State Options and Considerations for Sharing Medicaid Enrollment and Service Use Information with D-SNPs

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> **IN BRIEF:** New federal rules released in April 2019 require that Dual Eligible Special Needs Plans (D-SNPs) must, at a minimum, coordinate the delivery of Medicare and Medicaid benefits. The final rule includes new regulatory language effective January 1, 2020 and provides examples of ways that D-SNPs should coordinate their members' Medicare and Medicaid services. This technical assistance brief discusses issues and options for states to support D-SNPs in meeting this requirement.

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 (BH) benefits. All D-SNPs must nonetheless <u>coordinate</u> the delivery of Medicaid benefits (including BH and LTSS) for their enrollees. When Medicaid benefits are not covered by a D-SNP or a Medicaid managed care plan offered under the same parent company as the D-SNP, the benefits may be provided by a separate Medicaid managed care plan, or by fee-for-service (FFS) Medicaid providers. To coordinate Medicaid benefits in a meaningful way, D-SNPs need to determine what entity(ies) provide Medicaid benefits to their plan members. States can help by ensuring that D-SNPs have access to information about their enrollees' Medicaid plan enrollment and/or service use.

This technical assistance brief describes four options that states can use, individually or concurrently, to provide information to D-SNPs on their dually eligible members' Medicaid plan enrollment and/or service use. The best option(s) for a particular state will depend on a number of factors, including:

- Whether the state uses a managed care delivery system to provide Medicaid LTSS and/or BH benefits to dually eligible beneficiaries;
- The state's (and D-SNPs') existing data systems and technical capabilities; and
- The level of effort the state wishes to expend to ensure timely sharing of information.

How Information Sharing Enables Care Coordination and Delivery of Integrated Services

To coordinate the delivery of both Medicare and Medicaid benefits for their members, D-SNPs should know, and be able to communicate with, the entities providing those Medicaid benefits. States can provide D-SNPs with information on those Medicaid providers and plans. For example, in a state where a D-SNP's members receive Medicaid benefits through Medicaid managed care organizations (MCOs), knowing which Medicaid MCOs its members are enrolled in enables the D-SNP to:

- Involve care coordinators from the Medicaid MCO in collaborative assessments and care planning;

- Facilitate ongoing communication between D-SNP care coordinators and MCO care coordinators about beneficiary needs and service utilization;

- Transfer crossover claims to the correct entities to facilitate timely provider payment; and

- Assist D-SNP members with requesting access to Medicaid-covered services and/or filing grievances or appeals with their Medicaid MCO.

In a state in which Medicaid benefits are provided on a FFS basis, states can provide D-SNPs with information about their members' Medicaid service use, such as who is enrolled in a particular home- and community-based services (HCBS) waiver, or which members receive care (and from whom) for certain BH conditions. Sharing this information and providing key points of contact at the agencies or provider entities administering these services enables D-SNPs to communicate with those entities and helps ensure that their members receive all needed services in a coordinated fashion.

For information about the types of care coordination D-SNPs must provide in accordance with the new definition of coordination, effective January 1, 2020, see the call out box **D-SNP Coordination Requirements**.

D-SNP Coordination Requirements

In the CY2020-CY2021 final rule for Medicare Advantage, Part D, and Programs of All Inclusive Care for the Elderly (PACE),[1] the Centers for Medicare & Medicaid Services (CMS) notes that "coordination" may encompass "a wide range of activities that a D-SNP may engage in for their dual eligible members," including (but not limited to) the following activities for enrollees identified through health risk assessments and/or individualized care plans as having functional limitations or mental health needs:

- "Verify[ing] the enrollee's eligibility for LTSS or behavioral health services under Medicaid;

- Determin[ing] how the enrollee receives such services (through FFS Medicaid or through another Medicaid managed care product); and/or

- Mak[ing] arrangements with the applicable Medicaid program (state Medicaid agency or managed care plan) for the provision of such services by the appropriate payer or provider."

