



De-Mystifying Data: How Medicare Data Can Support Medicaid Agencies



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De-Mystifying Data: How Medicare Data Can Support Medicaid Agencies

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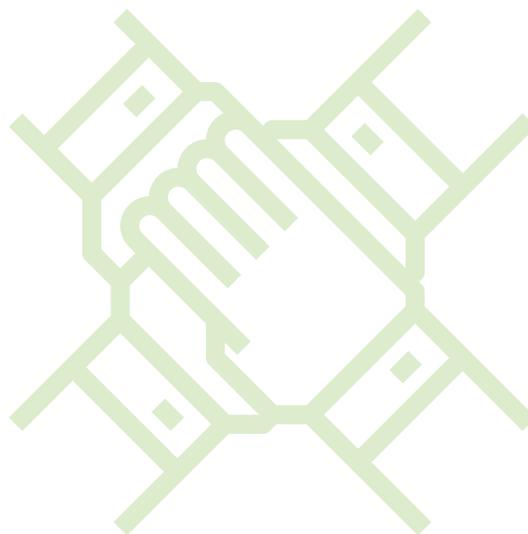
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The ADvancing States **MLTSS Institute** was established in 2016 in order to drive improvements in key managed long-term services and supports (MLTSS) policy areas, facilitate sharing and learning among states, and provide direct and intensive technical assistance to states and health plans. The work of the Institute will result in expanded agency capacity, greater innovation at the state level, and state/federal engagement on MLTSS policy.

ADvancing States represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation and the articulation of national policies that support long-term services and supports for older adults and individuals with disabilities.

The **Center for Health Care Strategies (CHCS)** is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to advance innovative and cost-effective models for organizing, financing, and delivering health care services, especially those with complex, high-cost needs.



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Both the ADvancing States' Board of Directors and the MLTSS Institute Advisory Council identified integrated care as a top priority for research and analysis in 2019. This is the third in a set of three technical assistance documents around integrated care programs examining areas of critical importance to states interested in exploring better ways to serve dually eligible individuals. This brief is focused on the availability and use of Medicare data. We hope that our state members find the series of briefs compelling and useful. We stand ready to assist them as they embark on efforts to drive integrated care for dually eligible individuals.

Sincerely,



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Introduction

Medicare data is an important tool to help states manage care for individuals who are dually eligible for Medicare and Medicaid. Key demographic, clinical, service utilization and spending information about this population spans both programs, different providers and potentially separate health plans, limiting states' ability to get a full picture of and meet individuals' needs if they rely on Medicaid data alone.

A range of state stakeholders that work to develop and monitor programs for the dually eligible population can benefit from access to Medicare data. These include: (1) state Medicaid directors; (2) Medicaid agency teams focused on Medicare-Medicaid integration activities, as well as other areas that impact dually eligible individuals, such as complex care or coordination initiatives, pharmacy and quality management units, finance and program integrity; and (3) state staff at partner agencies, such as aging and disability units that oversee Medicaid-financed or other social service programs that enroll dually eligible individuals.

All states can use Medicare data in some way to improve care for dually eligible individuals.

This issue brief outlines several reasons why states should consider using Medicare data to support Medicaid program planning, care coordination, and program integrity efforts. The appendix provides more detailed information about data sources and other resources available to help states obtain and analyze this valuable data.

Comparing Medicare and Medicaid Benefits

Medicare is the primary payer for most primary and acute care services and prescription drugs for dually eligible individuals. **Table 1** lists the benefits commonly used by this population, highlighting which are covered by Medicare and then by Medicaid. This table can help state staff become familiar with Medicare benefits and for which services Medicare data can be useful. The number of major services categories covered by Medicare also illustrates the need for states to access Medicare data to have a clear picture of service utilization and diagnostic information about beneficiaries with complex needs.

