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

Frequently Asked Questions

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1. Types of Available Data

1.1. Can state Medicaid agencies ("states") 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 historic, 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 (HH).
- Part A Hospice.
- Part B Carrier (physician and related claims).
- Part B Durable Medical Equipment (DME).
- Medicare–Medicaid Linked Enrollee Analytic Data Source (MMLEADS).
- Medicare Provider Analysis and Review (MedPAR).
- Medicaid Enrollee Supplemental File (MESF).

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.

1.2. What enrollment and eligibility data files are available?

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

1.3. Can state Medicaid agencies request assessments data?

Yes, states 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.

1.4. Our state currently receives data feeds for Medicare Parts A and 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?

States can request a secondary, enhanced COBA feed, which will include all Parts A and B claims. A second feed permits the state to segregate how the feed is received and processed.

1.5. 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 a 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 (BCRC) of their claims selection options via Section IV of the COBA Attachment.

1.6. 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.

1.7. 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.

1.8. 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, states can obtain a test COBA ID and limit the size of the incoming eligibility. The state would ask the data distributor about the test COBA ID following approval of the COBA data request package.

1.9. What is the MBI?

MBI stands for Medicare Beneficiary Identifier (MBI). The Medicare Access and CHIP Reauthorization Act of 2015 ("the Act") mandated the removal of the Social Security Number-based Health Insurance Claim Number (HICN) as the identification number for Medicare beneficiaries. The primary goal of the Act was to reduce the risk of medical identity theft. The HICN will be replaced by the MBI on new Medicare cards. As a result of the initiative to replace the HICN, there will be some slight changes to the Medicare data states receive.

1.10. How do states access the MBI for Historic Parts A and B and COBA data?

For historic Parts A and B data, a new MBI crosswalk is now available. To obtain the crosswalk, states must request the file through a Data Request and Attestation (DRA) update.

Beginning in late February 2018, states should have received a production COBA MBI crosswalk file. The crosswalk file shows all active members that the states have sent to BCRC, along with the associated HICNs and MBIs. In the COBA E01 response file, the MBI identifier is added to each record.

1.11. How do states access the MBI for Part D Prescription Drug Event (PDE) data?

In late March/early April 2018, states that receive Part D PDE data received a test Part D file that included an additional field for the "MBI_ID." The addition of the "MBI_ID" field (element #26) was the only change in the test file and the "MBI_ID" field was intentionally left blank. Official production of the updated Part D PDE file, which includes the new "MBI ID" field, began with the next cycle run.

1.12. Is Part C/Medicare Advantage data available?

Unfortunately, this data type is not available publicly via the SDRC process. However, if/when this data type does become available, SDRC and CMS will provide all state Medicaid agencies with the necessary resources, such as data dictionaries, tip sheets, and webinar presentations.

1.13. Where can I locate the data dictionaries for the crosswalk files (i.e., BENE ID to HICN, BENE ID to Social Security number (SSN), and BENE ID to MBI)?

The crosswalk files, which help state Medicaid agencies merge the Medicare data with their Medicaid data, can be utilized with both the historic Parts A and B and the Part D PDE data. The data distributor can only generate the crosswalk files for the current year; however, the crosswalks can be used with data from previous years, since the files are continuously being updated and are sent with each historic Parts A and B data shipment. The data distributor has not created data dictionaries for these crosswalks, and therefore the data dictionaries for the crosswalks are not available online. For more information on crosswalks, contact the SDRC Support Team at SDRC@EconometricaInc.com or (877) 657-9889.

1.14. Can we request Medicare data for specific providers and/or all Medicare beneficiaries?

Through the SDRC process, state Medicaid agencies will receive Medicare data for all dually eligible beneficiaries living in their respective jurisdictions. These files cannot be subset for only specific criteria, such as providers, and cannot include Medicare-only beneficiaries.

1.15. Are the data files provided by SDRC raw or processed data?

CMS offers a variety of data files to support care coordination and program integrity initiatives for the dually eligible population. This includes, but is not limited to:

- Parts A, B, C, and D eligibility and enrollment data.
- Parts A and B claims data.
- Part D PDE data.
- Assessments (IRF-PAI, Swing Bed, MDS, OASIS) data.