D-SNPs are also expected to assist individuals with requesting service authorizations and filing grievances and appeals related to Medicaid services, in accordance with the revised regulations for 2020 described at 42 CFR 422.562(a)(5). These expectations include "assisting the enrollee in identifying the enrollee's specific Medicaid managed care plan or fee-for service point of contact," helping the enrollee make contact with that entity, and helping the enrollee obtain documentation to support their request for service authorization or appeal. **Note that D-SNPs must comply with the federal requirement that they coordinate the delivery of their enrollees' Medicare and Medicaid benefits whether or not states provide them with the information on Medicaid services described in this brief.**

In addition to requiring D-SNPs to coordinate the delivery of Medicaid benefits for their members, the CY2020-2021 final rule also created new D-SNP integration requirements that go into effect January 1, 2021. As a result of these new requirements, many D-SNPs will need to share information with the state or the state's designee on hospital and skilled nursing facility admissions for at least one designated group of high-risk D-SNP enrollees, to improve coordination and support provided during transitions in care settings. ICRC has shared information about these new D-SNP integration and information-sharing requirements in two technical assistance briefs released in 2019.[2]

Options for Sharing Key Information with D-SNPs to Enable Care Coordination

This section describes four options that states can use to provide D-SNPs with Medicaid enrollment and/or service use information for unaligned enrollees. It also provides examples of states using each option. Note also that CMS can provide some Medicaid eligibility and service use information to D-SNPs (see the call out box **Medicaid Eligibility and Service Use Information Provided to D-SNPs by CMS**).

Option 1: Allowing D-SNPs to access state Medicaid beneficiary eligibility portals

Many states have utilized web-based portals to allow health care providers to verify patients' Medicaid eligibility at the point of service, and some states use these portals to share information about Medicaid plan enrollment so providers can bill the appropriate entity for services rendered to Medicaid beneficiaries. These portals typically draw Medicaid eligibility information directly from a state's Medicaid Management Information System (MMIS), which contains real-time eligibility information. These portals may also provide additional details about Medicaid-enrolled beneficiaries, such as their category of Medicaid eligibility, eligibility for coverage of Medicare cost-sharing, Medicaid plan enrollment, and receipt of certain LTSS and/or BH services. Granting D-SNPs access to these portals is one strategy states can use to allow D-SNPs to verify beneficiaries' Medicaid eligibility prior to enrolling them in the D-SNP, identify D-SNP members' Medicaid managed care plan enrollment when applicable, and/or determine whether beneficiaries are already receiving certain LTSS and/or BH benefits for which they appear to be eligible.[3]

Allowing D-SNP access to a state's Medicaid beneficiary eligibility portal typically involves three steps:

1) The state may require the D-SNP to sign data use and/or security agreements to ensure appropriate use of the data (e.g., allowing access to Medicaid managed care plan enrollment and/or service use information only for dually eligible beneficiaries that are already enrolled in or requesting to enroll in the D-SNP for their Medicare benefits, and explicitly forbidding use of that information to market to potential enrollees);

2) The state or a designee may need to provide the D-SNP with appropriate login credentials, when such credentials are required; and

3) The state or designee may want to provide the D-SNP with training and/or instructions for accessing and using the portal.

Before granting D-SNPs portal access, states may wish to establish agreements with D-SNPs that identify which entity will bear any costs associated with the implementation of these steps. Additionally, the state will need to determine whether the D-SNPs must access portal information via single queries about individual enrollees, or whether batch querying (or data "scraping") to gather information from the portal for a group of (or all of) the D-SNP's enrollees will be allowed and enabled.

State Example: Hawaii

Hawaii has built on the provider information portal that it originally established to help providers determine which entity they should bill for services (the state or an MCO) to enable D-SNPs to obtain information on where their unaligned dually eligible enrollees are obtaining their Medicaid services, and whether they are receiving certain types of LTSS and BH services. The main information the portal provides that can be of use to D-SNPs – in addition to basic eligibility and enrollment information – is information on which Medicaid MCO a beneficiary is enrolled in. Because LTSS was in the past provided by separate MCOs in Hawaii, the provider portal includes codes carried over from that period that identify whether an enrollee is receiving LTSS (even though the both medical and LTSS services are now provided by the same MCOs). Similarly, because Medicaid services for beneficiaries with serious and persistent mental illness are provided by a single specialized statewide MCO for all Medicaid MCO enrollees, the provider portal enables D-SNPs to determine whether or not their enrollees are obtaining BH services from that specialized MCO.

Hawaii enables D-SNPs to obtain access to this information by enrolling in the portal as a provider, an arrangement developed several years ago in response to D-SNP interest in obtaining the information. Hawaii has a detailed handbook for providers and D-SNPs that provides information on how to access the portal, and what information is available through it.[4]

While the Hawaii provider portal does not enable D-SNPs to determine what specific types of LTSS are being provided (HCBS waiver services or institutional services) or details on the BH services being provided by the specialized statewide MCO, the portal does enable D-SNPs to determine what entity is providing those services. Hawaii Medicaid staff noted that more fine-grained information on Medicaid services being provided to D-SNP enrollees in unaffiliated plans could be included in the provider portal if a state wanted to use specific service codes in its MMIS claims payment system to enhance the information in the portal, but that developing such enhancements would likely require additional state and/or contractor resources.

