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Advancing Medicare and Medicaid Integration: An Update on Improving State Access to Medicare Data

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Introduction

This is the second in NAMD's Working Paper Series titled, "Advancing Medicare and Medicaid Integration." NAMD's October 2011 working paper presented the overarching policy and operational challenges Medicaid Directors experience when seeking to access and utilize Medicare data.[1] Specifically, states face overly burdensome and costly operational hurdles in accessing Medicare data; they must navigate inconsistent federal policies for obtaining the data; and they lack a mechanism that translates and diffuses any successful state experiences with obtaining and utilizing Medicare data.

The Center for Medicare and Medicaid Services (CMS), including the Medicare - Medicaid Coordination Office, has made great strides in the last several months to assist states that wish to obtain Medicare data to help improve care coordination for enrollees of both Medicare and Medicaid. CMS also has begun to make critical improvements in the process for states to obtain historical and more recent Medicare Parts A and B data and some historical Part D data. However, more work needs to be done to make Medicare data readily accessible and useable for states.

This paper builds on NAMD's previous recommendations. The proposals are targeted towards meeting the shared goals of Medicaid Directors' and the federal government to: advance integration of Medicaid and Medicare in ways that facilitate a more efficient delivery system that provides better care for Medicaid and low income Medicare clients in a more cost rational manner.

NAMD's three overarching requests to improve states' ongoing access to the evolving sources of Medicare data include:

- States wish to continue working with CMS to streamline the current process and policies for accessing Medicare data.
- States that have or are pursuing access to the currently available Medicare data need additional technical assistance and training in order to maximize the utility and application of the data.
- States also have identified the need for access to additional Medicare data sets that could help facilitate care coordination, improve the quality of care, and result in more efficient use of health care resources.

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[1] "Aligning Medicare and Medicaid: Barriers to Access for State Medicaid Programs," October 5, 2011: http://medicaiddirectors.org/node/190

Continue to improve the process for state access to Medicare data

CMS has taken important first steps to improve Medicaid's access to Medicare data. However, Medicaid Directors believe additional process improvements could further streamline and expedite this interaction in ways that help Medicare and Medicaid achieve their shared goals in a more cost effective, timely manner. Directors strongly believe this is feasible without compromising the integrity of Medicare data.

Broaden the permissible uses of Medicare data. Currently CMS limits a state Medicaid agency's use of Medicare Parts A, B, and D data to care coordination purposes only. However, states have several other policy and programmatic uses for the data beyond care coordination that are consistent with broader shared goals of the Medicare and Medicaid programs. Through our Association, Medicaid Directors are committed to working with CMS to ensure states can employ Medicare data for these purposes.

As an example, with a Coordination of Benefits Agreement (COBA) for data, states can obtain supplemental data and crossover claims data for individuals dually eligible for Medicare and Medicaid. While CMS has made it easier to access such data, the agency prohibits states from using the data for anything beyond coordination of care. Medicaid Directors seek authority to utilize the full claims history data to improve a state's understanding of the utilization patterns of Medicare enrollees. This could expand a state's understanding of Medicare pricing information, which in turn impacts the Medicaid delivery system and reimbursement rate structures. States also could use Medicare data to assist them in designing provider feedback mechanisms. These two additional uses are consistent with the direction and types of information needed to advance Medicare and Medicaid integration initiatives.

In addition, expanded use of Medicare data presents a significant opportunity to strengthen states' Medicaid program integrity activities where there is overlap with Medicare – an area Medicaid Directors have long indicated requires improved information sharing. For example, Medicare providers can submit Medicare crossover claims to Medicaid indicating coinsurance and deductible amounts due from the state. However, without more complete Medicare data, states are challenged in trying to determine if providers listed the correct amounts or in confirming that the claim was for an individual truly enrolled in Medicare. Accessing Medicare data for these purposes could assist states in their efforts to reduce duplication of services and duplicate billings between the Medicare and Medicaid programs, and in turn produce cost efficiencies for the state and federal governments.

Further, states that have acquired Medicare data for integrated care demonstrations with the Medicare-Medicaid Coordination Office have identified potential program integrity issues. However, they currently are unable to act on this information – now or when demonstrations take effect – due to the limited permissible uses of the data.

Establish a single CMS-state DUA. Medicaid Directors strongly urge the Medicare - Medicaid Coordination Office to develop a single data use agreement (DUA) for use between a state and Medicare. Currently states have multiple DUAs, with one state reporting that it alone has 24 DUAs with CMS. The ongoing negotiations, different DUA agreement terms, and misaligned renewal periods for each state's various DUAs create unnecessary administrative burdens for states and CMS. In addition, differences in confidentiality rules require states to design different methods and policies for housing the data.

