SDRC
State Data Resource Center

Using and Requesting Medicare Data for Medicare-Medicaid Care

Frequently Asked Questions

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Glossary of Terms

- **BCRC**: Benefits Coordination & Recovery Center (COBA data distributor)
- **CCW**: Chronic Conditions Data Warehouse
- **CMS**: Centers for Medicare & Medicaid Services
- **COBA**: Coordination of Benefits Agreement; also refers to COBA data file that contains raw Parts A or B claims data
- **CPI**: Center for Program Integrity
- **Crosswalk files**: A file that links certain terms/numbers across data files; can be utilized with both the historical Parts A and B and the Part D PDE data
- **DME**: Durable Medical Equipment
- **DMP:** Data Management Plan (a protocol written by the Medicaid agency to address how the data files will be held, managed, and processed)
- **DRA:** Data Request and Attestation form (CMS data sharing agreement that outlines the terms of use governing Medicaid agencies' access to Medicare data)
- **DUA:** Data Use Agreement
- **EFT**: Electronic File Transfer
- **ERC:** Error Return Codes
- **FFS**: Fee-for-Service
- **GDIT**: General Dynamics Information Technology (CCW data distributor)
- **HCBS:** Home- and Community-Based Services
- **HH:** Home Health
- **HICN**: Health Insurance Claim Number (Medicare Claim Number)
- **HIPAA:** Health Insurance Portability and Accountability Act of 1996
- **ICN:** Internal Control Number
- **IEA**: Information Exchange Agreement (CMS data sharing agreement that establishes the terms, conditions, safeguards, and procedures for the exchange PHI/PII data between CMS and a Medicaid agency)
- **IRF-PAI**: Inpatient Rehabilitation Facility-Patient Assessment Instrument data file
- **LIS**: Low-Income Subsidy
- **MA**: Medicare Advantage
- **MAPD**: Medicare Advantage Prescription Drug Contracting
- **MARx**: Medicare Advantage/Prescription Drug System
- **MAX**: Medicaid Analytic eXtract
- **MBD**: Medicare Beneficiary Database
- **MBI:** Medicare Beneficiary Identifier
- **MBSF**: Master Beneficiary Summary File

- **MedPAR**: Medicare Provider Analysis and Review data file
- **MESF**: Medicaid Enrollee Supplemental File
- **MDS**: Minimum Data Set
- **MMA**: Medicare Modernization Act of 2003
- **MMCO**: Medicare-Medicaid Coordination Office
- **MMLEADS**: Medicare-Medicaid Linked Enrollee Analytic Data Source
- **NDC:** National Drug Code
- **NPI:** National Provider Identification
- **OASIS:** Outcome and Assessment Information Set
- **PDE**: Prescription Drug Event
- **PHI**: Protected Health Information
- **PII**: Personally Identifiable Information
- **PMA**: Participating Medicaid Agency
- **PUF:** Public Use File
- **QDWI:** Qualified Disabled Working Individual
- **QI:** Qualifying Individual
- **QMB**: Qualified Medicare Beneficiary
- **ResDAC**: Research Data Assistance Center (CMS helpdesk/technical assistance contractor)
- **ROI**: Return on Investment
- **SDRC**: State Data Resource Center (CMS helpdesk/technical assistance contractor)
- **sFTP**: Secure File Transfer Protocol
- **SLMB**: Specified Low-Income Medicare Beneficiary
- **SNF**: Skilled Nursing Facility
- **SSN**: Social Security Number
- **TBQ**: Territory Beneficiary Query file

Chapter 1: Getting Started with Data

1.1 Types of Available Data

CMS makes available many types of data to state and territory Medicaid agencies for Medicare-Medicaid care coordination, program integrity, and quality improvement purposes. For an updated list of data types available, please visit the Medicare Data section of the SDRC website.

1.2 Medicare Parts A & B Claims Data

1.2.1 Can Medicaid agencies request specific types of Parts A or B claims, or must Medicaid agencies receive the entire set of claims?

Agencies that want historical, final-action claims data for Parts A and B services may request any or all of the below file types for dually eligible individuals:

- Part A Inpatient
- Part A Outpatient
- Part A SNF
- Part A HH
- Part A Hospice
- Part B Carrier (physician and related claims)
- Part B DME
- MMLEADS
- MedPAR
- MESF

Medicaid agencies may also request non-final-action Parts A and B claims through one of two ways:

- The Coordination of Benefits Agreement (COBA) data file, either:
  - Medicaid agencies may request to reuse their existing primary, initial COBA data; or
  - Medicaid agencies may request a secondary, enhanced COBA data feed that includes the entire set of Parts A and B claims. Please note that Medicaid agencies often select which claims to include or exclude from their primary, initial COBA data feed. The secondary, enhanced COBA feed would include all available Parts A and B claims.
- Monthly non-final action Parts A and B file from the CCW.

