DEPARTMENT OF HEALTH & HUMAN SERVICES
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MMCO - CMCS Informational Bulletin

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SUBJECT: Access to Medicare Data to Coordinate Care for Dual Eligible Beneficiaries

The Federal Coordinated Health Care Office ("Medicare-Medicaid Coordination Office") and the Center for Medicaid, CHIP and Survey & Certification (CMCS) are issuing this Informational Bulletin to inform State Medicaid Agencies of the availability of and process for requesting timely Medicare Parts A, B and D claims/event data for their dual eligible beneficiaries to support care coordination. Having access to Medicare data is an essential tool for States seeking to coordinate care, improve quality, and control costs for dual eligible beneficiaries. States whose requests are approved will be able to combine Medicare Parts A and B claims and Medicare Part D Prescription Drug Event (PDE) data and link to the State's Medicaid data for whole-person analysis of the dual eligible experience. States may also request Medicare eligibility and enrollment data on their dual eligible beneficiaries.

The Centers for Medicare & Medicaid Services (CMS) has permitted states to request access to **Medicare Part D PDE data** since 2008, but until now, had limited availability to "final action data" (i.e., not subject to subsequent adjustment). However, States have expressed concerns that final action data are not timely enough to support care coordination. For example, currently final action data are only available for dates of service through 2009. We are pleased to announce that CMS is now making available to States more timely "non-final action" (i.e., subject to subsequent adjustment) Medicare Part D PDE data for the specific purpose of supporting care coordination activities that have the potential to improve care for dual eligible beneficiaries at the individual level. These data will be made available at no cost to States. Please see Attachments 1-3 for details. For all other uses permitted by 42 CFR 423.505, States will continue to be limited to final action data.

CMS has provided States the ability to request timely **Medicare Parts A and B claims data** since 2008, and **Medicare Parts A, B, C, and D eligibility/enrollment data** since 2009. We have learned some States are unaware of these options, so are including a reminder in this Informational Bulletin. For details on the availability of and process for requesting Medicare Parts A and B claims data, please see Attachment 4. For details on requesting access to Medicare eligibility and enrollment data, please see Attachment 5. Both are available at no cost to States. Please note that at this time, Medicare Part C health plan encounter data are not collected.

For Additional Information

We hope these data will help States as they seek to coordinate and improve care for people eligible for Medicare and Medicaid.

States that have additional questions may contact the Medicare-Medicaid Coordination Office at MedicareMedicaidCoordination@cms.hhs.gov.

Attachments (5):

1 – Process for Requesting Medicare Part D PDE Data
2 – Limitations of Medicare Part D PDE Data
3 – Medicare Part D PDE Data Element Availability
4 – Process for Requesting Medicare Parts A and B Claims Data
5 – Process for Requesting Medicare Eligibility/Enrollment Data

Attachment 1 – Process for Requesting Medicare Part D PDE Data

As described in the October 3, 2008 State Medicaid Letter, States have been able to request "final action" (i.e., not subject to subsequent adjustment) Medicare Part D Prescription Drug Event (PDE) data since 2008. CMS is now permitting States to request more timely non-final action Medicare Part D PDE data, specifically for care coordination activities that have the potential to improve care for dual eligible beneficiaries at the individual level. Please note that there are limitations to the data, e.g., the data are subject to lags that may impact their efficacy for care coordination (please see Attachment 2 for additional details).

The release of Medicare Part D PDE data by CMS is governed by 42 CFR 423.505(m), which includes various privacy protections for these data, and requires CMS to allow only the release of minimum data necessary to a requestor. Accordingly, States will only receive PDE data on individuals who are full-benefit dual eligible beneficiaries in that particular State, and must justify the necessity for each data element requested for their care coordination efforts. CMS has determined that financial data elements will not be made available, nor will internal plan and pharmacy prescription identification numbers. Please see Attachment 3 for the list of specific data elements available for release.

Given the sensitivity of these data, States requesting these data will need to provide strong protections for them. CMS will only permit these data to be shared with downstream entities if necessary to support specific care coordination efforts, and the State must demonstrate how it will ensure that the downstream entities safeguard these data. Please note that CMS will generally not approve further re-release or sharing from the first level downstream entity to other downstream entities. Finally, please note that these data will not be permitted to be used by the State Medicaid Agency, nor matched with files from other State agencies, for any purpose other than care coordination for dual eligible beneficiaries, e.g., investigating fraud or conducting research.