Option 2: Conveying Medicaid enrollment and/or service use information in enrollment files or other files that are routinely shared with D-SNPs

States can also convey Medicaid enrollment and/or service use information to D-SNPs by adding that information to standard eligibility files or other files that states routinely share with D-SNPs. In some states, these files are only sent once, upon initial D-SNP enrollment. Other states may transmit these files more frequently – for example, on a monthly, weekly, or even daily basis. The latter case provides more current information, but states with limited capacity may need to balance D-SNPs' need for current information with resource limitations. Sharing of Medicaid enrollment and/or service information at the point of D-SNP enrollment at least provides D-SNPs with a starting point for care coordination, even if that information cannot be shared more frequently.

> **State Example: Minnesota**
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> Minnesota sends all of its Medicaid health plans, including D-SNPs involved in its Special Needs Basic Care (SNBC) and Minnesota Senior Health Options (MSHO) programs, a comprehensive report for new enrollees. This report is sent seven days after a new plan member's initial enrollment and shares information about 27 different elements, including the individual's waiver case manager name (if applicable), LTSS provider information, information about the beneficiary's assessed need for assistance with activities of daily living and/or instrumental activities of daily living, personal care attendant services received, mental health services received, durable medical equipment received in the last 12 months, and all current diagnoses. This report is only sent upon initial enrollment to facilitate initial identification of immediate care coordination needs. With this information, D-SNPs are expected to make contact with the member's LTSS and BH case managers and providers and maintain information about the member's needs and service use moving forward.

Option 3: Allowing D-SNPs to use 270 transactions to request Medicaid enrollment and/or service use information (and conveying that information in 271 response files)

270 and 271 transactions are standard, electronic data interchange functions that allow service providers to request health care eligibility information for their patients from payers (e.g., state Medicaid agencies). Providers use a 270 file to request a patient's eligibility information, and payers use a 271 file to respond and share the patient's eligibility information. 270 and 271 transactions are part of the ASC X12 transaction set, which was established to ensure that information shared among health care entities is transferred in standard formats and in a HIPPA-compliant manner.

State Medicaid agencies and other health care payers typically use 270/271 files to convey benefit eligibility and cost-sharing information to health care providers, but 270/271 files can also be used to transmit data on Medicaid enrollment and/or service use to D-SNPs, if states wish to use them for this purpose and enable D-SNPs to access and use these types of transactions. For example, if a state allows D-SNPs to use 270 transactions to request Medicaid enrollment information, a D-SNP can send a 270 "inquiry" transaction to the state requesting Medicaid managed care enrollment information, as of a particular date, for the D-SNP members included in the file. The state's 271 response file would contain the enrollment information requested in the D-SNPs 270 transaction, drawn from data in the state's MMIS or other relevant database(s).

State Example: Tennessee

In Tennessee, D-SNPs are able to access a beneficiary eligibility portal for initial and ad hoc identification of their unaligned members' Medicaid eligibility and Medicaid managed care plan enrollment. After members' initial enrollment, the state allows D-SNPs to use 270 transactions to request current Medicaid (TennCare) enrollment information for all of their plan members. The D-SNPs use this information to coordinate and share information with TennCare plans, in accordance with state requirements (e.g., D-SNPs are required to notify their members' TennCare plans when members are admitted to a hospital or a skilled nursing facility).[5]

When a Tennessee D-SNP submits a 270 transaction to the state requesting TennCare enrollment information for the members included in the file, the state sends a 271 response file with the members' TennCare enrollment information. The D-SNPs can use the information from these monthly 271 response files to populate their enrollment and care management systems with members' TennCare enrollment information. In Section A.2.c.3.a of its 2019 D-SNP contract, Tennessee requires D-SNPs to "update [their] enrollment databases, including, but not limited to, MCO assignment within twenty-four hours of receipt of said files."

Option 4: Providing D-SNPs with specific points of contact for FFS Medicaid LTSS and/or BH assessments and service administration

Some states may not have Medicaid beneficiary eligibility portals, or, in some cases, the portal may not contain data critical to care coordination. For example, in states with FFS Medicaid delivery systems, key points of contact for LTSS or BH service delivery may be located within state agencies or provider entities, instead of at Medicaid managed care plans, and contact information for those state or provider entities may not always be listed in beneficiary eligibility portals. In these cases, states may wish to use other mechanisms to enable D-SNP identification of the appropriate point of contact for coordination of their members' Medicaid LTSS and/or BH benefits.