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

While obtaining a sample enhanced COBA data feed is not possible, Medicaid agencies can obtain a test enhanced COBA ID to receive a limited set of eligibility data. Medicaid agencies can

ask BCRC about obtaining a test enhanced COBA ID following CMS' approval of the enhanced COBA data request package.

1.3 Medicare Advantage Encounter (Part C) Data

1.3.1 Does the enhanced COBA data include encounter data for demonstration beneficiaries?

No, the enhanced COBA data feed does not include Part C data, whether for demonstration or otherwise.

1.3.2 Is Part C/Medicare Advantage encounter data available?

Unfortunately, this data type is not available via the SDRC process. If/when this data type does become available, SDRC and CMS will provide all Medicaid agencies with the necessary resources for requesting and understanding the data file, such as data dictionaries, tip sheets, and webinar presentations.

1.4 Additional CMS Data

1.4.1 What is the difference between the MMLEADS and MMLEADS Public Use File (PUF) data?

The main difference is the MMLEADS data are Medicaid agency-specific while the MMLEADS PUF includes information for the relevant cohorts nationally and for each state.

The MMLEADS data type is a suite of analytic files for Medicare and Medicaid enrollees that include information on eligibility, enrollment, cost, utilization, physical health conditions, and mental health conditions. This data type is built from the MBSF data, Parts A, B, and D claims data, Medicare enrollment and premium data, and MAX data. MMLEADS contain data for dually eligible beneficiaries, Medicare-only beneficiaries, and Medicaid-only beneficiaries with a disability. The record layout is located on the CCW website.

The MMLEADS PUF is derived from the MMLEADS data and includes most of the same information contained in the regular MMLEADS. The data are stratified by state and Medicare/Medicaid enrollment type. Within each state/enrollment group, the PUF provides percentages of enrollees by various demographic and enrollment metrics (e.g., age, race/ethnicity, Medicare and Medicaid enrollment sub-groups, etc.), percentages of enrollees with chronic conditions, and Medicare/Medicaid utilization counts, spending, and population rates of utilization.

Medicaid agencies must request CMS's approval for the MMLEADS file from the CCW, but do not need approval to download the PUF data in an Excel format.

1.4.2 Can we request Medicare data for specific providers?

No, the SDRC process does not support subsets for specific criteria, such as providers.

1.4.3 Can we request data for all Medicare beneficiaries?

No, with the exception of MMLEADS (as described in Question 1.4.1). Through the SDRC process, Medicaid agencies can request Medicare data for all dually eligible beneficiaries living in their respective jurisdictions. These data are limited to only dually eligible beneficiaries and do not include all Medicare beneficiaries, (i.e., Medicare-only beneficiaries).

Chapter 2: Format and Structure of Data

2.1 File Format

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

The crosswalk files, which help Medicaid agencies link the Medicare data with their Medicaid data, can be utilized with all available Medicare data through SDRC's process. GDIT 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 historical Parts A and B data shipment. GDIT has not created data dictionaries for these crosswalks, and therefore the data dictionaries for the crosswalks are not available online.

2.1.2 Are the data files provided by SDRC raw or processed data?

Most of the data files made available through the Medicare-Medicaid Data Sharing Program are processed, including the following files:

- Parts A, B, C, and D eligibility and enrollment data (MBSF)
- Parts A and B claims data from the CCW
- Part D PDE data
- Assessments (MDS 2.0, MDS 3.0, OASIS-B1 and C, Swing Bed, and IRF-PAI) data

The enhanced COBA data (a secondary feed) are raw data.

2.2 File Naming Conventions

2.2.1 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 Medicaid agency's DRA number, the pound signs (#) would be replaced with the request number automatically generated by GDIT, and the "YYYY" would be replaced with the year of the corresponding timeframe.

2.2.2 What are the naming conventions for the historical Parts A and B data?

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

- Historical 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

❖ Historical Part B:

- Carrier – carrier_demo_codes_res0000*****_req######_YYYY
- DMERC – dmerc_demo_codes_res0000*****_req######_YYYY

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

2.2.3 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 Medicaid agency's DRA number, the pound signs (#) would be replaced with the request number automatically generated by GDIT, and the "YYYY" would be replaced with the year of the corresponding timeframe.

2.2.4 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 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.

2.3 Linking Data Files

2.3.1 What is the MBI?

MBI stands for Medicare Beneficiary Identifier. The Medicare Access and CHIP Reauthorization Act of 2015 ("the Act") mandated the removal of the SSN-based HICNs as the identification number for Medicare beneficiaries. The primary goal of the Act was to reduce the risk of medical identity theft. The MBI replaced the HICN on new Medicare cards and in claims starting in 2020.

2.3.2 How do Medicaid agencies access the MBI for Historical Parts A and B and enhanced COBA data?

For historical Parts A and B data, an MBI crosswalk is available. To obtain the crosswalk, agencies must request the file through a DRA update.

