Requesting and Using Medicare Data for Medicare-Medicaid Care Coordination and Program Integrity: An Overview

This overview is designed to help States integrating care for beneficiaries eligible for both Medicare and Medicaid (also known as “Medicare-Medicaid enrollees”) through a Medicare-Medicaid Coordination Office (MMCO) demonstration or through other care coordination and program integrity initiatives understand the Medicare data available to them. It addresses three key questions:

1) What is available?

States can request *summary files*, like the Master Beneficiary Summary File (MBSF), that aggregate annual utilization measures at the level of the patient, or they can request *claim or event files* that contain cost and detailed utilization data at the level of the claim (i.e., multiple claims per visit and per beneficiary, per year).

Additionally, States can request the Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS). MMLEADS is a suite of 2006-2012 linked data files for Medicare and Medicaid eligibility, enrollment, utilizations, and expenditure data. This data includes health care information for all dually eligible Medicare-Medicaid enrollees, and, for comparison purposes, all Medicare-only beneficiaries and Medicaid-only beneficiaries with disabilities. MMLEADS provides utilization and expenditure metrics based on MMCO’s preferred method of identifying Medicare-Medicaid enrollees (e.g., from the monthly "State MMA File"), while also keeping the flexibility to generate metrics according to other user-defined criteria. MMLEADS contains a linking variable for linking to other data (e.g., survey, assessment, claims).

Medicare service use and expenditure patterns do not change substantially from year-to-year, so older data may be sufficient for program planning purposes.

2) What can it be used for?

There are three general categories of analyses: *program planning* (high-level analyses on identifiable populations), program integrity, or *care coordination* (patient-level analyses, often in real time).

States that use Medicare data for program planning purposes can use the MBSF for annual statistics and use claims files for more detailed analyses, like utilization at the patient or provider level. States can use claims data for care coordination, but should note that, without linking to health record data, they may not be able to answer questions about gaps in care or duplication of services. The MBSF and claims data are also useful for identifying beneficiaries and healthcare providers that may be engaging in fraud, waste or abuse.

3) Where to get it?

The Medicare-Medicaid Coordination Office (MMCO) has made four main data request processes available to States at no cost through the State Data Resource Center

(SDRC):

- *MMCO-A/B Historical* for historical Parts A or B summary or claims data;
- *MMCO-Assessments* for MDS, OASIS, and IRF-PAI Assessments data,
- *MMCO-COBA (Coordination of Benefits Agreement)* for current and ongoing Parts A or B claims data; and
- *MMCO-Part D* for historical and current/ongoing Part D prescription drug event (PDE) data.

The Center for Program Integrity has collaborated with MMCO to make the same data available through these processes available to States for program integrity purposes.

Details of the MMCO processes for requesting Medicare data are available through the State Data Resource Center (SDRC)

A group of Medicare data experts dedicated to helping States understand, acquire, and/or use Medicare data for Medicare-Medicaid care coordination and program integrity purposes. States can locate information on SDRC resources at the SDRC Website (http://www.statedataresourcecenter.com) or submit questions by email to: sdrc@econometricainc.com.

What Is Available?

There are two types of Medicare data files available to States: (1) summary files, and (2) detailed claims, event, and assessments data. For each type of data, States receive information regarding dual-eligible beneficiaries residing in the State.

Summary files contain summary measures on utilization and spending per year *by beneficiary* and may include additional identifiers that allow users to analyze by population or service-type sub-group. The **Master Beneficiary Summary File (MBSF):**

- Provides summary data on Medicare Parts A/B services and costs, by type of service, for each beneficiary at the individual level for the full year. Service types include hospital inpatient and outpatient services, physician and related services, durable medical equipment (DME), skilled nursing facility (SNF), home health, and hospice;
- Provides individual-level beneficiary identifiers and demographics, including information about Medicare eligibility and dual (Medicaid) status; and
- Includes individual-level diagnoses from the Centers for Medicare & Medicaid Services (CMS) Chronic Condition Warehouse (CCW).

Claims and event data files contain records for each service paid for a given beneficiary, as well as extensive demographic and service-level identifiers. The unit of record is the claim, which means some beneficiaries may have multiple episodes of care and episodes of care may have more than one claim. MMCO will provide all data elements in Parts A and B claims available to States. Only certain data elements will be made available on Part D data, referred to as Part D prescription drug event (PDE) data. For example, the PDE data will not contain any cost information.