States can facilitate or require the production of LTSS or BH contact lists to enable exchange of Medicare and Medicaid eligibility and service use information to help improve coordination of benefits for dually eligible beneficiaries. For example, a state may develop, require D-SNPs to develop, or ask another entity to develop[6] contact lists that include information for state agencies and/or providers responsible for conducting assessments and/or overseeing service delivery for LTSS and BH services, so that D-SNPs can easily reach the right teams within those agencies/provider entities when their members exhibit a need for these services.

The level of detail included in a contact list should balance the following:

1) D-SNPs' ability to communicate effectively with the entities necessary to achieve care coordination goals and improve or maintain their members' health; and

2) Producing a list that is relatively simple to use and maintain.

Lengthy, detailed contact lists can be unwieldy to use and quickly become out of date with staff turnover or changes in staff responsibilities. Shorter lists that identify single, shared phone numbers and/or email addresses that are accessed by multiple staff (for example, "LTSSassessments@company.com") can often be easier to use and maintain.

State Example: Minnesota

In Minnesota's Special Needs Basic Care (SNBC) program, dually eligible beneficiaries with disabilities who are age 18 to 64 can voluntarily enroll in D-SNPs that cover Medicare and many Medicaid services. However, certain LTSS benefits are carved out of SNBC and are instead covered through FFS Medicaid. For example, personal care attendant services, certain home care services, certain HCBS waiver services, and most long-term nursing facility stays are all covered by FFS Medicaid, instead of SNBC D-SNPs. Additionally, SNBC D-SNPs are required to coordinate with state-certified Medicaid behavioral health homes that manage BH, physical health, and social services for individuals with serious mental illness.

In order to ensure that SNBC members' full range of services are coordinated, even when LTSS and social services are provided by entities outside of the D-SNP, Minnesota includes language in its SNBC contract that requires D-SNPs to coordinate with county social service staff when an enrollee is in need of any of the following services: "… (1) Pre-petition screening, (2) Preadmission screening for HCBS, (3) County Case Management for HCBS, (4) Child protection, (5) Court ordered treatment, (6) Case Management and service providers for people with developmental disabilities, (7) Relocation service coordination, (8) Adult protection, (9) Assessment of medical barriers to employment, (10) State medical review team or Social Security disability determination, (11) Working with Local Agency social service staff or county attorney staff for Enrollees who are the victims or perpetrators in criminal cases." (Section 6.1.5.11 of Minnesota's 2019 SNBC model contract).[7]

Minnesota's SNBC contract also requires D-SNPs to develop and maintain "key county contact telephone numbers for customer service and other personnel to use in assisting Enrollees who require a referral to the county"[8] and "written communication protocols for communications with county social service agencies, community agencies, behavioral health homes, nursing homes, residential and home care providers involved in providing FFS care to SNBC enrollees,"[9] to ensure that D-SNPs are well prepared to communicate efficiently and effectively with all necessary external entities. D-SNPs are also required to "provide the state with a designated [D-SNP] contact for BHH [behavioral health home]-related matters to facilitate the sharing of member information and coordination of services for Enrollees receiving BHH services."[10]

Through enforcement of these contractual requirements and regular meetings with D-SNPs to discuss best practices in care management and care coordination, Minnesota ensures that both the D-SNPs and the entities involved in FFS care delivery know who to contact to communicate about member needs.

> **Medicaid Eligibility and Service Use Information Provided to D-SNPs by CMS**
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> In addition to information shared by states, D-SNPs can obtain some information on Medicaid eligibility and service use via files directly from CMS:
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> - The **Medicare Advantage Medicaid Status Data File**[11] is sent monthly to Medicare Advantage plans, including D-SNPs, and provides information on plan members' dual eligibility status. This file uses dual status codes to indicate whether a particular individual receives Medicare Savings Program benefits (QMB, SLMB, QI, or QDWI)[12] and/or full Medicaid benefits, and provides start and end dates for all Medicaid benefits received.
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> - The **Daily Transaction Reply Report (DTRR)** is a file provided to Medicare Advantage plans, including D-SNPs, on a daily basis to help the plans ensure that their membership records align with those maintained by CMS, and therefore ensure proper plan payment. In the DTRR, D-SNPs are able to see which of their members are eligible for $0 Medicare Part D copayments, which are required when the member has received HCBS and/or resided in a long-term care facility at some point during the current or previous calendar year.
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> - The **Monthly Membership Report (MMR)** serves as a basic accounting file of payments and adjustments that Medicare Advantage plans, including D-SNPs, receive for their members. With data provided in the MMR, D-SNPs can identify which of their plan members have resided in a long-term care facility for 90 or more days.
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> While these data files offer D-SNPs important information about their dually eligible members, these files cannot tell a D-SNP with which Medicaid managed care plans their members are enrolled (in states using managed care to delivery Medicaid services). Additionally, the LTSS service information identifiable in these files is less precise than the data that can be provided by state Medicaid agencies (e.g., the precise start and end dates for a member's receipt of HCBS or institutional care). Therefore, the data in these files may be best used as a supplement to information provided by state Medicaid agencies in identifying vulnerable plan members with the greatest need for care coordination assistance.