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

2.3.3 How can a Medicaid agency link beneficiary data across data sources?

Medicaid agencies can use beneficiary demographic elements, which include "BENE_ID," "DOB_DT," "GNDR_CD," "RACE_CD," "CNTY_CD," and "ZIP_CD," to link beneficiary data across data sources. The "BENE_ID" and "DOB_DT" elements are permanent, while the "GNDR_CD," "CNTY_CD," and "ZIP_CD" elements are unlikely to change (the "GNDR_CD" variable can change if a beneficiary goes through a gender transition, while the "CNTY_CD" and "ZIP_CD" variables can change if a beneficiary moves). All of these elements can be located in the base claim files across all settings (e.g., to link monthly, non-final action Parts A and B claims files to the annual, final action Parts A and B files). Additionally, using the "CLM_ID" element in the base claim files for all settings will link each unique claim across different time ranges (e.g., if an inpatient stay straddles between two calendar months).

Medicare and Medicaid beneficiary data can be linked using crosswalk files. Agencies can request three crosswalk files through the SDRC process: 1) "BENE_ID" to "HICN" crosswalk, 2) "BENE_ID" to "SSN" Crosswalk, and 3) "BENE_ID to MBI" Crosswalk. These crosswalks allow Medicaid agencies to link beneficiary data across their in-house Medicaid data and Medicare data received from CMS. Please contact SDRC for assistance and guidance on using the crosswalks.

2.4 Frequency of Data

2.4.1 How frequently does CMS share available data with Medicaid agencies?

Frequency of the CMS file exchanges, (i.e., MMA File Exchange, State Buy-in File Exchange, and TBQ File), depends on submission of Medicaid files. The CMS response files are triggered by the Medicaid agency submitting a request file. Effective April 1, 2022, the Interoperability and Patient Access final rule requires Medicaid agencies to submit and receive MMA Files and State Buy-in Files on a daily basis. See Section VII, Improving the Medicare-Medicaid Dually Eligible Experience by Increasing the Frequency of Federal-State Data Exchanges. Use of the TBQ File is voluntary, and the schedule for Medicaid agencies to submit TBQ Request Files is at the determination of the Medicaid agency.

Below are the frequency of available data under the Medicare-Medicaid Data Sharing Program:

- Enhanced COBA: daily or weekly
- Historical Parts A and B: monthly or annually
- Assessments: quarterly or annually
- MBSF: annually
- MMLEADS: annually

- MedPAR: annually
- MESF: annually
- Crosswalks: sent with the CCW data
- Part D PDE: monthly or annually

2.4.2 Are Medicare Parts A and B claims data available more frequently than on an annual basis?

Yes, Medicaid agencies can request Monthly A and B data from the CCW and/or a secondary, enhanced COBA feed on a daily or weekly basis. Monthly A and B data only contain claims with "From Date of Service" within the month covered by the file. Since monthly A and B data are pulled from CCW for a specific timeframe, any claims later received for that same service month will not be provided in future monthly files but are 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.

2.4.3 For Medicare Parts A and B historical 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 ("CLM_THRU_DT"). Each year's historical Parts A and B file includes dates processed up to six months after the end of the calendar year to allow time for claims from the end of that year to be submitted and processed.

2.4.4 Can a Medicaid agency 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 currently available.

Chapter 3: Understanding CMS Data Files

3.1 Medicare Parts A and B Data Files

3.1.1 Are both full- and partial-benefit dually eligible beneficiaries included in Medicare Part A and B or Part D data files?

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

3.1.3 Do all enhanced COBA claims have a unique claim identifier? And if so, what is that data element name?

Each claim includes an ICN, which is the number that Medicare assigns to the claim when received from the provider or billing vendors. However, it is theoretically possible for the same ICN to appear on two different claims. The ICNs on both the primary and secondary, enhanced COBA feeds, for the same claims, would be the same. For "original" claims, the number is reported in the 2300 REF with qualifier F8. For "adjusted" claims, the number is reported in the 2330B REF with qualifier F8 reported.

3.1.4 How can Medicaid agencies identify unique keys in the CCW data?

While there are numerous identifying fields in the CCW data, they do not necessarily make the file unique. For example, "AT_PHSYN_NPI" uniquely identifies the physician who was the attending physician for the services on the claim. At the same time, many records in the claims file will have the same "AT_PHYSN_NPI," so it does not have much to do with the uniqueness of the file.

For reference, you can find the unique keys for the CCW files your agency may receive in the below table.