Medicaid Directors believe a single DUA is the most efficient and effective way to achieve improvements in care for enrollees and system efficiencies for the federal and state governments. Currently states are required to continuously apply for one year or multiple year renewals in order to retain historical Medicare data continuously. Medicaid Directors request that CMS eliminate the sunset date for DUAs, so a state does not have to continuously apply for renewals. This would allow a state to retain the historical Medicare data continuously and not be mandated to destroy the Medicare data at the sunset of the DUA.

As needed, on an annual basis, a state and CMS would review, modify, and negotiate the DUA to make desired changes and justifications. For example, a state would modify the DUA to reuse data for new purposes rather than newly undertaking a separate DUA application. States would continue to provide an explanation for any and all uses of the data under a single DUA structure.

In addition, a single DUA could serve as a vehicle for data sharing agreements across the state. The single DUA should include a simplified and singular process to add downstream users, which include other state entities as well as local or county entities that perform multiple functions for state Medicaid programs. To standardize this process, states recommend that CMS create a downstream user and use justification worksheet template for a state to identify each downstream user and their different data uses. The justification worksheets would be best included as addendums or appendices to the single state DUA. This approach is particularly advantageous in states where different agencies or departments have responsibility for operating or contributing to various aspects of care for low income populations. For example, different agencies may carry out eligibility, long-term care, behavioral health, and program integrity functions,

among others. Under a single DUA arrangement, a state would consolidate all of these access points in order to better protect the integrity of the data and privacy of Medicare enrollees.

Finally, CMS must adapt its data access and use policies to reflect the evolving models of care used by states. For example, an increasing number of states are using a managed care delivery system model. Through this model, managed care organizations or similar entities are responsible for care coordination. CMS should work with states to ensure there is a way to permit at least some limited sharing with these entities.

Equalize data security policies. The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule protects the privacy of individually identifiable health information. In addition, the HIPAA Security Rule sets national standards for the security of protected health information shared electronically. The confidentiality provisions of the Patient Safety Rule protect identifiable information from being used to analyze patient safety events and improve patient safety. States, like all covered entities subject to HIPAA, must comply with these HIPAA rules, including when handling data for Medicare beneficiaries.

Medicaid Directors strongly agree that this data must remain secure. However, states request that CMS apply consistent privacy and security policies for protected health information. That is, states should not be subject to different rules for handling Medicare beneficiary data than that required for Medicaid beneficiaries.

Currently CMS requires different security policies – beyond what is required by HIPAA – when states request historical Medicare data and Medicare data through the COBA. The result is this may require some states to store the Medicare data on servers separate from a state's main servers. In turn, this can make it difficult operationally to integrate and use the data in any meaningful way while also increasing costs for the state and federal government. If states cannot integrate this data into their data warehouses – with appropriate user access restrictions – or share summary reports on their secure internal network servers without additional CMS restrictions, reporting on this data is likely to remain very inefficient.

Eliminate fees for state access to Medicare data. Medicaid Directors applaud CMS' decision to allow states to request access to certain Medicare data sets for care coordination purposes at no cost. This policy removed a major barrier to Medicaid's initiatives to improve care coordination for the Medicare and Medicaid dually eligible population. In addition, Medicaid Directors request that CMS extend access at no cost to the additional Medicare data sets discussed in this paper.

However, the current policy fails to recognize state Medicaid agencies as partners in the delivery and coordination of care for individuals likely or potentially dually eligible for the Medicare and Medicaid programs. The ongoing restrictions and hurdles to obtaining such data perpetuate disincentives for states to improve care and services to the pre-dual population (low income Medicare enrollees who are likely to become eligible for Medicaid) in their states. In other words, states can obtain Medicare data for dually eligible individuals at no cost, but there is a fee to obtain other Medicare data sets or files for non-duals or pre-duals. This policy disconnect impedes state planning and development for initiatives targeted to this vulnerable population. In turn, inefficiency in planning and delivery of services results in higher costs for states and the federal government.

Notably, when Medicare data is obtained without a fee, states *still* must invest an inordinate amount of time and resources to transform the data into a useable format. For example, a typical state must contract with their Medicaid fiscal intermediary to restructure the Medicare data from a text file into the state's preferred format and enter the data into a data warehouse. Only then can the state utilize the data for care coordination purposes. These activities typically are included in a Medicaid agency's information technology (IT) budget. The Medicaid Director justifies these resources in the agency's budget request to the governor and/or legislature and prioritizes it in light of other pressing IT and programmatic requests.