Table 1. Medicare Versus Medicaid Coverage of Benefits for Dually Eligible Individuals

Program	Services
Medicare is primary payer; Medicaid is secondary payer	<ul style="list-style-type: none"> • Hospital/inpatient care—primary payer • Physician and ancillary services • Skilled nursing facility care (up to 100 days) • Home health care • Prescription drugs • Hospice • Durable medical equipment (DME)
Medicaid-only services available to dually eligible individuals	<ul style="list-style-type: none"> • Medicare cost sharing for hospital/inpatient care • Hospital care once Medicare benefits are exhausted • Medicare cost-sharing for physician services • Custodial or long-stay nursing home care (once Medicare benefits are exhausted) • Home and community-based services (HCBS), including some community-based behavioral health services • Some prescription drugs not covered by Medicare • Wrap-around benefits such as vision and dental • Non-emergency transportation • DME not covered by Medicare

Primary State Uses for Medicare Data

Medicare data can help Medicaid agencies with managed care and/or fee-for-service (FFS) delivery systems to improve program design, care delivery, and financial management. The value of particular data to specific states depends on state program goals, as well as staff and system capacity. Learning to use and analyze Medicare data requires focused state resources, and states need to prioritize this activity to support it. It is important to note that although the various uses for Medicare data featured in this brief are among the least resource intensive, most analyses require varying levels of data analytic capabilities. For example, while Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) data is an integrated data set that can be easily accessed via Excel, most data require use of an advanced data analytics software program and support from additional resources, often via external sources such as consultants, actuaries, or partner universities.

Although each state has a unique Medicaid delivery system, all states can use Medicare data in some way to improve care for dually eligible beneficiaries. Three key state uses of Medicare data are: (1) program planning; (2) care coordination; and (3) program integrity. Following is a discussion of the primary data uses, including examples of potential state goals, how Medicare data can be used to achieve those goals, and the specific Medicare data set that would be needed.

I. Program Planning

Medicare data on service use and spending can support program planning activities to improve health outcomes and manage utilization. Dually eligible individuals comprise only 15 percent of all Medicaid beneficiaries, but account for 32 percent of all Medicaid spending, underscoring the importance of developing effective programs to best serve this high-need, high-cost population.¹ This population is also very diverse, with various functional, behavioral health and medical needs driving the cost of care. As states face increasingly constrained budget environments, the examples below describe ways that Medicare data can help states to better target interventions for different sub-populations. Following are examples of how states can use data to support program planning to address priority issues.

All states can use Medicare data in some way to improve care for dually eligible individuals.

Addressing Key Health Issues: Spotlight on Mental Health and Substance Use Disorders

The Opportunity: Services to treat individuals with mental health and substance use disorders are a key benefit for which both payers have large roles for dually eligible individuals. About 21 percent of non-dual individuals with Medicaid only (i.e., no Medicare) have a mental health or substance use disorder diagnosis,² compared to 44 percent of dually eligible individuals who have at least one mental and/or cognitive condition.³ In addition, approximately 49 percent of dually eligible beneficiaries under the age of 65 have mental health or substance use disorder diagnoses.⁴ For dually eligible individuals with these needs, Medicare covers inpatient hospital stays, visits with psychiatrists, psychologists, as well as certain social workers and other traditional providers, and prescription drugs,⁵ while Medicaid can cover case management and certain community-based services that vary by state.

An Example of How Medicare Data Can Help: With high rates of inpatient stays, prescription drug utilization, and comorbid chronic conditions, understanding the full spectrum of health needs for dually eligible beneficiaries with mental health or substance use disorders is essential for developing effective, targeted interventions. States can use Medicare data to better understand the full picture of beneficiary needs, as well as costs and service utilization for those with and without those conditions.

Using Medicare data can also help states understand the prevalence of the most common mental health conditions (e.g., anxiety, bipolar disorder, and major depressive disorders, etc.) and utilization of Medicare behavioral health services. This knowledge can allow Medicaid agencies to tailor case management and other community-based services to the specific demographic and clinical needs of their dually eligible population. States can also compare prevalence information to the national average as well as across other states. For states that enroll some or all beneficiaries in managed care, sharing this data with their contracted MCOs can further improve integration and whole person care approaches.

