Using and Requesting Medicare Data for Medicare–Medicaid Care Coordination and Program Integrity Frequently Asked Questions

Topic	Last Revision Date
Types of Available Data	August 2016
Format and Structure of the Data	August 2015
Information Included in the Data	August 2015
Using the Data for Program Integrity	August 2016
Using the Data for Care Coordination	September 2014
Data Request Process	August 2016
Data Request Process: Program Integrity	September 2014
Data Request Process (IEA)	August 2015
Downstream Users	August 2016
CMS State File Exchanges	January 2018

Types of Available Data

- **Can State Medicaid Agencies request only the Parts A and B claim types that they do not currently receive, or are they required to receive the entire set of claims?**

  States that want historical, final-action claims data for Parts A and B services may request any or all of the following file types for Medicare–Medicaid Enrollees:

  - Part A Inpatient.
  - Part A Outpatient.
  - Part A Skilled Nursing Facility (SNF).
  - Part A Home Health.
  - Part A Hospice.
  - Part B Carrier (Physician and related claims).
  - Part B Durable Medical Equipment (DME).

  States requesting non-final-action Parts A and B claims through the Coordination of Benefits Agreement (COBA) process may request to reuse the subset of Parts A and B claims that they already get through their existing COBA feed, or they may request a second feed that would include the entire set of claims.

- **What enrollment and eligibility data files are available?**

  State Medicaid Agencies can request the Master Beneficiary Summary File (MBSF) and the crosswalk files, which include information about enrollment and eligibility. The MBSF and crosswalks can be used to link between the Medicare data and the State's Medicaid data. State Medicaid Agencies can also obtain Territory Beneficiary Query (TBQ) files, which provide enrollment information about dual-eligible beneficiaries. For more information on TBQ files, please see the Centers for Medicare & Medicaid Services CMS State File Exchanges section.

- **Can State Medicaid Agencies request Assessments data?**

  Yes, State Medicaid Agencies can request Assessments data files (Minimum Data Set (MDS), Outcome and Assessment Information Set (OASIS), Swing Bed, and Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI)) through the State Data Resource Center (SDRC). Assessments datasets consist of aggregated assessment data about patients in different types of sub-acute care settings, including nursing facilities, inpatient rehab facilities, and home healthcare.

- **Our State currently receives data feeds for Medicare Parts A/B data for coordination of benefits; these feeds exclude non-monetary claims and claims for individuals with third-party insurance. We would like to include these claims going forward, but we are concerned about keeping them separate from our existing claims. How can we handle these claims to be sure that we are not at risk for paying them?**

State Medicaid agencies can request a second COBA feed, which will include all Parts A and B claims. A second feed permits the State Medicaid agency to segregate how the feed is received and processed.

- **What is the difference between the initial COBA feed and the secondary, enhanced COBA feed?**

  The secondary COBA feed is the type of COBA feed available for request through SDRC. It is a separate, enhanced feed that includes all the elements of the initial COBA feed that the State may be receiving for coordination of benefits plus additional claim types that are typically excluded (e.g., 100-percent denied, 100-percent paid), provided that such claims are not excluded by the State through the enhanced feed process. States apprise the Benefits Coordination & Recovery Center of their claims selection options via Section IV of the COBA Attachment.

- **Are some Part D data provided with the COBA data as well (rather than via the Integrated Data Repository)?**

  No, COBA data are limited to Parts A and B claims only. COBA does provide Part B DME claims from pharmacies in the National Council for Prescription Drug Program (NCPDP) format, but no Part D claims are available through COBA.

- **Are the encounter data for the demo beneficiaries available through the COBA data?**

  No, the COBA data feed does not include encounter data, whether for demonstration or otherwise.

- **Is it possible to obtain a sample COBA data feed during the testing/setting-up phase?**

  While obtaining a sample COBA data feed is not possible, State Medicaid Agencies can obtain a test COBA ID and limit the size of the incoming eligibility. The State Medicaid agency would ask the data distributor about the test COBA ID following approval of the COBA data request package.