The types of claims available consist of:

- **Part A or B final action claims** include only the last version of the claim provided (e.g., if a claim is adjusted twice, only the last version is provided). Because of the lag time required to ensure claims are "final," final action claims are only available for services paid through 2015. (MMCO-A/B Historical process)
- **Part A or B non-final-action claims** include each iteration of a claim (i.e., initial and subsequent adjustments) for a service billed from the current month forward. (States can choose to receive raw claims feeds as frequently as daily. Though this data is timelier than final action claims, it can include multiple claims for the same service and will require some effort to remove invalid or blank entries. Because of the claims processing lag time, it may not be a fully complete and accurate record of services provided during more recent periods. (MMCO-COBA process)
- **Assessments (MDS, OASIS, Swing Bed, and IRF PAI)** consist of aggregated assessment data about patients in different types of sub-acute care settings including nursing facilities, inpatient rehab facilities, and home health care. (MMCO-Assessments process)
- **Part D PDE data** has many (though not all) Part D data elements. Non-final-action PDE data are those that have not yet been included in the annual CMS financial

reconciliation process, while final action PDE data have been reconciled after the close of the calendar year, usually 10 months later. (MMCO-Part D process)

There are advantages and limitations to the summary and claims/event/assessment file types (see Table 1 and Table 2).

What Can It Be Used For?

Generally, States can request Medicare data on their Medicare-Medicaid enrollees to support program planning actual Medicare-Medicaid care coordination efforts provided to improve care at the individual beneficiary level, or to support program integrity activities.

States that use Medicare data for program planning purposes can find most of the information they need in the MBSF, including: (1) patient identifiers; (2) the sum of all Medicare fee-for-service reimbursements made during the calendar year by type of service; (3) annual number of visits by type of service (inpatient, outpatient, home health, physician office, or SNF settings); (4) presence of various condition and diagnosis categories during the year (for inpatient settings, the file also contains the Diagnosis Related Groups (DRGs) for each of the 10 first stays within the year); and (5) the date the beneficiary first met the clinical criteria to qualify for a condition or diagnosis category. Note that the MBSF does contain some Part D information, but is distributed as part of the MMCO A/B Historic process.

States can use claims files for more detailed analyses not limited to an annual time period, including utilization at the patient or provider level. States that are using claims data for program planning, program integrity, or care coordination purposes will likely only need a subset of the elements available in the larger claims file. The elements likely to be needed include:

- patient identifiers;
- place of service;
- dates of service (for inpatient claims, this includes dates of admission and dates of discharge);
- diagnoses codes (i.e., the patient's conditions when he or she presented to the clinician);
- procedures; and
- provider identifier (if performing provider-level analyses).

Table 3 on page 8 provides details on the kinds of Medicare-Medicaid program planning, care coordination, and program integrity analyses that can be done with Medicare data. Note that the care coordination and program integrity uses described in Table 3 are specific to the listed data type; for instance, the care coordination and program integrity uses authorized for Part D drug event data are substantially more limited than those authorized for COBA data.

Data Requests

Information on how to request Medicare data and what to expect upon receiving can be found at the SDRC Website (http://www.statedataresourcecenter.com). This site describes available file types; file record layout/data dictionary; contents of data package; data transfer details; and

required documents and contact information. In addition, this website's Data Request Details page (http://www.statedataresourcecenter.com/data-request-process-details.html) provides the forms required to request data.

Table 1. Advantages and Limitations of Master Beneficiary Summary Files (MBSF) Data Type

Advantages	Limitations
Individual-level summary data can be used for program design and planning purposes. Can be used to identify overlaps, gaps, and duplication in Medicare and Medicaid coverage and to help identify major savings opportunities through better integration/coordination. Can also be used for capitated rate-setting.	Does not include individual claim-level data detail, so details of individual service use (types of physician visits, for example) are not available.
Much easier to use than raw Medicare claims data.	
Much less lead time to start using data; only requires knowledge of statistical software programs, like SAS, to use.	
Can link to Medicaid claims data for **Medicare-Medicaid enrollees** at the individual level.	
Patterns of service use and costs are easier to identify because claims and event information is summarized by beneficiary.	
Includes some Part D prescription drug event (PDE) data.	

Table 2. Advantages and Limitations of Claims/Event/Assessment Data Files Data Type

Advantages	Limitations
Can be used to support person-level care coordination activities.	Data are voluminous, "raw," and can be hard to use. Requires significant resources to store, integrate, and use.
Data are timelier than the MBSF; though still have normal lag experienced in fee- for-service claims submission (may be up to one year for claims).	Data may not be current and complete for all services, since providers have up to a year to submit claims, and claims with errors or omissions may have been resubmitted.
Includes certain Part D PDE data.	Non-final action claims sets may need to be unduplicated to identify final action.
	Privacy Act requirements may limit sharing of data with providers, care coordinators, and others outside of the State agency receiving the data.
	Price/cost information is not available for Part D data.
	Encounter data for services provided through Medicare managed care plans are not available at this time.