Suggested Data Source(s): Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) Public Use File (PUF), Master Beneficiary Summary File (MBSF)

Supporting Planning Efforts to Meet the Needs of an Aging Population

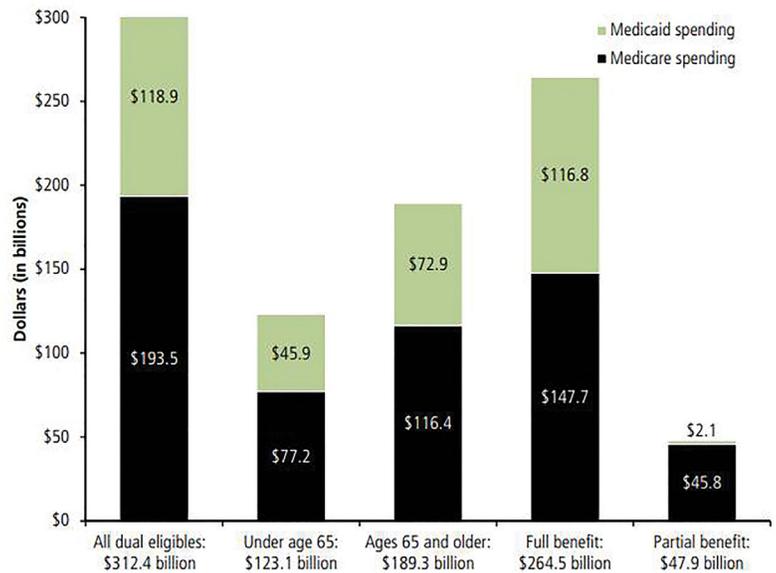
The Opportunity: Dually eligible individuals over the age of 65 accounted for eight percent of the Medicaid population in CY2013, but a disproportionate 20 percent of Medicaid spending.⁶ (Figure 1). By 2034, for the first time, almost as many people will be age 65 and older as under the age of 18.⁷ The percentage of Americans who are age 85 and older will more than double between 2010 and 2050.⁸ States will continue to see an increase in individuals aging into Medicare, and a growing subset becoming dually eligible and requiring Medicaid, including Medicaid-covered long-term services and supports (LTSS) in coming years. Cognitive and functional impairments often associated with aging pose a significant challenge to programs serving the dually eligible population. For example, Alzheimer's disease or a related dementia affect almost a quarter (23 percent) of all dually eligible individuals over the age of 65.⁹

An Example of How Medicare Data Can Help: Using Medicare Minimum Data Set (MDS) and Outcome and Assessment Information Set (OASIS) data from skilled nursing facility (SNF) stays and home health utilization can allow Medicaid agencies to identify cognitive and/or functional impairment issues in their dually eligible populations and plan new services and supports accordingly. This data can also inform nursing facility and home health quality initiatives, which are becoming even more critical during the COVID-19 pandemic. Additionally, MMLEADS PUF and MBSF data can help states level-set and understand the prevalence of Alzheimer’s disease among their dually eligible population compared to Medicare-only and Medicaid-only individuals in their state.

Furthermore, supporting transitions that avoid re-admissions and move individuals out of institutions who do not need to be there into community-based settings are critical elements of state efforts to rebalance their LTSS system. MDS assessment data can be particularly helpful in identifying individuals who are cognitively and functionally capable of transitioning out of facilities back into the community. Such information can support state Medicaid agencies and/or their health plans deliver targeted and individualized services and social supports to facilitate successful transitions into community settings.

Suggested Data Source(s): MMLEADS, MBSF, MDS PUF, OASIS data

Figure 1. Medicare and Medicaid spending on dual-eligible beneficiaries by age and type, CY 2013



MDS assessment data can be particularly helpful in identifying individuals who are cognitively and functionally capable of transitioning out of facilities back into the community.

Managing Quality of D-SNPs

The Opportunity: Dual Eligible Special Needs Plans (D-SNPs) are a type of Medicare Advantage plan designed to serve the unique needs of dually eligible individuals. D-SNPs operate in 42 states, the District of Columbia, and Puerto Rico and currently enroll more than three million individuals.¹⁰ D-SNPs must sign a State Medicaid Agency Contract (SMAC) to operate in each state. States have the discretion to include a variety of requirements in these contracts to support Medicaid program administration, which provide states with a lever to gain important information from D-SNPs about their enrollees' Medicare experience.