Format and Structure of the Data

- **Where can I view the file layouts for the Medicare claims data?**

  For links to data dictionaries, file layouts, and other reference material for the historic Parts A/B, Coordination of Benefits Agreement (COBA), Part D data, and State Exchange Files (Medicare Modernization Act (MMA) and Territory Beneficiary Query (TBQ) data), refer to the Medicare Data Available – Data Dictionaries and File Layouts (http://www.statedataresourcecenter.com/medicare-data-availabledictionaries.html).

  For a general overview of the Medicare data available through the Medicare–Medicaid Coordination Office and how to use it, refer to *Requesting and Using*

Medicare Data for Medicare-Medicare Care Coordination and Program Integrity: An Overview (http://www.statedataresourcecenter.com/assets/files/Requesting_Data_for_Care_Coord_and_Program_Integrity.pdf).

- **How does CMS deliver data? In what format is the data in?**

  COBA: CMS distributes COBA data via electronic file transfer. Data are formatted as fixed-length flat files. The Self-Decrypting Archive Package includes an SAS program file to create SAS datasets from the flat file. The State Data Resource Center provides free software, Chiapas, to assist States with converting COBA data into a .csv file.

  Historical Parts A and B Data: The Centers for Medicare & Medicaid Services (CMS) distributes historical Parts A and B data via CDs, DVDs, or hard drives, depending on the file size. A Secure File Transfer System is not currently available to States; however, this system is being considered as a delivery option for the future. Data are formatted in fixed-column ASCII, variable-block files.

  Assessments: CMS distributes Assessments data (Minimum Data Set (MDS) 3.0, MDS 2.0, Outcome and Assessment Information Set (OASIS)-B1 and C, Swing Bed, Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI)) via USB flash drives or CDs. Data are formatted in fixed-column ASCII, variable-block files. For use with SAS, the prepared data package includes an SAS read-in program.

  Master Beneficiary Summary File (MBSF): CMS distributes MBSF data via USB flash drives or CDs. Data are formatted in fixed-column ASCII, variable-block files. For use with SAS, the prepared data package includes an SAS read-in program.

  Medicare–Medicaid Linked Enrollee Analytic Data Source (MMLEADS): CMS distributes MMLEADS data via USBs or CDs. Data are formatted in fixed-column ASCII, variable-block files. For use with SAS, the prepared data package includes an SAS read-in program.

  Crosswalks: CMS distributes crosswalks with Chronic Conditions Data Warehouse (CCW) data to enable linkages between Medicare data and Medicaid data. CMS distributes crosswalk data via USBs or CDs. Data are formatted in fixed-column ASCII, variable-block files. For use with SAS, the prepared data package includes an SAS read-in program.

  Part D Prescription Drug Event (PDE): CMS distributes Part D PDE data through electronic transfer. Data are formatted in Extended Binary Coded Decimal Interchange Code.

  MMA Response Files: State Medicare Advantage Prescription Drug (MARx) users can access the MMA response files for beneficiaries by logging into the MARx User Interface System. MMA response files are sent through the same electronic file transfer used by States to submit MMA request files to CMS.

TBQ Response Files: CMS distributes TBQ response files through electronic transfer using an electronic TBQ mailbox. Files are provided as tables with separate rows for each beneficiary.

- **Are final-action claims data for Parts A and B available in monthly or quarterly segments, or should it be received for the whole year?**

  Final-action historical Medicare Parts A/B claims data are currently only available as a full-year file.

- **For Medicare Parts A/B historic annual files, are the files cut based on the date of service or claim payment data?**

  Claims are aggregated based on the through-date of service on the claim (thru_dt). Each year's historic A/B file includes dates processed up to 6 months after the end of the calendar year in order to allow time for claims from the end of that year to be submitted and processed.

- **Can a State Medicaid agency request an annual Part D file to replace the monthly data files in order to confirm any netting performed on the data?**

  An annual replacement Part D file is not available at this time.

Information Included in the Data

- **Does the historic Parts A/B data include all claims, both paid and denied?**

  Yes, the data include all final action claims, both paid and denied.

- **What cost information is available on the Part D PDE data?**

  At this time, no cost information is included.