In order to ease states' financial burden and expedite states' utilization of the Medicare data, CMS should allow a state to request its preferred format for receiving the Medicare data as part of a single DUA. In doing so, the federal government would manipulate the source data to preserve value labels and coding information in the transfer of the data to states. This could reduce federal and state expenditures by eliminating the need for each state to undertake a cumbersome data conversion process.

Develop common Medicare-Medicaid taxonomy. Medicaid Directors request that the Medicare-Medicaid Coordination Office develop a taxonomy explaining the Medicare data provided to states. Currently it is not clear to a state Medicaid agency how Medicare defines the procedures or codes in the data provided. That is, there is no descriptive information or common terminology that allows states to crosswalk the Medicare data with Medicaid services and related information. A Medicare taxonomy for states would improve the efficiency and effectiveness of states' efforts to utilize the Medicare data and improve care coordination.

Establish a Medicare data "workbench." Over the longer-term Medicaid Directors encourage CMS to explore development of a workbench structure to allow states to

access and download Medicare Part A, B, and D data, similar to the Minimum Data Set workbench structure. The workbench is another approach to help ensure states have timely, standardized information with minimal federal interaction for available data. CMS could incorporate reporting functionalities which in turn would provide states the ability to aggregate data by provider type and fiscal year and to aggregate summary data across states. This would allow states to trend utilization and costs over time. CMS and states also could leverage this structure to create a single report to inform all states of trends within their respective populations. In turn, this functionality could help facilitate state comparisons and dissemination of innovation to migrate from one state to another.

Increase technical assistance opportunities for states

A number of states have received approval to obtain Medicare data, and several others have applications pending or are considering applying for access. CMS' Integrated Care Resource Center (ICRC) issued toolkits in early 2012 to help guide states through the application process, and these are proving helpful to states. Medicaid Directors identified the following additional resources and assistance as fundamental to ongoing progress.

Expand training and education opportunities. Medicaid Directors strongly urge CMS to redirect additional resources for training and education of state Medicaid staff. While the ICRC is a valuable resource for Medicaid agencies, there are insufficient opportunities to train state Medicaid staff on how to manipulate and apply Medicare data for Medicaid programs. This presents a major barrier to states' expeditious pursuit and use of data for care coordination purposes. States that have or are pursuing access to the currently available Medicare data need additional technical assistance and training in order to maximize the utility and application of the data.

Over the longer-term, Medicaid Directors encourage federal policymakers to consider establishing and funding a state/federal "Data Liaison" position in each state. These individuals could act as an interface between states and the federal government. By allowing an individual state worker to specialize in the data interaction between the states and the federal government, both partners will benefit from the specialization and expertise developed. Liaisons would distribute both relevant information and ease interactions between state and federal partners with regard to data needs.

Provide states with CMS contact lists. Medicaid Directors recommend that the Medicare-Medicaid Coordination Office develop a CMS staff contact list. Currently, several states report that it is difficult to identify key CMS personnel who can respond to

their questions. States believe a simple staff reference guide would assist them when they have specific questions about a particular part of the Medicare data application process or about particular data sets.

Expand state access to Medicare data sets

While the currently available Medicare Parts A, B, and D data will help states advance care coordination and improve the quality and efficiency of care for low income Medicare beneficiaries, states also are looking at other ways to expand upon their care coordination and delivery system alignment efforts. Currently states are restricted from accessing all or some of the data contained in the following Medicare data sets. Medicaid Directors request that CMS expand the availability of these data sets so that states may leverage the information in their program integration efforts.

Medicare Part C data. Recent trends indicate that Medicare eligible individuals increasingly will enroll in Medicare Advantage plans. Enrollment in Medicare Advantage plans increased from 11.7 million in 2011 to 12.8 million in 2012, exceeding the U.S. Department of Health and Human Services' (HHS) previous projections.[2] In addition, in 2012 HHS reported that 99.7 percent of Medicare beneficiaries have access to a Medicare Advantage plan.

Despite trends that Medicare beneficiaries are increasingly enrolling in Medicare Advantage plans, to date, CMS' Medicare data sharing efforts with states have focused largely on fee-for-service claims and a limited subset of Medicare Part D prescription drug plan data. Lack of access to the Medicare Part C data already creates a significant gap for states, and Medicaid Directors anticipate current policies will only further widen this gap. As CMS gains access to Part C data, Medicaid Directors request that Medicare-Medicaid Coordination Office simultaneously incorporate policies and processes to ensure state Medicaid programs can access this information. This data is essential both for states currently engaged in the duals demonstration projects and future waves of states that pursue integrated care models.