An Example of How Medicare Data Can Help: States can use publicly available Medicare data provided by the Centers for Medicare & Medicaid Services (CMS) to compare quality measure performance on different health indicators for D-SNP enrollees to Medicaid-only populations when standardized metrics are used. States can also monitor D-SNP performance through publicly available SNP Healthcare Effectiveness Data and Information Set (HEDIS) PUF on specific metrics such as cancer screenings. States can analyze trends among the members of their state's D-SNPs, including what percentage of D-SNP enrollees in the state are assessed for functional status.¹¹

States can also require D-SNPs to share certain quality indicators, such as Part C¹² and Part D Medicare Star Ratings, with the state agency to increase state insight into specific measures to support a state's health priorities, or used to create baseline quality standard for members.¹³ Some states include provisions in their SMACs for D-SNPs to immediately notify the agency if Star Ratings fall below a certain threshold.

Suggested Data Source(s): SNP HEDIS PUF; State Medicaid Agency Contract Required Reporting of Part C and D Medicare D-SNP Star Rating Data

II. Care Coordination and Management

Current Medicare data can enhance states' ability to support care coordination to reduce fragmentation and avoidable utilization across different delivery systems. As of December 2018, 29 Medicaid agencies received Medicare data from CMS for the purposes of coordinating care for dually eligible individuals.¹⁴ Outside of D-SNP-reported data, more current or "real-time" data is limited but may still be valuable to Medicaid programs to inform care coordination program design. Below are several examples of ways that Medicare data can support Medicaid care coordination.

Improving Coordination with D-SNPs

The Opportunity: While approximately one million dually eligible individuals were enrolled in an aligned health plan¹⁵ that covered their Medicare and Medicaid benefits in 2019, 90 percent of dually eligible individuals remain in uncoordinated systems. D-SNPs must comply with federal requirements outlined in the 2018 Bipartisan Budget Act and later promulgated in 2019 in CMS rules that seek to promote care coordination across Medicaid and Medicare by 2021.¹⁶ The new regulations require D-SNPs to give states and/or a designee (e.g., Medicaid managed care organizations) access to Medicare-covered inpatient admissions data for hospitals and skilled nursing facilities

for state-defined, high-risk dually eligible enrollee groups. States can use data-sharing requirements for D-SNPs to expand coordination of care for individuals enrolled in separate products or arrangements.

In addition, COVID-19 has highlighted the vast vulnerabilities in our health care system for providing comprehensive, coordinated care to high-need individuals as well as for maintaining preventive care and social services. CMS data has also shown that being dually eligible is the biggest predictor of COVID-19 infection and hospitalization across every indicator for the Medicare population.¹⁷ Dually eligible individuals, including nursing facility residents, those receiving home and community-based services, and individuals with intellectual and developmental disabilities, are among the most dependent on LTSS and susceptible to significant illness or mortality if infected.

States can use data-sharing requirements for D-SNPs to expand coordination of care for individuals enrolled in separate products or arrangements.

An Example of How Medicare Data Can Help: Sharing D-SNP data with states and/or state designees can support transitions across care settings and promote better care coordination for D-SNP enrollees. For example, Oregon, Tennessee, and Pennsylvania previously established processes for data sharing that can offer value to other states.¹⁸ Additional states are developing processes to meet the new requirements for 2021 and use this data to support care coordination and discharge planning activities with D-SNPs to help meet state Medicaid program goals (i.e., supporting care transitions and return to community, etc.).

When D-SNPs share real-time inpatient and emergency department admission data with states, Medicaid Managed Care Organizations (MCOs) or other responsible entities, they can intervene quickly and provide critically necessary services and supports to promote successful care transitions and prevent unnecessary readmissions. In addition to requiring sharing of admission data, states can also require D-SNPs to notify key parties about impending transitions of care, such as transitions from Medicare SNFs to long-term Medicaid facility stays. In times of public health emergencies, such as COVID-19, data on preventive service utilization, COVID-19 positive tests, and inpatient admissions/discharges can be collected and analyzed to stratify delivery of immediate response efforts to meet individuals' needs.