  For information on other data that can be requested, please refer to *Requesting and Using Medicare Data for Medicare-Medicare Care Coordination and Program Integrity: An Overview* (http://www.statedataresourcecenter.com/assets/files/Requesting_Data_for_Care_Coord_and_Program_Integrity.pdf).

- **Does the Part D data contain denied events?**

  No, denied events are not provided.

- **What information is included in National Council for Prescription Drug Programs (NCPDP) claims?**

  Here is an example of the NCPDP claim form: NCPDP Universal Claim Form Sample (http://www.lamedicaid.com/provweb1/manuals/UCFformInstruct.pdf).

  The following elements of the Medicare Part D file contain a response that references NCPDP claim format: Prescriber ID and Non-Standard Format. The Prescriber Identifier field on an NCPDP transaction is a provider identifier field and, as such, should carry a National Provider Identification (NPI) in almost all cases when populated. It is expected that most prescribers will be covered

entities and will therefore have an NPI assigned for use on all Health Insurance Portability and Accountability Act of 1996 (HIPAA) transactions, where required. However, if the prescriber is not a covered entity, s/he may not be required to have an NPI and may not opt to obtain one voluntarily. Thus, the prescriber would not have an NPI to include on the pharmacy transaction. For additional information on prescriber IDs, please refer to the *Prescriber Identifier on Part D NCPDP Pharmacy Claims Transactions* bulletin (https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/MemoNPIPrescriberID_050108v2.pdf).

- **Do the Part D data include prescriptions for health maintenance organization (HMO) beneficiaries, or only for Medicare fee-for-service (FFS) beneficiaries?**

  Yes, the Part D data includes prescriptions covered by Medicare Advantage managed care plans as well as FFS beneficiaries enrolled in a standalone Medicare Prescription Plan. All Prescription Drug Events (PDEs) available for a beneficiary should be included in the data, regardless of the beneficiary's FFS/managed care status.

  States can confirm by comparing the beneficiaries in the Part D data to the number of months of Medicare Advantage enrollment indicated in the beneficiary summary files. It might be useful to categorize the beneficiaries in the Part D data as no Medicare managed care, partial (1 to 11 months), and full-year Medicare managed care (12 months) and perform a count.

- **What are the limitations of Part D data?**

  The primary limitation is that Medicare Part D PDE data do not necessarily represent a complete picture of prescription drugs used by Medicare–Medicaid enrollees. In addition, the data are subject to time lags that may impact their efficacy for care coordination. A more detailed discussion of limitations is contained in Attachment 2 of the Medicare–Medicaid Coordination Office-Center for Medicaid, CHIP, and Survey & Certification bulletin *Access to Medicare Data to Coordinate Care for Dual Eligible Beneficiaries* (http://www.statedataresourcecenter.com/assets/files/Coordinated-Care-InfoBulletin.pdf).

- **How are full and partial dual-eligible beneficiaries defined and identified? Are both full and partial dual-eligible beneficiaries included in data provided through the State Data Resource Center process?**

  Beneficiaries who are Medicare enrolled and also meet all income and eligibility requirements for Medicaid are called "full duals" and receive all benefits covered by Medicaid, including custodial nursing home care, dental/eye care, mental healthcare, and other services not covered by Medicare. For full duals, Medicaid also pays all relevant Medicare Parts A/B premiums and all cost-sharing (deductibles and copayments). Full Medicare–Medicaid duals are identified by dual status codes 02, 04, and 08.

Medicare beneficiaries with incomes or assets slightly above the threshold for Medicaid eligibility may qualify for partial Medicaid benefits and are called "partial duals." Depending on the State, they may be eligible for limited Medicaid coverage and may receive assistance with some or all of their Medicare premiums and cost-sharing through the Medicaid program. Partial Medicare–Medicaid duals are identified by dual-status codes 01, 03, 05, and 06.

All data for individuals who were full or partial duals for at least 1 month in a calendar year will be included in that year's summary, enrollment, Parts A/B historic claims, and Assessments files. Medicare Part D annual files will only include PDEs for beneficiaries who were full duals for at least 1 month during the year.