Files	Specific Scenario	Unique Keys
MMLEADS	Records where "BENE_ID" is populated	"BENE_ID"
	Records where "BENE_ID" is missing	"MSIS_ID" + "D_STATE_CD"
	File as a whole	"BENE_ID" + "MSIS_ID" + "D_STATE_CD"
Historical Parts A & B – Base Claims Files	N/A	"BENE_ID" + "CLM_ID"
Historical Parts A & B – Revenue Center Files	N/A	"BENE_ID" + "CLM_ID" + "CLM_LINE_NUM"
Historical Parts A & B – Condition Code Files	N/A	"BENE_ID" + "CLM_ID" + "RLT_COND_CD_SEQ"

Files	Specific Scenario	Unique Keys
Historical Parts A & B – Occurrence Code Files	N/A	"BENE_ID" + "CLM_ID" + "RLT_OCRNC_CD_SEQ"
Historical Parts A & B – Span Code Files	N/A	"BENE_ID" + "CLM_ID" + "RLT_SPAN_CD_SEQ"
Historical Parts A & B – Value Code Files	N/A	"BENE_ID" + "CLM_ID" + "RLT_VAL_CD_SEQ"
Historical Parts A & B – Demonstrations/Innovations Code Files	N/A	"BENE_ID" + "CLM_ID" + "DEMO_ID_SQNC_NUM"
Historical Parts A & B – Line Files	N/A	"BENE_ID" + "CLM_ID" + "LIN+NUM"
MBSF – All Segments	N/A	"BENE_ID"

Medicaid agencies can also review the two on-demand tutorials on how to merge Medicare and Medicaid data with SAS and SQL; these tutorials are located on the SDRC Portal, a credentialed-based website for Medicaid agency and approved downstream user personnel. Please ask the SDRC Support Team how to obtain access.

3.2 Medicare Part D PDE Data Files

3.2.1 Does the Part D data include prescriptions for MA beneficiaries?

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

Medicaid agencies 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.

3.2.2 What are the limitations of Part D PDE data?

The primary limitation for Medicare Part D PDE data is it does not necessarily represent a complete picture of prescription drugs used by dually eligible individuals. 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 Eligibles".

3.2.3 Are both full- and partial-benefit dually eligible beneficiaries included in Medicare Part D PDE data files?

No, the Part D PDE files will only include PDEs for beneficiaries who were fully dual-eligible for at least one month during the year.

3.2.4 How can an agency determine the units of the quantity dispensed for each national drug code (NDC)?

For the "Quantity Dispensed" element, a drug database, such as RxNorm, would be needed to get the units for the quantity dispensed that are associated with a given NDC, which is found in the "Product Service ID" field (PDE element #9). The "Compound Code" (PDE element #14) will indicate whether it is a compounded item or not. Below are step-by-step instructions:

- Create an NDC-level file containing NDC and drug unit from a drug database. This drug database could either be the publicly available RxNorm database or a proprietary database, such as First Databank or Medi-Span.
- Merge the NDC file onto the PDE data.
    - In the PDE data, the NDC is contained within the "Product Service ID" field.

3.3 MMA and TBQ Files

For more information and additional frequently asked questions regarding the MMA, TBQ, and State Buy-in files, please see the Overview File and MMA Q&A.

3.3.1 How is the Medicare Part D eligibility start date determined in relation to Part A and Part B in the MMA and TBQ Files?

The Part D eligibility start date is the earlier of the Part A or B start dates. However, if either Part A or B have a retroactive effective date, the Part D eligibility start date is not retroactive. For instance, for a person who received notice of Part A/B entitlement in March of 2022 that they have Part A back to October 1, 2021, the Part D eligibility start date is March 1, 2022.

3.3.2 What are the reasons or scenarios for a single SSN to be associated with multiple individuals? Is this created in error?

There are some situations where multiple individuals are associated with a single SSN, like when a child is associated with their parent's SSN. In that case, the beneficiary ID code would be different and identify that it is a child. If multiple SSNs are associated with a single beneficiary, however, it is often a keying error. When CMS identifies these errors, CMS coordinates with the Social Security Administration to ensure the correct SSN is input. The correction then filters through the CMS data systems.

Chapter 4: Data Request Process

4.1 Data Request Process: General

4.1.1 Can Medicaid agencies that are not participating in an MMCO demonstration request CMS data using the Medicare-Medicaid Data Sharing Program?
Yes, all Medicaid agencies can request Medicare data for dually eligible individuals. There are request packages for each major request type. If an agency is currently not receiving data, a new data request package should be completed. If the Medicaid agency already receives data and wishes to use the data in another way, an additional data use package is required. The Data Request Process Details page lists the request packages by available Medicare data file.

4.1.2 Can Medicaid agencies make multiple historical data requests?
All available fields (variables) are provided with Parts A and B and Assessments data requests. The requestor specifies the fields (variables) of interest for Part D PDE requests via the specification worksheets. Additional fields (variables) for Part D PDE data can be added at a later date by submitting a Part D PDE additional data use request through SDRC.

4.1.3 Who should Medicaid agencies contact with data shipment questions?
Medicaid agencies should contact SDRC, who will work with the appropriate data distributors to provide accurate guidance to the agencies. When contacting SDRC, Medicaid agencies should provide as much detail as possible about their concerns/inquiries, such as timeframes and screenshots.