The majority of these files are processed. We do offer eCOBA data (a secondary feed) that is raw data.

2. Format and Structure of the Data

2.1. Where can I view the file layouts for the Medicare claims data?

For links to data dictionaries, file layouts, and other reference material refer to the SDRC Data Dictonaries and File Layouts website (https://statedataresourcecenter.com/pages/data-dictionaries/) For information on historic Parts A and B, MBSF, assessments, MedPARs, and MESFs, select the CCW Data link. For a general overview of the Medicare data available through the Medicare-Medicaid Coordination Office (MMCO) and how to use it, refer to Requesting and Using Medicare Data for Medicare-Medicaid Care Coordination and Program Integrity: An Overview(http://statedataresourcecenter.com/assets/files/Requesting_Data_for_Care_Coord_and_Program_Integrity.pdf)

2.2. How does CMS deliver data? In what format are data delivered?

- **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. SDRC provides free software, Chiapas, to assist states with converting COBA data into a .csv file.
- **Historical Parts A and B Data:** CMS distributes historical Parts A and B data via CDs, DVDs, or hard drives, depending on the file size. States can inquire with SDRC about receiving this type of data electronically via secure file transfer protocol (sFTP). Data are formatted in fixed-column ASCII, variable-block files.
- **Assessments:** CMS distributes assessments data (MDS 3.0, MDS 2.0, OASIS-B1 and C, Swing Bed, and IRF-PAI) via USB flash drives or CDs. States can inquire with SDRC about receiving this type of data electronically via sFTP. Data are formatted in fixed-column ASCII, variable-block files. For use with SAS, the prepared data package includes a SAS read-in program.
- **MBSF:** CMS distributes MBSF data via USB flash drives or CDs. Data are formatted in fixed-column ASCII, variable-block files. States can inquire with SDRC about receiving this type of data electronically via sFTP. For use with SAS, the prepared data package includes a SAS read-in program.
- **MMLEADS:** CMS distributes MMLEADS data via USBs or CDs. States can inquire with SDRC about receiving this type of data electronically via sFTP. Data are formatted in fixed-column ASCII, variable-block files. For use with SAS, the prepared data package includes a SAS read-in program.
- **MedPAR:** CMS distributes MedPAR data via CDs, DVDs, or hard drives, depending on the file size. States can inquire with SDRC about receiving this type of data electronically via sFTP. Data are formatted in fixed-column ASCII, variable-block files.
- **MESF:** CMS distributes MESF data via hard drives, CDs, or DVDs, depending on the file size. States can inquire with SDRC about receiving this type of data electronically via sFTP. Data are formatted in fixed-column ASCII, variable-block files.
- **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. States can inquire with SDRC about receiving this type of data electronically via sFTP. Data are formatted in fixed-column ASCII, variable-block files. For use with SAS, the prepared data package includes a SAS read-in program.

- **Part D PDE:** CMS distributes Part D PDE data through electronic transfer. Data are formatted in Extended Binary Coded Decimal Interchange Code (EBCDIC).
- **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 (UI) 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.

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

Monthly A and B data only contains claims with "From Date of Service' falling within the month covered by the file. Since monthly A and B data is pulled from CCW for a specific time frame, any claims later received for that same service month will not be provided in future monthly files but can be located in the annual file. The annual file is pulled once a year and captures adjustments, deletions, etc. which increases the accuracy of the data. Final-action historical Medicare Parts A and B claims data are currently only available as a full-year file.

2.4. For Medicare Parts A and B historic annual files, are the files cut based on the date of service or the claim payment date?

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

2.5. Can a state request an annual Part D file to replace the monthly data files to confirm any netting performed on the data?

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

2.6. What are the naming conventions for the crosswalk files?

Below are the crosswalk file naming conventions.

- BENE ID to HICN – bene_hicn_xwalk_res0000*****_req######_YYYY.
- BENE ID to SSN – bene_ssn_xwalk_res0000*****_req######_YYYY.
- BENE ID to MBI – bene_mbi_xwalk_res0000*****_req######_YYYY.