Suggested Data Source(s): D-SNP data, such as inpatient admission and service utilization

Managing Opioid Use and Misuse

The Opportunity: Dually eligible beneficiaries have approximately twice the rate of co-occurring substance use disorder and chronic pain compared to Medicare-only beneficiaries, and six times that of Medicaid-only adults with disabilities.¹⁹ With these higher rates comes an increased risk for opioid misuse.²⁰ High volumes of opioid prescriptions to treat chronic pain are directly associated with opioid addiction and associated overdose deaths.²¹ State Medicaid agencies historically have very limited opportunities to analyze prescription drug use for the dually eligible population. Reasons behind prescription opioid misuse and trends in prescribing patterns can be analyzed by state Medicaid agencies to inform appropriate interventions.

An Example of How Medicare Data Can Help: States can analyze Medicare Part D Prescription Drug Event (PDE) data to identify inappropriate trends in provider opioid prescribing to dually eligible individuals to provide additional care coordination and other services to reduce potential opioid misuse.^{22,23} States can also use this information to identify, and then collaborate with or issue corrective actions to high-risk providers to change prescribing patterns and better coordinate alternative services for dually eligible individuals. Uncovered trends can also inform changes to state regulations, laws, and policies based on high-risk prescribing patterns identified across the state or in particular regions.²⁴ Part D PDE data have a one-month lag, and they are useful to identify and monitor trends and change care coordination approaches accordingly.²⁵

Suggested Data Source(s): Medicare Part D Prescription Drug Event (PDE) data

III. Program Integrity

The Opportunity: Fraud, waste, and abuse divert considerable public dollars from the health and welfare of vulnerable populations. Preserving tight state budgets for critical services is of paramount importance across state Medicaid programs, particularly as states respond to the COVID-19 crisis. Medicare data may provide states with new insights to better monitor program integrity efforts. As of December 2018, eight states were receiving Medicare data from CMS to support program integrity efforts.²⁶

When Medicare and Medicaid both cover a service for dually eligible individuals, Medicare is the primary payer and Medicaid is considered the “payer of last resort.” Home health services, nursing facility services, and durable medical equipment are key overlapping benefits that often cause significant administrative burden for states and plans (as described in greater detail in the text box **The Issue of Overlapping Benefits**). Without the same opportunities and infrastructure for coordination across Medicare and Medicaid that are present in many managed care environments, challenges are often more prevalent in FFS delivery systems.²⁷

An Example of How Medicare Data Can Help: States can use Medicare data to compare patterns of service use and spending to analyze patterns of fraud or misuse, such as aberrant utilization and/or billing patterns for overlapping benefits to ensure that they do not make inappropriate payments for Medicare-covered services. In addition, states can use Medicare data to ensure individuals with access to Medicare-covered home health benefits are not using Medicaid personal care services at the same time unless there is a demonstrable need for both services.

Suggested Data Source(s): D-SNP Encounter Data, Historic Parts A and B Claims Data, MBSF

The Issue of Overlapping Benefits

For dually eligible individuals, Medicare and Medicaid both cover certain benefits, including durable medical equipment (DME) and home health. Medicare is the primary payer for these services, and Medicaid can pay for wrap around coverage and/or for beneficiary cost-sharing.

Each program has different coverage requirements for similar benefits. This can create significant confusion and frustration for dually eligible individuals, their caregivers, and providers when seeking access to these benefits because many states require that Medicare issue a denial prior to a Medicaid payment being issued.²⁸ This can result in Medicaid beneficiaries receiving a denial notice for a Medicare benefit when it is covered under Medicaid; it also results in delays in receiving needed services. Some efforts are underway to mitigate this issue, such as the Centers for Medicare & Medicaid Services' (CMS) recent issuance of the Integrated Denial Notice.²⁹ Programs that integrate Medicare and Medicaid in one accountable entity are in a position to manage this process internally to avoid sending confusing notices to enrollees and facilitate more timely access by reviewing for both Medicare and Medicaid coverage at the same time.

Understanding how dually eligible individuals use these overlapping Medicare and Medicaid benefits can help states identify opportunities to reduce beneficiary confusion about accessing services, prevent unnecessary denials and appeals, and improve service continuation as coverage transitions from Medicare to Medicaid.