- **Will the Part D PDE data be reconciled so that it only includes unique events?**

  PDE data always represent unique events. PDE data for dates of service in a given calendar year are considered fully reconciled 9 to 10 months after the end of a given calendar year. PDE data for more recent periods (non-final-action) may be adjusted, but adjustment occurs infrequently, as the Centers for Medicare & Medicaid Services (CMS) only adjust PDE data prior to reconciliation to correct specific data elements within a given event. CMS will share deletion and replacement events with States on an ongoing basis so that the State can adjust existing data as needed. For more information on PDE data adjustments, refer to the *PDE Data Netting Explanation* (http://www.statedataresourcecenter.com/assets/files/PDE_Data_Netting_Explanation.pdf).

Using the Data for Program Integrity

- **What is program integrity?**

  The purpose of program integrity is to safeguard the Medicaid program from fraud, waste, and abuse and to ensure the prudent use of taxpayers' dollars.

  Please refer to the Center for Program Integrity (http://www.cms.gov/AboutCMS/Components/CPI/Center-for-program-integrity.html) for more information.

- **Can Part D data be used for the purposes of detecting fraud, abuse, and waste?**

  The Medicare–Medicaid Coordination Office (MMCO) and Center for Program Integrity (CPI) approve data uses for care coordination and program integrity. Use is indicated and approved via the Information Exchange Agreement (IEA) and the Data Use Agreement (DUA). The data can be used for data analysis, data monitoring, or feedback for support interventions and/or intervention design at the individual dual beneficiary level. Data can also be used to detect fraud, waste, and abuse. At this time, data may not be used for any purpose not indicated in the IEA, including research or payment.

- **Are there restrictions for using any data types for program integrity?**

  MMCO currently approves data use for the primary purpose of care coordination. However, MMCO and CPI can approve the use of Medicare data for Medicaid program integrity initiatives via the IEA and DUA. At this time, data may not be used for any purpose not indicated in the IEA. A new IEA was published to include both care coordination and program integrity.

- **Are there any additional considerations for requesting Medicare data for program integrity purposes?**

  Yes, CPI requires State Medicaid Agencies asking for program integrity use justifications to include additional information about staffing; technical details, such as potential algorithms and analysis; expected timelines; and goals of the project(s) involved. In order to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CPI has an obligation to ensure that State Medicaid agencies are actively using the Medicare data and using it in accordance with Centers for Medicare & Medicaid Services-approved uses.

Using the Data for Care Coordination

- **Will the data that the Medicare–Medicaid Coordination Office is offering allow the State Medicaid agency to know what the individual's liability is on a real-time basis?**

  No. The Coordination of Benefits Agreement process will allow a very timely view of the Parts A and B data; however, the data generally have a lag time of 14 days. In addition, the State Medicaid agency will only receive Medicare data for beneficiaries who are also already eligible for Medicaid. Part D Prescription Drug Event (PDE) data are only submitted monthly, so unlike Parts A and B data, PDE data are not available in real time.

- **Our State is interested in obtaining Medicare data for an effort that deals with care coordination but is independent of the dual demonstration proposal. Can the State use the data requested for the dual demonstration for the purposes of our second effort?**

  Yes, but State Medicaid agencies must submit separate request applications to cover each intended use. If one entity is using a subset of the data for a purpose other than what was included in the original request, a second Data Use Agreement (DUA) needs to be submitted to cover the second intended use. The second user cannot qualify as a "downstream user" if they are requesting data for a purpose other than what was requested in the first DUA.

- **When linking beneficiary records across multiple data files, what is the best way to resolve cases where some beneficiary demographics match across the two files but others do not?**

  In cases where there is a partial match between beneficiary records in two different files, visual inspection may be useful to determine whether the records

represent a single beneficiary or two unique people. In a case where the Social Security number, gender, and last name match between two records but the date of birth is off by one digit, the analyst may decide that there is enough evidence to conclude that these two records represent the same beneficiary. Each State Medicaid agency will need to make its own determinations for what level of matching is required to equate two records.