The asterisks (*) would be replaced with the state Medicaid agency's DRA number, the pound signs (#) would be replaced with the request number automatically generated by the data distributor, and the "YYYY" would be replaced with the year of the corresponding timeframe.

2.7. What are the naming conventions for the historic Parts A and B data?

Below are the historic Parts A and B file naming conventions.

- Historic Part A:
    - Inpatient – inpatient_demo_codes_res0000*****_req######_YYYY.
    - Outpatient – outpatient_demo_codes_res0000*****_req######_YYYY.
    - Hospice – hospice_demo_codes_res0000*****_req######_YYYY.
    - Home Health – hha_demo_codes_res0000*****_req######_YYYY.
    - Skilled Nursing Facility (SNF) – snf_demo_codes_res0000*****_req######_YYYY.

- Historic Part B:
    - Carrier – carrier_demo_codes_res0000*****_req######_YYYY.
    - DMERC – dmerc_demo_codes_res0000*****_req######_YYYY.

The asterisks (*) would be replaced with the state Medicaid agency's DRA number, the pound signs (#) would be replaced with the request number automatically generated by the data distributor, and the "YYYY" would be replaced with the year of the corresponding timeframe.

2.8. What are the naming conventions for the MBSF?

Below are the MBSF file naming conventions:

- BASE (A/B/C/D) Segment – mbsf_base_summary_res0000*****_req######_YYYY.
- Chronic Conditions Segment – mbsf_cc_summary_res0000*****_req######_YYYY.
- Other Chronic or Potentially Disabling Conditions Segment – mbsf_oth_cc_summary_res0000*****_req######_YYYY.
- Cost & Use Segment – mbsf_costuse_summary_res0000*****_req######_YYYY.

The asterisks (*) would be replaced with the state Medicaid agency's DRA number, the pound signs (#) would be replaced with the request number automatically generated by the data distributor, and the "YYYY" would be replaced with the year of the corresponding timeframe.

2.9. What are the naming conventions for the Part D PDE data?

Below is the Part D PDE file naming convention:

- P#EFT.ON.G**.IDRPD.Y####M##.D######.T#######.

The asterisks (*) would be replaced with the state Medicaid agency's postal abbreviation, the "D######.T#######" time stamp would be replaced with the time when the data file was generated, and the "Y####M##" time stamp would be replaced with the data file's corresponding timeframe.

Information Included in the Data

2.10. Does the historic Parts A and B data include all claims, both paid and denied?

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

2.11. What cost information is available on the Part D PDE data?

At this time, no cost information is included.

2.12. Does the Part D data contain denied events?

No, denied events are not provided.

2.13. What information is included in 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 field used to identify the provider, 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, he or she 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).

2.14. Does 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 (MA) managed care plans as well as FFS beneficiaries enrolled in a standalone Medicare Prescription Plan. All 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 MA 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-year Medicare managed care (1–11 months)," and "full-year Medicare managed care (12 months)" and perform a count.

2.15. What are the limitations of Part D data?

The primary limitation for Medicare Part D PDE data is it does 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 MMCO–Center for Medicaid, CHIP, and Survey & Certification (MMCO–CMCS) bulletin *Access to Medicare Data to Coordinate Care for Dual Eligible Beneficiaries* (http://www.statedataresourcecenter.com/assets/files/Coordinated-Care-InfoBulletin.pdf).

2.16. How are full- and partial-benefit dual-eligible beneficiaries defined and identified? Are both full and partial benefit dual-eligible beneficiaries included in data provided through the SDRC process?

Beneficiaries who are enrolled in Medicare and meet all income and eligibility requirements for Medicaid are considered full-benefit dual-eligible beneficiaries and receive all benefits covered by Medicaid, including custodial nursing home care, dental care, eye care, mental healthcare, and other services not covered by Medicare. For full-benefit dually eligible beneficiaries, Medicaid also pays all relevant Medicare Parts A and B premiums and all cost-sharing (deductibles and copayments). Full-benefit dually eligible beneficiaries 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 considered partial-benefit dually eligible beneficiaries. 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-benefit dually eligible beneficiaries are identified by dual-status codes 01, 03, 05, and 06.