***If Medicaid agencies want to submit Medicare data samples to SDRC or any information that contains PHI or PII, please only submit these via the SDRC Portal for security reasons.*

4.1.4 Does a DRA contact change request impact who is listed on a Medicaid agency's COBA agreement?
No, the Medicaid agency would have to submit a separate contact change request for the enhanced COBA data, as this data type is not tied to the DRA form. Please contact the SDRC Support Team for more information.

4.1.5 Does MMCO allow agencies to utilize cloud-based solutions (e.g., Amazon Web Services, Dropbox) in Medicaid agencies' DMPs submitted for data under a DRA?
MMCO does allow Medicaid agencies to utilize cloud-based solutions, as long as the storing system still has the necessary security precautions in place.

4.2 Information Exchange Agreement (IEA)

4.2.1 What are IEAs?
An IEA is an agreement between CMS and a Medicaid agency that establishes the terms, conditions, safeguards, and procedures under which CMS will release the data to the agency and provides for additional protections above and beyond the DRA. The IEA needs to be signed by a

program official from the PMA. This individual will commit their organization to the terms of the IEA.

4.2.2 Are IEAs required for all CMS data requested by Medicaid agencies?

Yes, CMS requires an executed IEA for the disclosure and exchange of the Medicare-Medicaid Data Sharing Program, TBQ files, State Buy-in files, and MMA files.

4.2.3 Can we revise the language of the IEA to allow for cloud-based storage?

No, CMS Privacy prefers to keep the agreements standard across all entities for a given project. The IEA allows for cloud-based storage, and some Medicaid agencies have migrated to such a platform under the IEA, as is.

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

No, although Medicaid agencies' DRA forms should be current with the listed requestor and custodian(s). The IEA expires after five (5) years, at which point CMS and the Medicaid agency will review and execute a new agreement.

4.3 Data Request and Attestations (DRAs)

4.3.1 Can a Medicaid agency list a third-party data contractor as the data custodian on the DRA?

Yes, Medicaid agencies can contract with a third-party entity to receive the Medicare data on behalf of the Medicaid agency and to carry out a task. The Medicaid agency can list the third-party contractor as a data custodian on the DRA. The requestor of the data (i.e., the Medicaid agency) retains ultimate responsibility for the uses and security of the CMS data in accordance with the terms of the IEA and DRA.

4.3.2 How do I go about adding, editing, or removing a staff member to an already-existing DRA?

A current DRA requestor or custodian can request the addition or removal of an agency staff member to or from a DRA. If the requestor (and/or custodian(s)) no longer work for the Medicaid agency, a representative from the agency can make the request instead. New DRA custodians must complete and sign the DRA custodian form. New DRA requestors will need to update the contact information on the DRA form. All new signatories should read the full agreement to understand the terms and conditions. For detailed instructions, including email templates, please contact the SDRC Support Team.

4.4 Data Request Process: Program Integrity

4.4.1 Will the data request process for program integrity follow the established SDRC data request process?

Yes, the established SDRC data request process is used for both program integrity and care coordination data uses. The only difference is that Medicaid agencies will need to answer five

additional questions on the specification worksheets' "Use Justification" tabs. Please refer to the Medicare Data Request Process page for the detailed text and workflows related to requesting each data type and contact the SDRC Support Team for tailored guidance.

4.4.2 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. Medicaid agencies may submit an additional data use request package to add program integrity data uses to an existing DRA.

4.5 Data Request Process: Managing Downstream Users

4.5.1 Are contractors considered downstream users and can they receive derivative data from custodians?
The custodian(s) of the data are those individuals who receive or access the data files from CMS. These individuals are responsible for the agency observing the conditions of use as outlined in the IEA and DRA agreements. Additionally, custodians (and subcontracting/collaborating organization) are involved in the research and data analysis required for the approved specified Medicare data uses (i.e., the data analysis on care coordination or program integrity uses). A downstream user, on the other hand, receives and uses the data from the agency (or derivative data) to fulfill the user's contractual obligations to the agency. A downstream user is any person or entity (e.g., a treating practitioner contractor, business associate, or subcontractor of the PMA) that receives CMS data or individually identifiable derivative data from the PMA in accordance with the terms of the IEA and the corresponding DRA.

The key distinction is whether an entity is using the data to execute contractual obligations to the agency (downstream user) or if the entity is involved in the research for the approved data uses (subcontracting/collaborating organization). For further clarification or additional information, please contact the SDRC Support Team.

4.5.2 Do downstream users need to complete any forms to be added to the DRA?
No. For approved uses, the Medicaid agency is responsible for maintaining a list of downstream users. Please review the IEA for the terms and conditions that the Medicaid agency agrees to regarding receipt of CMS data and data sharing with downstream users. 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.