Types of Medicare Data

Some data is publicly available in PUFs, while other data must be requested and can be accessed via assistance from the State Data Resource Center³⁰ or obtained through a state's D-SNPs for those enrollees. Depending on the source, some Medicare data is several months or years old (i.e., historical), whereas other data sources are available in a more timely, real-time format.³¹ A few key resources can help states begin to understand which data they need and how to acquire and use the data.

Table 2 provides an overview of these key Medicare data sources; considerations for use; and where to access data. The appendix provides links to several organizations and resources that can support states in using and analyzing Medicare data.

Table 2: Key Medicare Data Sources below provides: (1) an overview of data featured in this brief; (2) what the data can tell states; (3) key considerations for how states might use it; and (4) how states can access the data. As discussed, some data is publicly available and other data must be requested from federal or private sources, including:

- The State Data Resource Center (SDRC), which provides technical assistances to states to help them receive and learn how to use Medicare data.
- The Medicare-Medicaid Coordination Office (MMCO), which compiles reports, data, and other resources to help states and researchers to better understand the health, health care needs, and health care experiences of dually enrolled individuals.
- States can require D-SNPs operating in their states to submit data to the state via contract requirements in State Medicaid Agency Contracts (SMACs). States have full discretion in writing data reporting requirements into their SMACs, while use of Medicare data provided by CMS is more restricted to certain usages.

Table 2.

Data	What is It?	Considerations for States	How Can States Get It?
<p>Historic Parts A and B Data</p>	<p>States can access claims data for each service paid for a given beneficiary, alongside demographic and service-level identifiers in Historic Parts A and B data. All Parts A and B claims data is available to states.</p>	<ul style="list-style-type: none"> • Part A or B final action claims are only available for services paid through 2018 due to the lag time in adjusting claims. • Part A or B non-final-action claims are available in two forms, and both include each iteration of a claim for a service. These can be available with a lag time of 3 months to as little as daily, although significant time and resources are required to process the more timely data. 	<p>Data requested via the State Data Resource Center.</p>
<p>Master Beneficiary Summary File (MBSF)</p>	<p>States can access utilization and spending information for a given beneficiary for the full year. Includes Medicare Parts A, B, C, and D services and costs.</p> <p>States can use the MBSF to access information about durable medical equipment, skilled nursing facility, hospice and home health service use, in addition to hospital inpatient, outpatient, and physician services. States can also use this source to identify potential over and duplicative payments for overlapping benefits.</p>	<p>Data is historic and currently available for years 2006–2018.</p>	<p>Data requested via the State Data Resource Center.</p>

Continues

Data	What is It?	Considerations for States	How Can States Get It?
Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) Public Use File (PUF)	<p>MMLEADS data provides an integrated data source for states on Medicare and Medicaid FFS payment. CMS created this linked data set to help states more easily analyze key attributes of their Medicare-Medicaid population and programs. Information includes demographics, enrollment, chronic condition prevalence, utilization, and payment levels.</p> <p>This source can be used to analyze key attributes of states' dually eligible populations and program trends to inform program planning.</p>	<ul style="list-style-type: none"> • Integrated data from 2006-2012 is available in linkable data files. • The file can be useful for planning and research purposes. In addition, it allows states to compare data across benefit types (full and partial duals, Medicaid-only, Medicare-only), across states, and over time. • MMLEADS PUF does not require states to engage with SDRC and provides a readily available source of data to analyze trends, as opposed to the MMLEADS State-specific data, which provides more detail but requires a longer planning time and engagement with SDRC to access. • This information does not include specific payment details for enrollees in Medicare or Medicaid managed care. 	<p>MMLEADS is a PUF available online to all states and researchers and is available at:</p> <p>https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics</p>
Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS)—state-specific data	<p>Similar to the PUF, these linkable data files show demographics, enrollment, chronic condition prevalence, utilization, and spending levels.</p>	<ul style="list-style-type: none"> • States might use this data to program plan to meet the needs of an aging population, and/or to better understand cost drivers to identify needed program changes. State-specific integrated data source for 2006-2012 for dually eligible enrollees. The file can be useful for planning and research purposes. • States can use to compare data across benefit types (duals, Medicaid-only, Medicare-only, etc.) and over time. • MMLEADS State Specific data provides states with more detailed data on their own state, compared to the PUF, which offers a snapshot of trends across states. 	<p>Data requested via the State Data Resource Center.</p>