Data Request Process

- **Can states that are not participating in a Medicare–Medicaid Coordination Office (MMCO) demonstration request historical Parts A or B data using the MMCO process?**

  Yes, all State Medicaid agencies can request the historical Parts A/B data. There are request package files for each major request type: New, Additional Data Use, and Update. If a Data Use Agreement (DUA) has not yet been established, the Parts A/B New package should be completed. If the State already has a DUA and wishes to use the data in another way, the Parts A/B Additional Data Use package is required. To add additional data files or years of data to an existing DUA, please complete the Parts A/B Update package. The Data Request Process Details page (http://www.statedataresourcecenter.com/data-request-process-details.html) lists the request packages by available Medicare data file.

- **Can researchers request Parts A and B data under the process available to State Medicaid agencies?**

  CMS is not able to offer data to researchers under the process available to State Medicaid agencies at no cost. Researchers must use the standard Research Data Assistance Center (ResDAC) process to request data. Please refer to ResDAC (http://www.resdac.org/).

- **Is there a cost to request Medicare data through the State Data Resource Center (SDRC) process?**

  There is no cost to State Medicaid agencies that request Medicare data through the SDRC process for care coordination or program integrity initiatives.

- **Can State Medicaid agencies make multiple historic data requests? For example, if we exclude some fields in our data-sharing agreement now, will it be possible to get the data we missed in the future?**

  All available fields (variables) are provided with Parts A and B data requests. The requestor specifies fields (variables) of interest for Assessments and Part D requests via the specifications worksheet. Additional fields (variables) for Assessments and Part D data can be added at a later date by submitting a DUA update.

- **How long will it take to receive the data once the request is complete?**

  The timeframe will depend on the complexity of the request and which type of data is requested.

- **On the specification worksheets, can we list the "file transfer mechanism" and "Electronic destination where files should be received" fields as "to be decided" (or TBD)? We currently have not determined how we would approach these two items.**

  Yes. However, the State Medicaid agency should describe the protocol for file management under any possible file transfer mechanism in the Data Management section of the worksheet.

- **Our fiscal agent is currently in the process of upgrading its hardware. How should we include this information in our data request?**

  Please include the information explaining the impact that the upgrade will have on the hardware in the Data Management section of specification worksheet.

- **How much detail do I need to include in the Use Justification tab?**

  Every use needs to be specifically listed. The data use should be detailed enough to allow the MMCO/Center for Program Integrity initial reviewers to understand how the use supports care coordination and program integrity as the Centers for Medicare & Medicaid Services (CMS) define them. Use justification should be included in Parts A/B, Assessments, Coordination of Benefits Agreement, or Part D specification worksheet tabs titled "Use Justification." You can locate these worksheets in the Data Request Documents and Links page (http://www.statedataresourcecenter.com/data-request-process-docs.html) of the SDRC website.

- **How do I go about requesting a DUA extension?**

  DUAs are scheduled to expire every 365 days. If a State Medicaid agency wants to continue using the Medicare data for care coordination and/or program integrity initiatives, the State must request a DUA extension. The State Medicaid agency will send an email to its CMS contact and request an extension. For detailed instructions, including email templates, contact the SDRC team directly for more information.

- **How do I go about requesting, adding, or removing a staff member to an already-existing DUA?**

  A current DUA requestor or custodian can request the addition or removal of a State Medicaid agency staff member to or from a DUA. If the requestor and custodian(s) no longer work for the State Medicaid agency, a representative from the State Medicaid agency can make the request instead. New DUA contacts will be asked to complete and sign the DUA Addendum form. For detailed instructions, including email templates, contact the SDRC team directly for more information.