States may request one historical baseline file and monthly files thereafter of non-final action Medicare Part D PDE data to support care coordination for dual eligible beneficiaries. There is no cost to States for Medicare Part D PDE data shared under this process. For more information on requesting non-final action Medicare Part D PDE for care coordination purposes, please visit our website at http://www.cms.gov/Medicare-Medicaid-Coordination.

Attachment 2 -- Limitations of Medicare Part D PDE Data

States interested in receiving non-final action (i.e., data that may be subsequently adjusted) Medicare Part D Prescription Drug Event (PDE) data for care coordination of their dual eligible beneficiaries should be aware there are some limitations to these data. As described below, the primary limitation is that Medicare Part D PDE data do not necessarily represent a complete picture of prescription drugs used by dual eligible beneficiaries. In addition, the data are subject to lags that may impact their efficacy for care coordination. A more detailed discussion of limitations follows.

- PDE data have lags that may reduce their efficacy for care coordination. State Medicaid Agencies may be used to obtaining prescription drug claims in close to real time when they are the primary payer. However, as noted below, PDE data are not claims. Medicare prescription drug plans must submit PDE data to CMS every 30 days; however, at this time there is no timely filing limit, except that related to the annual financial reconciliation process. In addition, while PDE data are loaded into CMS' system daily, CMS will only send files of these data once a month to States whose requests for non-final action data are approved.

- PDE data received may be non-final action; subsequent non-financial adjustments may occur. For example, a pharmacy may submit a corrected National Drug Claim (NDC) number or days supply. However, these types of adjustments are very rare.

- PDE data may not provide a complete picture of drugs dispensed to dual eligible beneficiaries. Reasons include:
    - PDE data are only available for dual eligible beneficiaries enrolled in a Medicare Part D prescription drug plan. Individuals not enrolled in those plans will have no PDE data. This includes individuals receiving their prescription drug coverage from other sources such as an employer/union plans (which may or may not claim the Part D Retiree Drug Subsidy), Veterans Administration, Tricare, or the Federal Employees Health Benefit Plan.
    - Dual eligible beneficiaries enrolled in a Medicare prescription drug plan may obtain drug coverage through other sources, e.g., drugs may be covered under Medicare Part B; Medicaid; a pharmaceutical patient assistance program outside of the Part D benefit; other coverage; or paid for out-of-pocket by a beneficiary. Prescription drugs explicitly excluded by Part D, as well as over the counter drugs, will not have PDE data associated with them.

- PDE data are not the same as individual drug claim transactions. Instead, they are similar to encounter data in that they represent summary extracts using CMS-defined standard fields. Requestors using the PDE data should keep in mind that a PDE is not the actual claim paid at the pharmacy, but a record of that claim that has been created by the Part D sponsor prior to its submission to CMS for payment reconciliation.

Attachment 3 -- Medicare Part D PDE Data Element Availability

This chart shows the non-final action data elements that are *available* for release to State Medicaid Agencies for care coordination for dual eligible beneficiaries. Please note that under CMS' minimum necessary data policy a requestor would not automatically receive *all* of the available elements, but would only receive those *necessary* for its care coordination efforts.

Identifiers	
Data Elements	**Availability**
Beneficiary ID (HIC Number, Cardholder ID, Patient date of birth)	Available
Plan ID (PBP identifier, Contract identifier)	Available
Prescriber ID (Prescriber Identifier)	Available
Pharmacy ID (Service provider identifier)	Available
Qualifying Identifiers (Service & Prescriber Identifier Qualifiers – codes that denote whether NPI, NCPDP, UPIN, state license number, DEA, or non-standard code is used)	Available
Internal plan/pharmacy prescription identification numbers (Claim Control Number - a code intended for the plan to identify unique events & Prescription Service Reference Number – a code assigned by the pharmacy at the time the prescription is filled)	Not available

Drug Utilization Information	
Data Elements	**Availability**
Date of Service	Available
Drug information (Product/Service Identifier, Quantity Dispensed, Days Supply, Compound Code, Fill Number, Dispensing Status.)	Available
Other utilization information (Dispense as Written/Product Selection Code, Drug Coverage Status Code)	Available

Drug Cost Information	
Data Elements	**Availability**
Total Drug Costs (Ingredient Cost, Dispensing Fee, Total Amount Attributable to Sales Tax)	Not available