Continues

Data	What is It?	Considerations for States	How Can States Get It?
Medicare Part D Prescription Drug Event (PDE) data	<p>This includes prescription drug cost and payment data for records of filled prescriptions by Medicare Part D beneficiaries including Medicare FFS beneficiaries and Medicare Advantage plan members.</p> <p>Example of the data elements described in Part D File Record Layout</p>	<ul style="list-style-type: none"> • Not all Part D elements are made available (i.e., Part D data does not contain any cost information nor denial events). • PDE data may not provide a full picture of all prescriptions prescribed/dispensed to a beneficiary. • Only available for full benefit dually eligible individuals in a state to support care coordination efforts. • Both historic (2007 to current with one-month lag) and monthly data available (one-month lag).³² 	<p>Data requested via the State Data Resource Center.</p>
Minimum Data Set (MDS)	<p>The MDS is part of a federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing facilities. Data are collected from a standardized health status screening and assessment tool that captures, among other data, residents' health and functional status. The assessment is required for Medicare payment of SNF stays.</p>	<ul style="list-style-type: none"> • Data includes: Clinical status measures; Physical functioning assessment; Psychological status measures; Psycho-social functioning measure; and End-of-life care decisions. • Data for CY 2010–2018 years are currently available. MDS 3.0 provides annual, historical data from 2010–2017, as well as current quarterly data with a one-quarter lag. • MDS assessments are completed at least every three months, often more frequently. These can provide more robust health data than is often found in claims data. 	<p>Data requested via the State Data Resource Center.</p>

Continues

Data	What is It?	Considerations for States	How Can States Get It?
MDS Public Report 3.0	The MDS 3.0 Frequency Report is a publicly available source of summarized information for active residents currently in nursing homes. Data is sourced from residents' MDS assessment record. The MDS assessment information for each active nursing home resident is consolidated to create a profile of the most recent standard information for the resident. If there is no activity for a resident in the last 150 days, then the resident is assumed to have been discharged and their information is no longer included in this report.	Information is easily accessible for use online without the need for advanced statistical or analytical skills or programs.	MDS Public Report 3.0 is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/Minimum-Data-Set-3-0-Frequency-Report
OASIS	Outcome and Assessment Information Set (OASIS) data is a CMS-required set of data that Medicare-certified home health agencies must collect and transmit for all adult patients whose care is reimbursed by Medicare and Medicaid. ³³	Provides annual data from 2007–2017 and quarterly data with a one-quarter lag. ³⁴	Data requested via the State Data Resource Center.
SNP HEDIS PUF	Dataset for all SNPs; includes specific HEDIS measures that D-SNPs are required to report. This can be used to compare D-SNP performance across 15 quality measures within a state or to overall SNP performance.		To access this data, go to this CMS website . To learn more on how to use this data, access this ICRC resource .

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Data	What is It?	Considerations for States	How Can States Get It?
D-SNP Data	<p>State Medicaid agencies can require D-SNPs to submit data to the state via State Medicaid Agency Contracts (SMACs). Many plans will be required to report admissions notification data from hospitals and skilled nursing facilities to states or designated entities in 2021.</p> <p>States can also require D-SNPs to submit to the state Medicare encounter data that shows enrollee service utilization, such as emergency room visits, inpatient admissions, and SNF stays. Other data that states could require from D-SNPs include quality measures (e.g., Stars Ratings, HEDIS or CAHPS), and grievance and/or appeals data. States could also include information about plan benefit packages to better understand plans' supplemental benefit offerings.</p>	<p>States and D-SNPs would need to identify data elements of most potential use, transfer formats, and frequency of data exchange.</p>	<p>States can require D-SNPs to share various data elements in D-SNP SMACs.</p>



Conclusion

Medicare data can be a valuable tool to support state Medicaid agencies and their partners in a variety of capacities, regardless of delivery system. This issue brief outlines ways for states to use Medicare data to achieve policy goals around improving care and reducing utilization and costs for their dually eligible populations. Depending on the state's goals and available resources for accessing and using available data sources, states can improve program design, care coordination, and other strategic opportunities for managing their dually eligible populations.