- **What is the difference between a "No Conflict of Interest" letter and a "Potential Conflict of Interest" letter?**

  The Conflict of Interest letter is a requirement for downstream users who are planning to use the Part D Prescription Drug Event data to assist a State

Medicaid agency with care coordination and/or program integrity initiatives. There are two templates available, and the downstream user will select and complete one Conflict of Interest letter. The "No Conflict of Interest" letter template is for downstream users who do not have a conflict between using the Part D Medicare data for any of their regular activities and for the State's planned care coordination and/or program integrity initiatives. If a downstream user may have a possible conflict with using the Medicare Part D data in its regular activities and in assisting the State Medicaid agency, the downstream user must complete the "Potential Conflict of Interest" letter template. The downstream user will describe how it will keep its regular business activities separate from the State's planned use of the Medicare data.

- **Will CMS accept a digital signature instead of a wet signature?**

  Per CMS regulations, CMS does not accept digital signatures.

Data Request Process: Program Integrity

- **Will the data request process for program integrity follow the established State Data Resource Center data request process?**

  Yes, the established data request process will be used for both program integrity and care coordination data uses. Please refer to the Medicare Data Request Process page (http://www.statedataresourcecenter.com/data-requestprocess.html) for the detailed text and workflows related to requesting each data type.

- **Can the proposed program integrity data uses be listed on the same specifications worksheet as the care coordination data uses?**

  Yes, the specification worksheets were modified to include program integrity as an option for data usage.

- **Can an existing care coordination Data Use Agreement (DUA) be updated with program integrity data uses?**

  Yes. The Medicare–Medicaid Coordination Office, along with the Center for Program Integrity, can approve the use of Medicare data for Medicaid program integrity initiatives via the Information Exchange Agreement (IEA) and DUA. At this time, data may not be used for any purpose not indicated in the IEA. A new IEA was published to include both care coordination and program integrity, and States may submit an "Additional Data Use" request package to add program integrity data uses to an existing DUA.

Data Request Process: Information Exchange Agreement (IEA)

- **What are IEAs?**

  An IEA is an agreement between the Centers for Medicare & Medicaid Services (CMS) and a State Medicaid agency. The agreement establishes the terms,

conditions, safeguards, and procedures under which CMS will release the data to the State Medicaid agency and provides for additional protections above and beyond the Data Use Agreement (DUA). The IEA needs to be signed by a program official from the participating State Medicaid agency. This individual will commit their organization to the terms of the IEA. The participating State agency program official should be the same individual who signed the DUA as the user, #16.

- **Are IEAs required for all CMS data requested by State Medicaid agencies?**

  No, IEAs are not required for Territory Beneficiary Query (TBQ) files or Medicare Modernization Act (MMA) response files. MMA and TBQ files are provided as part of monthly data exchanges between CMS and State Medicaid agencies of demographic and Medicare and Medicaid eligibility information on dual-eligible beneficiaries.

- **Why is an IEA required in addition to the DUA?**

  An IEA provides for additional protections for the release of CMS data to State Medicaid agencies that are above and beyond the DUA.

- **Can a State Medicaid agency list a third-party data contractor as the data custodian on the DUA?**

  Yes, States can contract with a third-party entity to receive the Medicare data on behalf of the State Medicaid agency and to carry out a task. The State Medicaid agency can list the third-party contractor as the data custodian on the DUA. There must also be an agreement, contract, or relationship between the contractor and the State Medicaid agency related to use of the data. The requestor of the data (i.e., the State Medicaid agency) retains ultimate responsibility for the uses and security of the information.

Downstream Users

- **Does each downstream user need to sign a signature addendum?**

  For approved uses, the State Medicaid agency is responsible for approving any subsequent sharing with downstream entities, including securing a signature to the Data Use Agreement (DUA) Addendum, and any subsequent renewals (i.e., as the underlying DUA must be renewed by the State each year).

  - If the downstream user includes individuals who provide care coordination or other clinical services to dual-eligible beneficiaries, the State Medicaid agency will secure a signature to DUA Attachment A.
  - Only one signature is needed per downstream entity. The signatory must be someone who can legally bind the entity to the provisions of the addenda.

- **What is the difference between a DUA Addendum form and a DUA Attachment A form?**

  A DUA Attachment A form is completed by a downstream user provider who delivers care coordination or other clinical services to dual-eligible beneficiaries. The DUA Attachment A form will be signed by the downstream user and a representative of the State Medicaid agency. A DUA Addendum form is completed by a downstream user who provides analytical services for the use of the Medicare data.