Chapter 5: Receiving the Data

5.1 Receiving Chronic Conditions Warehouse (CCW) Data

5.1.1 How does our agency receive CCW data?

To receive data from CCW (i.e., Historical Parts A and B, Monthly Parts A and B, MedPAR, MDS 3.0, OASIS B1 and C, IRF-PAI, Swing Bed, MBSF, MESF, MMLEADS, and crosswalks), your agency may choose between online downloads via AXWAY or physical data shipments via a disk or USB.

5.1.2 What is AXWAY?

The CCW data distributor GDIT provides a Secure File Transfer Portal (sFTP) called AXWAY to send encrypted data files directly to Medicaid agencies. When the data are prepared and available for download, the state or territory would receive an email from the vendor that notifies users of the data availability and contains a decryption password. Medicaid agency users can then log into AXWAY and download the files directly and the data are available to download for 90 days.

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

Each Medicaid agency can have a maximum of two people with AXWAY access to receive the CCW data files on its behalf. The only requirement is that the AXWAY account holders must be listed on the Medicaid agency's DRA. SDRC strongly recommends agencies have two account holders in case one person is out-of-office or similarly unavailable.

5.2 Receiving Part D Prescription Drug Event (PDE) Data

5.2.1 How does our agency receive Part D PDE data?

To receive Part D PDE data, your agency will need to establish an electronic file transfer (EFT) connection between the data distributor and your agency (or chosen custodian). The data are then pushed automatically to your established system on an annual or monthly basis.

5.2.2 How do we establish an EFT connection to receive Part D PDE data?

Your agency will need to complete two EFT forms: 1) EFT Setup Form, in which your agency will complete sections B3, D1, D2, D3, and D7. CMS will complete all others; and 2) The EFT Partner Server Questionnaire, in which your agency will complete all sections. SDRC recommends you utilize your IT department as available to assist in answering the technical questions. Please contact SDRC for additional information and assistance.

5.3 Receiving Enhanced Coordination of Benefits Agreement (COBA) Data

5.3.1 How does our agency receive enhanced COBA data?

To receive COBA data, your agency will need to establish an electronic file transfer (EFT) connection between the COBA data distributor (i.e., BCRC) and your agency. The data are then

pushed automatically to your established system on a daily or weekly basis. Please contact SDRC for more information.

Chapter 6: How to Use the Data

6.1 Using the Data: General Information

6.1.1 What are allowable data uses to request CMS data via the Medicare-Medicaid Data Sharing Program?

MMCO and CPI approve data uses for care coordination, quality improvement, and program integrity as indicated and approved via the IEA and DRA. The data can be used for data analysis, data monitoring, program planning, 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 (program integrity). At this time, data may not be used for any purpose not indicated in the IEA, including research or payment.

6.2 Using the Data for Care Coordination

6.2.1 Will the data available via the Medicare-Medicaid Data Sharing Program allow a Medicaid agency to know what the individual's liability is on a real-time basis?

No. The enhanced COBA 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, compared to monthly Parts A and B which has an approximate three-month lag time. In addition, a Medicaid agency will only receive Medicare data for beneficiaries who are also already eligible for Medicaid. CMS shares Part D PDE data monthly with an approximate one-month lag time.

6.2.2 Our Medicaid agency currently requests and uses Medicare data, and we are interested in obtaining Medicare data for a separate care coordination effort (independent of the currently-approved use). Can the Medicaid agency use the data requested for the previous use for our second effort?

Yes, your agency may re-use data received under an existing data request, but CMS must approve the additional data use. Please see the instructions on submitting an additional data use package.

6.3 Using the Data for Program Integrity

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

Yes, in a program integrity request, CPI requires Medicaid agencies to include additional information about staffing, technical details such as potential algorithms and analyses, expected timelines, and goals of the project(s) involved. In order to comply with HIPAA, CPI has an obligation to ensure that Medicaid agencies are actively using the Medicare data and using it in accordance with CMS-approved uses. Medicaid agencies using data for program integrity purposes must also meet with SDRC on a quarterly basis to discuss their data usage and project progress.

6.3.2 What is program integrity ROI and what is considered a "good" ROI for a Medicaid agency's program?

Return on investment (ROI) measures the amount gained or lost relative to an investment. ROI is measured by the return from cost recoveries and cost avoidance relative to the cost of the approach (e.g., personnel/staff/contractor time, system investments, etc.).

As a ratio, ROI simplifies differences among Medicaid agencies and approaches while allowing for direct comparison. Medicaid agencies can choose ROI as a performance measure to identify which activities are of high value. For SDRC-related reporting purposes, total recovered amount can be reported for quantifiable recoveries or estimated for non-quantifiable recoveries.

There is not a specific amount that is considered a "good" or "bad" ROI for Medicaid agencies.