All data for individuals who were full or partial-benefit dually eligible beneficiaries for at least 1 month in a calendar year will be included in that year's summary, enrollment, Parts A and B historic claims, and assessments files. Medicare Part D files will only include PDEs for beneficiaries who were fully dual-eligible for at least 1 month during the year.

2.17. 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 CMS only adjusts 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).

2.18. Is the "BENE_ID" variable available in the Part D PDE data?

Through the SDRC process, state Medicaid agencies can only receive 26 PDE elements. Although the "BENE_ID" is not provided, states can use both the BENE ID to HICN and BENE ID to MBI crosswalk files to link the Part D PDE data via elements #3, the HICN, and #26, the BENE MBI ID, to both Medicare historic Parts A and B data and Medicaid data.

2.19. For the MBI transition, will CMS be gradually making the transition from HICNs to MBIs?

Since MBIs became available on April 1, 2018, CMS considered the timeframe from April 1, 2018, to December 31, 2019, to be the gradual transition period. Starting on January 1, 2020, CMS will not accept any claims that are submitted with HICNs.

2.20. Will a dually eligible beneficiary have the potential to have multiple MBIs, as they could have multiple HICNs?

No, each dually eligible beneficiary will be assigned one MBI, and this number will appear with the most current HICN on the crosswalk files.

2.21. What are the policies regarding state Medicaid agencies sharing substance use disorder (SUD) Medicare data with recipients of historical Medicare data?

The relevant Federal regulation, 42 CFR Part 2, is outlined in the August 22, 2019, HHS factsheet and Cornell University's Legal Information Institute website. Under Subpart D, §2.53, "Audit and Evaluation," paragraph C discusses disclosing personally identifiable information (PII) for beneficiaries with SUD to Medicare, Medicaid, and CHIP. State Medicaid agencies can share this information as long as they are for approved downstream users for the approved uses.

State Medicaid agencies should still abide by all terms and conditions of both the Information Exchange Agreement (IEA), DRA, and all internal and state laws.

3. Using the Data for Program Integrity

3.1. 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 (CPI) website (http://www.cms.gov/About-CMS/Components/CPI/Center-for-program-integrity.html) for more information.

3.2. Can Medicare data be used for the purposes of detecting fraud, abuse, and waste?

MMCO and CPI approve data uses for care coordination and program integrity. Use is indicated and approved via the IEA and DRA. The data can be used for data analysis, data monitoring, or feedback to support interventions and/or intervention design at the individual 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.

3.3. Are there any additional considerations for requesting Medicare data for program integrity purposes?

Yes, in a program integrity request, CPI requires states 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 HIPAA, CPI has an obligation to ensure that states are actively using the Medicare data and using it in accordance with CMS-approved uses.

4. Using the Data for Care Coordination

4.1. Will the data that MMCO is offering allow a state to know what the individual's liability is on a real-time basis?

No. The COBA process will allow a very timely view of the Parts A and B data; however, the data generally has a lag time of 14 days, compared to monthly Parts A and B which has a 3-month lag

time. In addition, a state will only receive Medicare data for beneficiaries who are also already eligible for Medicaid. Part D PDE data are only submitted monthly, so unlike COBA, PDE data are not available in real time.

4.2. 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 states must submit separate data 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 request package needs to be submitted to cover the second intended use as part of the state's DRA with CMS. The second user cannot qualify as a "downstream user" if they are requesting data for a purpose other than what was requested in the original DRA.

4.3. 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 will need to make its own determinations for what level of matching is required to equate two records.

5. Data Request Process

5.1. Can states that are not participating in an MMCO demonstration request historic Parts A or B data using the MMCO process?