- **Do downstream users need to list their subcontracted business associates on the Medicare Part D Conflict of Interest letter?**

  Yes, subcontracted businesses of downstream users must also be listed as downstream users on the Conflict of Interest letter.

Downstream User Quarterly Reports

- **Do States submit quarterly reports for downstream user activity for all data types?**

  States need to submit quarterly reports on downstream user activity for Historic Parts A/B, Assessments, and Part D data files. However, States do not need to submit quarterly reports on downstream user activity for Medicare Modernization Act or Territory Beneficiary Query data files.

- **Are States required to report downstream user activity by users who use the data for program integrity activities?**

  Yes, State Medicaid agencies are required to submit quarterly downstream user reports summarizing downstream users' care coordination and/or program integrity activities, as described within the Historic Parts A/B, Assessments, and Part D specification worksheets.

- **Should the same downstream user report templates be used for program integrity as care coordination?**

  The downstream user report template can be used for both the care coordination and/or program integrity data uses, allowing State Medicaid Agencies to include all downstream users for activity related to Historic Parts A/B, Assessments, and Part D data files in one report. Please contact the State Data Resource Center Team for assistance with report templates and submission instructions.

Centers for Medicare & Medicaid Services (CMS) State File Exchanges

- **Why do States submit Medicare Modernization Act (MMA) files?**

  MMA files allow CMS to establish the Low-Income Subsidy (LIS) status of dual-eligible beneficiaries and auto-assign beneficiaries to Medicare Part D plans; calculate States' Phase-Down contribution payments; and identify beneficiaries for whom States have made low-income subsidy determinations since the last MMA file.

- **How do States submit MMA files?**

  States submit MMA Request Files each month to CMS using the Medicare Advantage Prescription Drug (MARx) User Interface (UI) System. More information about the MARx UI System can be found in Section 2 of the *Medicare Advantage Prescription Drug (MAPD) State Users Guide*. For system account assistance, contact the MAPD Help Desk at MAPDHelp@cms.hhs.gov or (800) 927-8069.

- **How frequently do States submit MMA files?**

  States must submit at least one MMA file at a minimum of once each month. However, States are encouraged to submit multiple MMA files to CMS throughout the month to provide current information on updated dual eligibility status. More information about submitting MMA files and the benefits of submitting multiple files throughout the month can be found in this Q&A document (http://www.statedataresourcecenter.com/assets/files/MMA_QA.pdf).

- **What is the difference between an MMA Request File and an MMA Response File?**

  An MMA Request File refers to the data file(s) that States submit to CMS each month. These files include the names, demographic information, and Medicaid and Medicare eligibility status of dual-eligible beneficiaries.

  CMS automatically generates and returns an MMA Response File for each MMA Request File. The MMA Response File includes beneficiaries whose data provided in the MMA Request File matches to the CMS Medicare Beneficiary Database (MBD), Error Return Codes (ERC) for files where beneficiary information did not match the MBD, data from the MBD, and counts by month for each month of enrollment information in the MMA Request File.

- **How do I request Territory Beneficiary Query (TBQ) files?**

  To request TBQ files, States must first set up a file transfer account using CMS' Enterprise File Transfer process. To learn more about this process, please contact the State Data Resource Center at SDRC@EconometricaInc.com or (877) 657-9889.

- **What is the difference between a TBQ Request File and TBQ Response File?**

  A TBQ Request File represents a data exchange between CMS and the States. To determine beneficiary eligibility and enrollment information as part of the process for LIS enrollment, participating States request information from the CMS MBD through the TBQ Request File. TBQ Request Files contain the names, addresses, and demographic information of beneficiaries whose records were submitted through MMA files.

  CMS validates the incoming TBQ Request File and notifies the State of acceptance or rejection of the file based on the match between information in the TBQ Request File and MBD records. If the file is rejected, no further action is taken. If the file is accepted, MBD sends a TBQ Response File containing beneficiary names, residence addresses, demographic information, and the latest entitlement information for each TBQ Request File.