Chapter 7: CMS-State File Exchanges

7.1 TBQ File

7.1.1 What is the TBQ file?

The Territories & States Beneficiary Query (TBQ) File is a query process that CMS offers to states and territories for Medicare Parts A, B, C, and D eligibility and enrollment data on the queried beneficiaries. The Medicare data included in the TBQ File is pulled from the same database as the MMA Response File (i.e., the CMS Medicare Beneficiary Database, or MBD) but on an ad hoc basis. Medicaid agencies may query CMS as frequently as daily for Medicare beneficiary eligibility determination. For more information on the TBQ File, see the Medicare Advantage Prescription Drug State User Guide.

7.1.2 How do I request TBQ files?

To request TBQ files, Medicaid agencies must first set up a file transfer account using CMS' EFT process. To learn more about this process, please contact the SDRC Support Team.

7.1.3 What is the difference between a TBQ request file and TBQ response file?

The TBQ File process begins when the state or territory submits a "finder file" of beneficiaries for query; this finder file is referred to as the TBQ Request File. The TBQ Request File contains the names, addresses, and demographic information of beneficiaries. CMS validates the incoming TBQ Request File and notifies the Medicaid agency of acceptance or rejection of the file based on the match between information in the TBQ Request File and CMS MBD records. If the file is rejected, no further action is taken. If the file is accepted, CMS then issues a "response file" which includes Medicare Parts A, B, C, and D eligibility and enrollment data on the queried beneficiaries; this file is referred to as the TBQ Response File. The TBQ Response File contains beneficiary names, residence addresses, demographic information, and the latest entitlement information.

7.1.4 Can we populate only the SSN field in the TBQ Request file?

Yes, Medicaid agencies can use the SSN field in the TBQ Request File. For more information on the TBQ File layout, see the Medicare Advantage Prescription Drug State User Guide.

7.1.5 What is the turnaround time to receive a TBQ Response File?

After a Medicaid agency submits a TBQ Request File, the turnaround time is typically within 24 hours. The TBQ Request Files are processed on a first-in, first-out basis.

7.1.6 What are file naming details for the TBQ Request File and TBQ Response File?

The table below provides the file name details for the TBQ Request and Response Files.

File Description	Sender	Recipient	File Name	Record Length
TBQ Request File	Medicaid Agency	CMS MBD	T#EFT.IN.CMSxx.TBQ.Dyymmdd.Thhmmsst	100 bytes
TBQ Response File	CMS MBD	Medicaid Agency	T#EFT.ON.Gxx.TBQRSP.Dyymmdd.Thhmmsst	4,000 bytes

***Where "xx" = 2 position state abbreviation. (Example: Maryland = MD.)*
****Where "Dyymmdd.Thhmmsst" = date timestamp of the file. (Example: D211007.T1344297.)*

7.1.7 Can agencies submit two TBQ Request Files to receive two TBQ Responses Files for our internal purposes?

Yes, agencies can submit two TBQ Request Files to receive two TBQ Response Files for the agency's use. While both Request Files must follow the same naming convention, agencies can distinguish the two Request and Response Files by noting different values in one or more of the fields that the CMS MDB does not evaluate or use. For instance, the TBQ process does not require or evaluate any values within these fields: Family ID, Beneficiary Suffix, and MPI; Medicaid agencies are free to use these fields as they wish. CMS MDB will return the exact data entered in these fields within the Request File when returning the Response File.

7.1.8 What does the testing process entail for the TBQ File?

After an electronic file transfer (EFT) mailbox is established, the CMS Office of Information Technology (OIT) MBD Team, which includes the CMS contractor Peraton, will coordinate testing with de-identified, test data. The testing phase will include these steps:

1. The CMS OIT MBD Team will send a set of records for testing purposes to the Medicaid agency via email.
2. The Medicaid agency will use the test set to create a test TBQ Request File. The CMS OIT MBD Team will confirm receipt of the test file via email.
3. The CMS OIT MBD Team will process the test TBQ Request File and send the test TBQ Response File to the Medicaid agency. The CMS OIT MBD Team will notify the Medicaid agency of transmission via email.
4. The Medicaid agency will confirm receipt of the test TBQ Response File via email and validate the test TBQ Response File and confirm success/unsuccessful results via email.

7.1.9 What are the data match criteria for the TBQ File?

There are several different data elements that can be matched on a beneficiary. For more information on the TBQ Request and Response File layout, fields, and match criteria, see the Medicare Advantage Prescription Drug State User Guide.

7.1.10 Since the TBQ moved to a cloud-based platform, are there any changes that Medicaid agencies need to make to use this new platform?

No changes are necessary to how you submit/receive your TBQ file. CMS will continue to support the current EFT set up for TBQ files.

7.1.11 Is there a limit on the number of records that can be submitted in a TBQ Request File?

CMS no longer has a limit on the number of records that can be submitted in a TBQ Request File. However, while file processing is much quicker on the cloud, hard limits do exist within the transmission tools, and it still requires time, which must be shared among all the states and territories. Please be cognizant of others when submitting files with more than 1 million transactions. CMS strongly encourages Medicaid agencies to notify the CMS contractor (MEPBSSupport@peraton.com) at least 72 hours prior to sending a file containing their entire population.