Table 3. Options for Analyzing Medicare Data

Type of Analysis	Summary Description	Key Area/Activities
Program Planning	Characterized by high-level analyses that create aggregate statistics on identifiable populations.	• *Basic Utilization and Cost Information:* service use and cost information for both Medicaid and Medicare for the major service categories broken out by age or eligibility; • *Diagnostic Snapshot:* utilization and costs by certain diagnostic categories/comorbidities; • *Care Coordination Opportunities:* look for areas of high overlap between Medicaid and Medicare utilization or potentially avoidable utilization; and • *Dual Subsets and Care Opportunities:* identify opportunities to improve care and reduce costs by population subsets.
Care Coordination and Program Integrity–Historical Parts A/B	Characterized by patient-level analyses	These data can be used to support interventions or the design of interventions—at the level of Medicare-Medicaid enrollees—that have the potential to improve the care of these beneficiaries. Uses can include analysis, monitoring, and feedback related to care coordination and/or program integrity.
Care Coordination and Program Integrity–Part D Data	Characterized by patient-level analyses	These data can be used to support interventions or the design of interventions—at the level of Medicare-Medicaid enrollees—that have the potential to improve the care of these beneficiaries. Uses can include analysis, monitoring, and feedback.

Type of Analysis	Summary Description	Key Area/Activities
Care Coordination and Program Integrity – COBA A/B Data	Characterized by patient-level analyses	These data can be used for patient- or provider-level analyses, often in real time. Data analyses could support the following quality assessment and improvement activities: • Outcomes evaluation; • Development of clinical guidelines; • Case management and care coordination; • Population-based activities relating to improving health or reducing health care costs., Contacting of health care providers and patients with information about treatment alternatives or related functions that do not include treatment; • Reviewing the competence or qualifications of providers; • Evaluating provider and practitioner performance or evaluating health plan performance; and • Conducting training programs in which students, trainees, or practitioners in areas of health care learn or improve their skills as health care providers; or training of non-health care professionals. • Analyzing aberrant utilization and/or billing patterns.
Care Coordination and Program Integrity – Assessments Data	Aggregated data about patients in different types of sub-acute care settings including nursing home facilities, inpatient rehab facilities and home health care	These data can be used to support interventions or the design of interventions—at the level of Medicare-Medicaid enrollees—that have the potential to improve the care of these beneficiaries. Uses can include analysis, monitoring, and feedback.

Table 4. For States Making an Initial Data Request: Available Data and Processes Explained

Request Process	Type of Data Available	Time Period Data Covers	Population	Time Lags in Claim Submission	Data Transmission Method	Cost	Routine Use States: Approved Uses	Routine Use State: Notes on Downstream Use
MMCO A/B Historical process (CCW)	Part A and B data: MBSF – final action claims, Identifier Crosswalk: BENE ID to HIC and BENE ID to SSN	2007-2015	Full and partial dual eligibles (CMS identifies)	At least 1 year	USB hard drives	Free	Care coordination activities; Program integrity activities	Data Use Agreement (DUA) signature addenda for *all downstream entities* for approved data uses. Addenda must be kept on file with the state. Quarterly reporting.
MMCO Assessments process (CCW)	MDS, OASIS, Swing Bed, and IRF-PAI.	2007-2015	Full and partial dual eligibles (CMS identifies)	Unknown	USB hard drives	Free	Care coordination activities; Program integrity activities	DUA signature addenda for *all downstream entities* for approved data uses. Addenda must be kept on file with the state. Quarterly reporting.
MMCO Coordination of Benefits Agreement (COBA) process	(Second/ enhanced feed) Part A/B non-final action claims	Current date forward	Full and partial dual eligibles (State identifies via finder file)	75% of claims submitted within 30 days	Data feeds (daily or weekly)	Free	Care coordination, quality improvement, health care operations, and treatment; Program integrity activities	COBA attachment required if second file requested (DUA is *not* required); State agency must have a Business Associate Agreement with each downstream user
MMCO Part D process (IDR)	Part D final action PDE data	2007-2015 (As State proposes and CMS approves)	Full dual eligibles only (CMS identifies)	Unknown	Electronic file transfer (EFT)	Free	Care coordination activities; Program integrity activities	DUA signature addenda for *all downstream entities* for approved data uses. Addenda must be kept on file with the state. Possible Attachment A. Conflict/no conflict of interest letter. Quarterly reporting.
MMCO Part D process (IDR)	Part D non-final action PDE data	January 2015+	Full dual eligibles only (CMS identifies)	Unknown	Electronic file transfer (EFT)	Free	Care coordination activities; Program integrity activities	DUA signature addenda for *all downstream entities* for approved data uses. Addenda must be kept on file with the state. Quarterly reporting.