State Uses: State access to Medicare Part C data would provide information about a beneficiary's history, care management, and service utilization – all essential data elements for state initiatives to integrate care with Medicaid services or, as appropriate through programs like Money Follows the Person, to help delay or prevent eligibility for

[2] U.S. Department of Health and Human Services, February 1, 2012: http://www.hhs.gov/news/press/2012pres/02/20120201a.html

Medicaid. This data is needed in order to effectively coordinate care provided to individuals and to measure the effectiveness of current and future initiatives in reducing the total cost of care. We request that CMS immediately begin engaging states in discussions to develop a process for states to access this data.

Medicare Parts A, B, and D data. States currently can request access to historical and ongoing Medicare Parts A and B data. However, this data is limited to dually eligible individuals. This leaves out significant information about the Medicare population that is *likely* or that states could work to *prevent* – or at a minimum delay – from becoming Medicaid eligible if the state were able to offer targeted service interventions. As an example, some states would like to target interventions to Medicare beneficiaries with income levels between 150 and 200 percent of the federal poverty level.

In addition, the Medicare Part D data available to states is limited to claims information and contains no cost information. This presents a considerable challenge for states seeking to improve care management, particularly for the dually eligible population, as well as effective program integrity activities because of the variation in cost thresholds for products in the Part D versus the Medicaid programs.

State Uses: Several states are considering expanding the Money Follows the Person (MFP) program to individuals *likely* to become dually eligible for Medicare and Medicaid. Currently MFP is designed to transition Medicaid eligible seniors and persons with disabilities from nursing homes to community living. More robust data about Medicare-only beneficiaries with income below a certain threshold level would allow states to target these individuals early on and transition them back into the community once they become Medicaid eligible and meet MFP program requirements. Specifically, states need encounter data, assessment, and outcomes data, and other types of data to enable targeted interventions.

The expansion of Part D data to include cost information also is essential for more effective Medicaid program integrity activities. In the long term, such data would enable states to work with CMS to create truly integrated care programs for the dually eligible population.

Common Medicare Enrollment (CME): The CME contains Medicare eligibility data, Part D enrollment, and low-income eligibility information.

State Uses: States would use information from the CME to target potential Medicaid beneficiaries, case management and care coordination and program integrity across eligibility systems.

Inpatient Rehabilitation Facility - Patient Assessment Instrument (IRF-PAI): The IRF-PAI collects data to determine the payment for every Medicare Part A fee-for-service patient admitted to an inpatient rehabilitation unit or hospital.[3]

State Uses: The IRF-PAI would be used for quality measures, assessment and improvement activities; outcomes evaluation; Health Care Conditions and risk adjustment; improving health or reducing health care costs by controlling long-term care costs for Medicaid; enhancing case management and coordination of care for dually eligible beneficiaries; providing, coordinating, or managing health care and related services by one or more health care providers; and targeting potential beneficiaries for transitioning back into their home or community.

***Long Term Care Minimum Data Set Repository*:** The Minimum Data Set (MDS) is a standardized, primary health status screening and assessment tool, which forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid.[4] The MDS contains items that measure physical, psychological, and psycho-social functioning. The items in the MDS give a multidimensional view of the patient's functional capacities, and can be used to present a nursing home's profile.

State Uses: Medicaid Directors request direct access to the MDS for purposes of improving ongoing care provided to nursing home residents, many of whom are eligible for Medicaid. This information would assist states in assessing the needs of residents, including the type of care they require and whether there may be alternatives to nursing home level of care for Medicaid eligible residents. In addition, access to this data would help inform a state's reimbursement system and its monitoring of the quality of care provided to nursing facility residents.

Medicare Beneficiary Database (MBD): The MBD is the singular, authoritative, database of comprehensive data on all individuals in the Medicare program, including the individual's Medicare health insurance coverage, Medicare health plan and demonstration enrollment, and demographic information.[5]

States Uses: Access to the MBD would enhance a Medicaid agency's ability to design programs for the provision, coordination, or management of health care and related

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[3] See: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/downloads//irfpaimanual040104.pdf
[4] See: http://www.resdac.org/mds/data_available.asp
[5] See: http://www.itdashboard.gov/investment?buscid=268

services by one or more health care providers; coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; and referral of a patient for health care from one health care provider to another.