Coverage Information	
Data Elements	**Availability**
Date Paid	Available
Plan Paid Amounts (Covered D Plan Paid Amount, Non-covered Plan Paid Amounts)	Not available
Beneficiary cost sharing (Patient Pay Amount)	Not available
Other Payer Amounts (Other True Out of Pocket Amount, Patient Liability due to Other Payer Amount	Not available
Low-Income Subsidy Amount	Not available
Other Financial Information (Gross Drug Cost below Out-of-pocket Threshold, Gross Drug Cost Above Out-of-pocket Threshold)	Not available

Other Descriptive Data	
Data Elements	**Availability**
Patient gender	Available
Catastrophic Coverage Indicator (Catastrophic Coverage Code)	Not available
In-network versus OON or MSP claim (Pricing Exception code)	Available
Electronic versus Paper Claim (Non-Standard format Code)	Available
Original versus Adjusted PDE (Adjustment/Deletion code)	Available

Attachment 4 – Process for Requesting Medicare Parts A and B Claims Data

As described in the October 3, 2008 State Medicaid Director Letter, State Medicaid Agencies that have executed a modified Coordination of Benefits Agreement (COBA) may seek CMS' permission to re-use Medicare Parts A and B claims sent to States to pay dual eligible beneficiaries' Medicare cost-sharing for additional specified care coordination and quality improvement purposes.

States may request to re-use COBA data for activities that fall within paragraphs (1) and (2) of the Health Insurance Portability and Accountability Act (HIPAA) definition of health care operations (see 45 CFR 164.501). The COBA data are "non-final action," i.e., subject to subsequent adjustment, which may result in more than one record for a given service. However, these data are timely, as there is only a two week lag between the time the claims are adjudicated by Medicare and the time that a State would receive them, so they are still effective in supporting care coordination.

States whose requests are approved may re-use older crossover claims they have stored in their systems for the new purposes. On a go-forward basis, they may also re-use data received in their existing crossover file, or may obtain a second file of crossover and non-crossover claims. These data are available at no cost to States. Please refer to the October 3, 2008 State Medicaid Director Letter for detailed procedures, on our website at: http://www.cms.gov/SMDL/SMD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&itemID=CMS1215727&intNumPerPage=10. **However, please send requests for information to MedicareMedicaidCoordinaton@cms.hhs.gov rather than the e-mail address listed in that State Medicaid Director letter.**

Attachment 5 – Process for Requesting Medicare Eligibility/Enrollment Data

This section describes two mechanisms that CMS makes available to State Medicaid Agencies to confirm enrollment in Medicare Parts A, B, C and D. The first is the online query tool called the Medicare Advantage & Part D Integrated User Interface (MAPD IUI), which allows States to query at the individual beneficiary level. The second is the Territory Batch Query (TBQ), which allows States to query on a batch basis by submitting a TBQ file to CMS.

Individual Look-Up

The MAPD IUI is an online query tool that allows role-based access to States for Medicare eligibility, low income subsidy (LIS) status, and detailed health plan enrollment information at an individual beneficiary level. States have a defined role that permits access to certain screens within the MAPD IUI. Access to this query is granted through a web based registration process referred to as the Individuals Authorized Access to the CMS Computer Services (IACS). Users will need to register for an IACS User ID in order to access the MAPD IUI. For more information on the IACS registration process or the MAPD IUI, contact Carolyn Lawson at 410-786-0704 or Carolyn.Lawson@cms.hhs.gov or Clarice Burrell at 410-786-3344 or Clarice.Burrell@cms.hhs.gov.

Batch Query Process

The TBQ is a voluntary batch query finder file process. For each TBQ file the State submits, CMS will return a response file. If the State's submitted record for a given beneficiary is successfully matched to the CMS database, the record returned will contain the eligibility and enrollment information pertaining to that beneficiary; if not, the response record will contain an appropriate return code indicating the record was not matched. The response record will be almost identical to the current MMA RESPONSE FILE record, except for a few fields which would remain blank (i.e., pertaining to Phasedown billing activity). The submission of the file should occur using the same mechanism used for the MMA files. The file will be differentiated from the MMA file by the use of a unique file name.

For additional information on the TBQ process or file layout, please contact Carolyn Lawson at 410-786-0704 or Carolyn.Lawson@cms.hhs.gov or Goldy Austen at 410-786-6450 or Goldy.Austen@cms.hhs.gov.