Conclusion

D-SNPs are better positioned to successfully coordinate benefits for enrollees when they can efficiently identify and communicate with the entity(ies) responsible for their enrollees' Medicaid benefits, particularly LTSS and BH benefits. Additionally, timely access to Medicaid enrollment and service use information will become increasingly important as many D-SNPs aim to meet new information-sharing requirements in 2021.[13]

Any state in which at least some D-SNP enrollees receive Medicaid benefits outside of the D-SNP can use the techniques described in this technical assistance brief.

When developing new information-sharing processes, ongoing engagement with stakeholders (e.g., Medicaid managed care plans or other entities responsible for overseeing delivery of BH or LTSS benefits) is important. Collaboration will allow the state to ensure:

- The entities involved have the resources and capacity necessary to participate;

- The initiative is executed timely and efficiently; and

- The information shared improves the quality and coordination of care provided to dually eligible beneficiaries.

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** 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. Available at: https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf. See pages 15700-15704 for discussion regarding the requirement that D-SNPs coordinate Medicare and Medicaid benefits for their members.

[2] ICRC has released a brief and a technical assistance tool that provide information about new D-SNP integration and information sharing requirements for 2021, and options for states and D-SNPs that need to meet those new requirements. The brief, released in July 2019, is "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. The technical assistance tool, released in September 2019, is "Information Sharing to Improve Care Coordination for High-Risk Dual Eligible Special Needs Plan Enrollees: Key Questions for State Implementation," available at: https://www.integratedcareresourcecenter.com/resource/information-sharing-improve-care-coordination-high-risk-dual-eligible-special-needs-plan.

[3] Not every state includes LTSS or BH service information in Medicaid beneficiary eligibility portals. However, when such information is available, D-SNPs can use that information to identify whether members who seem to be eligible for LTSS or BH services are already receiving those services. Additionally, when LTSS and/or BH provider information is available in a state's Medicaid beneficiary eligibility portal, the D-SNP may also be able to identify the provider(s) from whom its members are receiving those services, in order to communicate with those providers to coordinate LTSS and/or BH assessments and coverage.

[4] Hawaii DHS Medicaid Online (DMO) Web-Based Eligibility/Enrollment Verification, available at: https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/Provider-Resources/DMOEligibilityandEnrollmentUserManual.pdf. See pp. 37 and 39 for screen-shot examples of the type of information that D-SNPs can obtain through the provider portal.

[5] See ICRC's Technical Assistance 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, for more information on Tennessee's information sharing requirements and processes.

[6] In some cases, an entity other than the D-SNP or the state Medicaid agency may be well positioned to create lists of key contacts. For example, a staff member from a state Department on Aging could create a list of key contacts at Area Agencies on Aging (AAAs) and/or Aging and Disability Resource Centers (ADRCs), or a state agency responsible for services delivered to individuals with

Intellectual and Developmental Disabilities (I/DD) could create a list of key contacts for I/DD waiver assessment and service delivery. D-SNPs, Medicaid managed care plans, state agencies, and/or providers could also work together to create key contact lists through joint work groups.

[7] Minnesota 2019 Special Needs Basic Care (SNBC) model contract is available at: https://mn.gov/dhs/assets/2019-snbc-model-contract_tcm1053-370134.pdf.

[8] See section 3.13.14.2 of Minnesota 2019 SNBC model contract, op cit.

[9] See section 6.1.5.10 of Minnesota 2019 SNBC model contract, op cit.

[10] See section 6.1.17.1 (a) of Minnesota 2019 SNBC model contract, op cit.

[11] Detailed information about the Medicare Advantage Medicaid Status Data File is provided in Section 7.7 of the CMS Medicare Advantage Plan Communication User Guide, v13.2, available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Downloads/Plan-Communication-User-Guide-v132-August-30-2019.pdf.

[12] For information about Medicare Savings Program eligibility and benefits, see the CMS document "Dually Eligible Individuals – Categories," available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf.

[13] ICRC has released two resources that provide information about new D-SNP integration and information sharing requirements for 2021, and options for states and D-SNPs that need to meet those new requirements. See endnote 2 for more information and links to these two documents.