Yes, all states can request the historic Parts A and B data. There are request package files for each major request type: New and Additional Data Use. If a DRA has not yet been established, a new Parts A and B package should be completed. If the state already has a DRA and wishes to use the data in another way, the Parts A and B Additional Data Use package is required. The Data Request Process Details page (https://statedataresourcecenter.com/pages/request-process-details/) lists the request packages by available Medicare data file.

Note: In 2018, CMS transitioned data sharing between CMS and states through SDRC from the Data Use Agreement (DUA) process to the DRA process. With this change, states no longer need to complete annual update requests to add additional years of data to existing data requests.

5.2. Can researchers request Parts A and B data under the process available to states?

CMS is not able to offer data to researchers under the process available to states. Researchers must use the standard Research Data Assistance Center (ResDAC) process to request data. Please refer to ResDAC's website (http://www.resdac.org/) for more information.

5.3. Is there a cost to request Medicare data through the SDRC process?

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

5.4. Can states 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 PDE requests via the specifications worksheet. Additional fields (variables) for assessments and Part D data can be added at a later date by submitting a request through the SDRC.

5.5. 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. Additional considerations include other states' requests in the queue, response times to address SDRC and/or CMS feedback, the number of revisions, and holiday/vacation schedules. SDRC will provide status updates to the requesting state Medicaid agency on anticipated data shipment dates.

5.6. 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 should describe the protocol for file management under any possible file transfer mechanism in the "Data Management" tab of the specification worksheet.

5.7. 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" tab of the specification worksheet.

5.8. 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 CMS reviewers to understand how the use supports care coordination and program integrity as CMS define them. A description of the intended use should be included in the designated specification worksheet on the "Use Justification" tab. You can locate these worksheets in the Data Request Documents and Links page (https://statedataresourcecenter.com/pages/data-request-docs/) of the SDRC website.

5.9. How do I go about requesting, adding, or removing a staff member to an already-existing DRA?

A current DRA requestor or custodian can request the addition or removal of a state staff member to or from a DRA. If the requestor and custodian(s) no longer work for the state, a representative from the state can make the request instead. New DRA custodians will be asked to complete and sign the DRA Additional Custodian form. New DRA requestors will need to update the contact information on the DRA form. For detailed instructions, including email templates, contact the SDRC Support Team at SDRC@EconometricaInc.com or (877) 657-9889.

5.10. What is the difference between a "No Conflict of Interest" letter and a "Potential Conflict of Interest" letter?

The Conflict of Interest (COI) letter is a requirement for downstream users who are planning to use the Part D PDE data to assist a state with care coordination and/or program integrity initiatives. There are two templates available, and the downstream user will select and complete one COI letter.

The "No Conflict of Interest" letter template is for downstream users who do not have a conflict between using the Part D PDE 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 has a possible conflict with using the Medicare Part D PDE data in its regular activities and in assisting the state, 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.

5.11. Will CMS accept a digital signature instead of a wet signature?

CMS does not accept digital signatures on the IEA. CMS does, however, accept digital signatures on the DRA form and the DRA Additional Custodian form. For questions regarding other documents, contact the SDRC Support Team at SDRC@EconometricaInc.com or (877) 657-9889.

5.12. Who should state Medicaid agencies contact with data shipment questions?

State Medicaid agencies should contact SDRC, who will work with the appropriate data distributors to provide accurate guidance to the states. When contacting SDRC, state Medicaid agencies should provide as much detail as possible about their concerns/inquiries, such as timeframes and screenshots. If state Medicaid agencies want to submit Medicare data samples to SDRC, please only submit them via the SDRC Assistance website for security reasons.

5.13. Can we see other state Medicaid agencies' data request package materials?

Unfortunately, SDRC cannot provide this information due to privacy reasons. Nonetheless, the SDRC Support Team will provide tailored guidance to your state Medicaid agency throughout every step of the data request process.

5.14. Does a DRA contact change request impact who is listed on a state Medicaid agency's COBA agreement?

No, the state Medicaid agency would have to submit a separate contact change request for the COBA data, as this data type is not tied to the DRA form. Please contact the SDRC Support Team for more information.