7.1.12 What data sharing agreements govern the TBQ File?

Medicaid agencies sign an IEA and an accompanying DRA form with CMS for certain Medicare data, including the TBQ File. Please contact SDRC at SDRC@acumenllc.com or (888) 805-5228 with questions regarding your Medicaid agency's data sharing agreements, and with questions regarding the data you receive.

7.1.13 Can we use the TBQ File instead of the Medicare Modernization Act (MMA) File?

No. The TBQ File is an optional data query made available to Medicaid agencies to access Medicare eligibility and entitlement data. The MMA File Exchange is an operational file exchange as established in the Medicare Prescription Drug Improvement and Modernization Act of 2003, where Medicaid agencies identify all people who are dually enrolled in both Medicare and Medicaid to CMS. Effective April 1, 2022, the Interoperability and Patient Access final rule requires Medicaid agencies to submit MMA Files to CMS on a daily basis.

7.1.14 Who should I contact with questions regarding the TBQ Files?

Please contact the Medicare Advantage Prescription Drug (MAPD) Help Desk at MAPDHelp@cms.hhs.gov or (800) 927-8069 regarding issues with TBQ File transmission or receipt. Please contact SDRC at SDRC@acumenllc.com or (888) 805-5228 with questions regarding your Medicaid agency's data sharing agreements, and with questions regarding the data you receive.

7.1.15 My agency was participating in the EDB state file exchange. Why are we no longer receiving EDB response files?

CMS retired the EDB State File Exchange on June 30, 2022, as a part of its modernization efforts.

7.1.16 Why did CMS retire the EDB State File Exchange?

CMS modernized its data systems. As part of these modernization efforts, CMS reduced redundancies between the EDB State File Exchange and the TBQ File by retiring the EDB State

File Exchange. Additionally, CMS modernization efforts to the TBQ File included a cloud-based platform and unlimited record count queries.

7.2 MMA File

7.2.1 Why do state Medicaid agencies submit MMA files?
MMA files allow CMS to establish the LIS status of dually 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.

Territories do not participate in the MMA File Exchange.

7.2.2 How do state Medicaid agencies submit MMA files?
State Medicaid agencies submit MMA Request Files each day 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 State User Guide. For system account assistance, contact the MAPD Help Desk at MAPDHelp@cms.hhs.gov or (800) 927-8069.

7.2.3 How frequently do state Medicaid agencies submit MMA files?
As of April 1, 2022, states Medicaid agencies must submit at MMA files daily 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.

7.2.4 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 state Medicaid agencies submit to CMS each day. These files include the names, demographic information, and Medicaid and Medicare eligibility status of dually 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 MBD, ERCs 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.

7.2.5 Is there a resource that contains technical guidance regarding the submission of the MMA file?
Yes, the Medicare Advantage Prescription Drug State User Guide provides technical instructions for submitting the MMA file to CMS as well as for the request and response file layouts.

7.2.6 How does a Medicaid agency 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 status 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 the below MSP categories:

- QMB Program: Helps pay premiums, deductibles, coinsurance, and copayments for Part A, Part B, or both programs
- SLMB Program: Helps pay Part B premiums
- QI Program: Helps pay Part B premiums
- 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 their state's Medicaid agency. More information about categories of eligibility for dually eligible beneficiaries is available online.

7.2.7 What is the MMA File 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 HCBS care.

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 Medicaid agencies submit accurate current-month institutional status and retroactive records reflecting institutional status changes in prior months. For example, if a Medicaid agency 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.

7.2.8 What are the MMA File institutional status indicator field values?

The institutional status indicator shows that a beneficiary resides in a medical institution, 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 Medicaid agency 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 HCBS delivered under a Section 1115 demonstration, a 1915I 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 of 1935.
- N – Indicates that a beneficiary does not meet the criteria for Y or H.
- 9 – Unknown.

7.2.9 Does the MMA File HCBS indicator include all HCBS programs?

The HCBS indicator includes many, but not all, types of HCBS programs. A Medicaid agency 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 of 1935. 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).

7.2.10 Where can I find more information on the MMA File?

For more information and additional frequently asked questions regarding the MMA File, please see and MMA Q&A. Example questions described in this document include:

- Should states that submit daily MMA Files continue to submit one full monthly file?
- Should the daily file submissions be on "business days" only?
- When CMS rejects the whole MMA File (i.e., rather than just a specific record), how can a state know what caused CMS to reject the whole file?

Additional information can be found in the Understanding CMS Data: An Overview of the MMA File Exchange, Buy-In File Exchange, and TBQ File. For comprehensive details regarding the MMA File, please see the Medicare Advantage Prescription Drug State User Guide.