Medicare Health Outcomes Survey: The Medicare Health Outcomes Survey (HOS) is an assessment of a Medicare Advantage Organization's ability to maintain or improve the physical and mental health functioning of its Medicare beneficiaries over a two-year period of time, based on functional status and health outcomes measurement.[6]

State Uses: States request access to the HOS beneficiary level data files, similar to that provided to the Quality Improvement Organizations (QIOs), for all Medicare Advantage Organizations within their state. The specific data of interest to states includes the beneficiary level data, the frailty scores, and information about the functional acuity of beneficiaries.

States would employ this data to inform their work with the Medicare-Medicaid Coordination Office to advance financial alignment models for the Medicare and Medicaid population. Specifically, the HOS would inform states efforts to enter into three-way contracts with Medicare Advantage organizations in the duals demonstrations, or Medicaid providers if states are not currently participating in this initiative with CMS. In addition, this information would inform states as they assess whether to move forward with a contract or agreement with a Medicare Advantage Dual Special Needs Plan (Dual SNP). States also may wish to pursue other approaches for improving care coordination for this population and to analyze information about individuals who are likely to become dually eligible for Medicare and Medicaid.

Medicare Provider Analysis and Review (MedPAR): The MedPAR file contains data from claims for services provided to beneficiaries admitted to Medicare-certified inpatient hospitals and skilled nursing facilities.[7]

State Uses: States would use this data to help improve the health of Medicaid and low income Medicare beneficiaries and reduce health care costs by controlling long-term care costs for Medicaid. In addition, the MedPAR file would give state Medicaid agencies information needed to enhance case management and coordination of care for dually eligible beneficiaries as well as the provision, coordination, or management of health care

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[6] See: http://www.hosonline.org/Content/Default.aspx

[7] See: http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/IdentifiableDataFiles/MedicareProviderAnalysisandReviewFile.html

and related services by one or more health care providers. MedPAR also would allow states to target potential beneficiaries for transitioning back into their home or community.

Outcome and Assessment Information Set (OASIS): OASIS is the instrument used to collect and report performance data by home health agencies.[8] Since 1999, CMS has required Medicare-certified home health agencies to collect and transmit OASIS data for all adult patients whose care is reimbursed by Medicare and Medicaid with the exception of patients receiving pre- or postnatal services only. Related to OASIS, states request access to the Outcome-Based Quality Improvement (OBQI) report contains risk-adjusted outcome measures derived from OASIS data.

State Uses: States have multiple uses for OASIS data, including monitoring and measuring the quality and performance of home health agencies and assessing changes in a patient's health status over time. States are increasingly retooling their long-term care systems. They are developing patient-centered models of care with a strong emphasis on allowing individuals to remain in their communities as long as practical.

As home health agencies become a more integral part of Medicaid delivery system and payment reforms, states require full information about the quality of services provided by home health agencies and the outcomes for home health patients. In particular, Medicaid – and Medicare – would benefit if states had more complete information about the changes in a home health patient's health status at various points in time. This information is integral to improving patient care and enabling states to develop contracts with providers, including ensuring application of appropriate risk-adjustment tools. It also may provide important information for state program integrity oversight activities.

Provider Enrollment Chain and Ownership System (PECOS): The PECOS data file provides information about Medicare provider and supplier enrollment.[9] States currently have access to PECOS for program integrity purposes, specifically for automatically and continuously approving Medicaid providers that are already Medicare providers.

State Uses: States are seeking broader access to the PECOS file to inform programs and activities impacting provider network capacity, adequacy, and expansion. This is particularly important as states design and develop integrated Medicare and Medicaid delivery systems. States could use this information to contact health care providers and patients with information about treatment alternatives and related functions that do not

[8] See: https://www.cms.gov/HomeHealthQualityInits/01_Overview.asp#TopOfPage
[9] See: https://pecos.cms.hhs.gov/pecos/login.do

include treatment, review the qualifications of health care professionals, and refer a patient for health care from one health care provider to another.

Conclusion

More than half of the state Medicaid agencies are currently working with the Medicare-Medicaid Coordination Office to advance integrated care programs for the Medicare – Medicaid dually eligible population. Many other states are interested in developing integrated care programs in the future. In the meantime, every state wants to use all available tools to provide better, coordinated care for low income individuals.

NAMD is committed to working with CMS to advance these recommendations for process improvements and expanding the states' access to the rich body of information about low-income Medicare enrollees.