5.15. Does MMCO allow states to utilize cloud-based solutions (e.g., Amazon Web Services, Dropbox) in state DMPs submitted for data under a CMS/MMCO DRA?

MMCO does allow states to utilize cloud-based solutions, as long as the storing system still has the necessary security precautions in place.

5.16. Can student/faculty researchers from universities be provided access to SDRC data files?

SDRC provides files to state Medicaid agencies, only, to help support their dually eligible population. If a state Medicaid agency partners with a university, then the university can access the files as a downstream user, custodian, or sub-collaborator. The files can only be used for the state Medicaid agency's approved data uses.

6. Data Request Process: Program Integrity

6.1. Will the data request process for program integrity follow the established SDRC 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 (https://statedataresourcecenter.com/pages/request-process/) for the detailed text and workflows related to requesting each data type.

6.2. 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.

6.3. Can an existing care coordination DRA be updated with program integrity data uses?

Yes. MMCO and CPI can approve the use of Medicare data for Medicaid program integrity initiatives via the IEA and DRA. At this time, data may not be used for any purpose not indicated in the IEA. States may submit an "Additional Data Use" request package to add program integrity data uses to an existing DRA.

7. Data Request Process: Information Exchange Agreement (IEA)

7.1. What are IEAs?

An IEA is an agreement between CMS and a state. The agreement establishes the terms, conditions, safeguards, and procedures under which CMS will release the data to the state and provides for additional protections above and beyond the DRA. The IEA needs to be signed by a program official from the participating state. This individual will commit their organization to the terms of the IEA. The participating state program official should be the same individual who signed the DRA as the requestor.

7.2. Are IEAs required for all CMS data requested by state Medicaid agencies?

No, IEAs are not required for TBQ files or MMA response files. MMA files are provided to the states at minimum monthly and can be received on a daily basis. Similarly, TBQ files can be received as frequently or infrequently and it up to the state's digression.

7.3. Why is an IEA required in addition to the DRA?

An IEA provides for additional protections for the release of CMS data to states that are above and beyond the DRA.

7.4. Can a state list a third-party data contractor as the data custodian on the DRA?

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

7.5. Do we need to re-sign the IEA if our original signatory is no longer with our state Medicaid agency?

No, although state Medicaid agencies' DRA forms should be current with the listed requestor and custodian(s).

8. Downstream Users

8.1. Do downstream users need to complete any forms to be added to the DRA?

No. For approved uses, the state is responsible for maintaining a list of downstream users and submitting quarterly reports detailing downstream user activity to MMCO and CPI. Since CMS transitioned data sharing through the SDRC to the DRA process, downstream users no longer need to complete the DUA Addendum form or the DUA Attachment A form.

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

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

8.3. How many personnel can have access to AXWAY, and what are the requirements?

Each state Medicaid agency can have a maximum of two people with AXWAY access to receive the monthly and historic Parts A and B, MBSF, assessments, MedPAR, MESF, and/or crosswalk files on its behalf. The only requirement is that the AXWAY account holders must be listed on the state Medicaid agency's DRA form.

9. Downstream User Quarterly Reports

9.1. Do states submit quarterly reports for downstream user activity for all data types for care coordination and/or program integrity purposes?

States need to submit quarterly reports on downstream user activity for historic and monthly Parts A and B, assessments, and Part D PDE data files. However, states do not need to submit quarterly reports on downstream user activity for MMA or TBQ data files.

9.2. 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 care coordination and/or program integrity data uses, allowing states to include all downstream users for activity related to historic Parts A and B, assessments, and Part D PDE data files in one report. Please contact the SDRC Support Team at SDRC@EconometricaInc.com or (877) 657-9889 for assistance with report templates and submission instructions.

10. CMS State File Exchanges

10.1. Why do states submit 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 LIS determinations since the last MMA file.

10.2. How do states submit MMA files?

States submit MMA Request Files each month to CMS using the MARx 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 (https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/MAPD-State-User-Guide.html).

For system account assistance, contact the MAPD Help Desk at MAPDHelp@cms.hhs.gov or (800) 927-8069.

10.3. 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 Medicare–Medicaid eligibility status.

