admitting facility
	Admitting Diagnosis
	Admitting Physician
	Primary Care Physician
Discharge planning documents	Discharge date and time
	Discharge disposition
	Discharging facility
	Discharge diagnosis
	Discharge instructions including medication list
Medication profile and utilization	Medication name
	Medication dosage
	Medication frequency
	Condition being treated by medication
Pending or completed referrals to community resources	Referral name
	Referral reason
Pending or completed referrals to LTSS	Support service type
	Support service facility
	Waiver information
Coordination of Care	Health Plan Case Manager Name
	Health Plan Case Manager Contact Information

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. Available at: https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf. (See pp.15710-15718 and *42 CFR 422.107(d))*

[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 information-sharing strategies highlighted in this brief may still be of interest to states with D-SNPs that meet the FIDE or HIDE SNP bar; however, the D-SNPs would not be required to provide these notifications to the state or the state's designee where enrollment in the D-SNP and affiliated Medicaid MCO is not always aligned.

[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. CBOs partnered with 448 acute-care hospitals with high readmission rates to deliver care transition services to enrolled high-risk Medicare FFS beneficiaries, with the purpose of reducing readmissions and demonstrating measurable savings to Medicare. 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] 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.federalregister.gov/documents/2019/04/16/2019-06822/medicare-and-medicaid-programs-policy-and-technical-changes-to-the-medicare-advantage-medicare

[5] 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 for dually eligible individuals 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 be sending the standardized set of health data classes and constituent data elements contained in the U.S. Core Data for Interoperability (USCDI). The proposed rule does not specify the mechanism by which data should be exchanged. In addition, CMS is proposing that these health plans participate in trust networks to improve the interoperability of data exchange. These provisions would take effect April 1, 2022 if the rule is finalized as proposed. For more information 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

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

[7] Virginia's provider-led Emergency Department Care Coordination program includes broad hospital participation and the state has a related legislative requirement for Medicaid MCOs and D-SNPs to participate and receive alerts. The state Medicaid agency plans to develop a care coordination portal that would leverage this data, and Florida's HIE based Event Notification Service includes over 200 hospitals and a growing number of health plans. Florida's system was piloted in 2013 and launched statewide in 2018 as fee-based subscription service for health plans including Medicaid MCOs to obtain real-time data on hospitalizations and ED visits.

[8] Coordinated Care Organizations (CCOs) are regional networks of health care providers that receive a global budget to provide physical health care, addiction and mental health, and dental services, non-traditional health-related services, and cost sharing for

QMB duals. When the CCO model was introduced in mid-2012, all Medicaid managed care plans in Oregon were transitioned to CCOs, and most dually eligible beneficiaries who were previously in managed care became enrolled in a CCO.

[9] Six D-SNPs operate in Oregon with total enrollment of 23,158 as of May 2019.

[10] See: https://www.oregon.gov/oha/HPA/OHIT/Resources/CCO%20HIT%20Summary%20Report%20July%202015.pdf

[11] Emergency Department Information Exchange or EDie is a technical solution offered by Collective Medical Technology to support admission, discharge, and transfer event notifications from hospitals and other inpatient settings. In 2014, the OHA, working with the Oregon Health Leadership Council and the Oregon Association of Hospitals and Health Systems, launched EDie to help address the high cost of emergency department (ED) utilization.

[12] Oregon utilized a State Innovation Model grant to bring EDie to Oregon. For ongoing access to the Collective Platform web platform, the state pays a per member per month payment for a base package for all Medicaid lives in the state, for which it receives an enhanced federal financial participation rate (HITECH 90/10). This Medicaid subscription covers access to the technology platform for CCOs, tribal health clinics, FFS contractors, and Medicaid state programs and contractors that benefit from real-time access to the ADT data (i.e., AAAs, ADRCs, state hospitals, public health units).

[13] The Medicare Skilled Nursing Facility Value-Based Payment Program imposes penalties on SNFs with high hospital readmission rates, and rewards those with low rates. For details see: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/SNF-VBP-Page.html

[14] See Oregon's 2017-2020 Strategic Plan for Health Information Technology and Health Information Exchange at https://www.oregon.gov/oha/HPA/OHIT/Documents/OHA%209920%20Health%20IT%20Final.pdf and the Oregon Health Leadership Council's EDIE page at http://www.orhealthleadershipcouncil.org/edie/

[15]Among high utilizers with a care guideline in their EDie record, ED visits decreased by 40% in the 90 days after an initial care guideline was created. A two-year comparison of high utilizers with and without a care guideline showed that patients with a care guideline had a 10 percent decrease in ED visits compared with a 0.3 percent decrease in high utilizer patients without a care guideline. The full 2017 EDie evaluation report is available at: http://www.orhealthleadershipcouncil.org/wp-content/uploads/2017/09/EDIE-Evaluation-Report-Final-8-21-17-v.1.pdf

[16] Since 2015 all TennCare MCOs are required to have (or develop) a statewide affiliated D-SNP. The state of Tennessee also decided to maintain its contracts with existing D-SNPs that are not affiliated with a Medicaid MCO; however, TennCare will not contract with any new D-SNPs that are not contracted (through a competitive procurement process) to also provide Medicaid benefits.

[17] A sample Tennessee D-SNP contract for 2019 is available at: https://www.integratedcareresourcecenter.com/sites/default/files/TN%202019%20D-SNP%20contract.pdf

[18] "Affiliated D-SNPs" are D-SNPs that have also been awarded a competitively procured contract to provide Medicaid services; "unaffiliated D-SNPs" are contracted only to provide Medicare benefits.

[19] The exchange of admission data occurs between an unaffiliated D-SNP and a TennCare MCO or from affiliated D-SNPs to a TennCare MCO that is serving an unaligned member.

[20] States can directly host a file-transfer-protocol (FTP) site which can be administered and maintained by the state and requires state resources including hardware and a server for data storage, or a state (or health plan) can pay for an external, hosted secure file transport service that would use a web-based interface to transfer data securely between users of the service.

[21] The Tennessee Quarterly Duals Care Coordination report template is available at: https://www.integratedcareresourcecenter.com/sites/default/files/Tennessee%20Duals%20Coordination%20Quarterly%20Reporting%20Template-2018.xlsx