More information about submitting MMA files and the benefits of submitting multiple files throughout the month can be found in the MMA Q&A document (http://www.statedataresourcecenter.com/assets/files/MMA_QA.pdf).

10.4. 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.

10.5. How do I request TBQ files?

To request TBQ files, states must first set up a file transfer account using CMS' Electronic File Transfer (EFT) process. To learn more about this process, please contact SDRC at SDRC@EconometricaInc.com or (877) 657-9889.

10.6. 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.

10.7. Is there a resource that contains technical guidance regarding the submission of the MMA file?

Yes, the MAPD SUG provides technical instructions for submitting the MMA file to CMS as well as for the request and response file layouts. The MAPD SUG can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/MAPD-State-User-Guide.

10.8. How does a state derive the dual status code? If the recipient is eligible for both Medicaid and Medicare, does that determine that they are dually eligible?

Dually eligible individuals are enrolled in both Medicare and Medicaid. This includes beneficiaries enrolled in Medicare Part A and/or Part B who are receiving full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through one of these MSP categories:

- Qualified Medicare Beneficiary (QMB) Program: Helps pay premiums, deductibles, coinsurance, and copayments for Part A, Part B, or both programs.
- Specified Low-Income Medicare Beneficiary (SLMB) Program: Helps pay Part B premiums.
- Qualifying Individual (QI) Program: Helps pay Part B premiums.
- Qualified Disabled Working Individual (QDWI) Program: Pays the Part A premium for certain disabled and working beneficiaries.

We encourage MMIS systems maintainers who create the MMA file to connect with the eligibility staff in a given state's Medicaid agency. More information about categories of eligibility for dually eligible beneficiaries is available online at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf.

10.9. What is the institutional status indicator?

The institutional status indicator denotes whether a full-benefit dually eligible individual receives Medicaid-covered nursing facility, immediate care facility, inpatient psychiatric hospital, or home and community-based services (HCBS).

CMS uses this field to establish the correct beneficiary copayment levels. In addition, to ensure that CMS provides the zero-copayment level for the correct effective date, it is essential that states submit accurate current-month institutional status and retroactive records reflecting institutional status changes in prior months. For example, if a state has reported an individual as having institutional status for the first time in February, even though the first full month in the institution was January, a retroactive enrollment record showing this update is needed.

10.10. What are the institutional status indicator field values?

The institutional status indicator shows that a beneficiary resides in a medical institution or a nursing facility or receives HCBS. Valid values for the indicator are:

- Y – Indicates that a full-benefit dually eligible beneficiary is enrolled in a Medicaid paid institution for the full reporting month or is projected by the state to remain in the institution for the remainder of the month.
- H – Indicates that a full-benefit dually eligible beneficiary receives HCBS in any period during the month. This includes home- and community-based services delivered under a section 1115 demonstration, a 1915(c) or (d) waiver, or a state plan amendment under 1915(i), or through a Medicaid managed care organization with a contract under section 1903(m) or section 1932 of the Social Security Act.
- N – Indicates that a beneficiary does not meet the criteria for Y or H.
- 9 – Unknown.

10.11. Does the HCBS indicator include all HCBS programs?

The HCBS indicator includes many, but not all, types of HCBS programs. A state should populate the field with the H indicator for full-benefit dually eligible individuals receiving HCBS delivered under a section 1115 demonstration, a 1915(c) or (d) waiver, or a state plan amendment under 1915(i), or through a Medicaid managed care organization with a contract under section 1903(m) or section 1932 of the Social Security Act. It does not include HCBS or personal care programs authorized under 1905(a), 1915(j) (self-directed personal care under a state plan), or 1915(k) (community first choice services).

10.12. How is the Medicare Part D eligibility start date determined, in relation to Part A and Part B?

The Part D start date is the earlier of the Part A or B start dates, but if either A or B has a retroactive effective date, the Part D effective date is not retroactive (e.g., for a person who received notice of Part A/B entitlement in the month of March of 2019 that they have Part A back to October 1, 2018, the Part D effective date is March 1, 2019).