Appendix: Summary of Medicare Data Technical Assistance Resources

Two CMS-funded resource centers provide technical assistance to help states use Medicare data and understand the implications of different analyses, as well as many documents, webinars, and other publications to support states in accessing and using Medicare data.

Resource Center	Description	Examples of Key Resources
State Data Resource Center (SDRC)	SDRC is available through support from CMS to provide states with support, assistance, and guidance on how to request, access, and use Medicare data provided by CMS to support their dually eligible beneficiaries. States can go to https://statedataresourcecenter.com/ to learn more.	<ul style="list-style-type: none"> Requesting and Using Medicare Data for Medicare-Medicaid Care Coordination and Program Integrity: An Overview. Available at: https://statedataresourcecenter.com/assets/files/Requesting_Data_for_Care_Coord_and_Program_Integrity.pdf Using and Requesting Medicare Data for Medicare-Medicaid Care Coordination and Program Integrity Frequently Asked Questions. Available at: https://www.statedataresourcecenter.com/assets/files/SDRC_FAQ.pdf

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Resource Center	Description	Examples of Key Resources
Integrated Care Resource Center (ICRC)	<p>ICRC is a national initiative of CMS' Medicare-Medicaid Coordination Office, coordinated by Mathematica and the Center for Health Care Strategies. ICRC helps states develop integrated care programs that coordinate medical, behavioral health, and LTSS for dually eligible individuals. It is available to provide a variety of technical assistance services, including one-on-one and group technical assistance. States can go to https://www.integratedcareresourcecenter.com/ to learn more.</p>	<ul style="list-style-type: none"> • D. Chelminsky. How States Can Better Understand their Dually Eligible Beneficiaries: A Guide to Using CMS Data Resources, November 2018. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/CMS_Data_Resources_Nov_2018.pdf • D. Chelminsky. How States Can Monitor Dual Eligible Special Needs Plan Performance: A Guide to Using CMS Data Resources, January 2018. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_How_States_Can_Monitor_DSNP_Performance_1.26.18.pdf • D. Chelminsky. N. Clark, C. Vasquez. Using Medicare Data to Support Integrated Care for Dually Eligible Beneficiaries, May 2019. Available at: https://www.integratedcareresourcecenter.com/webinar/using-medicare-data-support-integrated-care-dually-eligible-beneficiaries (webinar) • D. Chelminsky. How States Can Use Medicare Advantage Star Ratings to Assess D-SNP Quality and Performance, October 2019. Available at: https://www.integratedcareresourcecenter.com/resource/how-states-can-use-medicare-advantage-star-ratings-assess-d-snp-quality-and-performance • A. Kruse, N. Archibald, and R. Lester. Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations, August 2019. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_InfoSharing_HospitalSNF%20082819.pdf • A. Kruse. Information Sharing to Improve Care Coordination for High-Risk Dual Eligible Special Needs Plan Enrollees: Key Questions for State Implementation, September 2019. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/D_SNP_Info_Sharing_Key_Qs_9_19.pdf

Continues

Resource Center	Description	Examples of Key Resources
<p>Additional Resources</p>	<p>The resources provided here come from a variety of different reputable sources from which states can learn more about using Medicare data to support their dually eligible populations and programs.</p>	<ul style="list-style-type: none"> • Chronic Condition Data Warehouse, Medicare-Medicaid Linked Enrollees Analytic Data Source (MMLEADS V2.0) User Guide, June 2019: Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMLEADsv20_UserGuide_062017.pdf • CMS. Integrated Medicare-Medicaid Data to Inform Data Driven Decision Making. Available at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/integrated-medicare-medic-aid-data.pdf • L. Palmer Barnette. Center for Health Care Strategies, Integrating Medicare and Medicaid Data to Support Improved Care for Dual Eligibles, July 2010. Available at: https://www.chcs.org/resource/integrating-medicare-and-medic-aid-data-to-support-improved-care-for-dual-eligibles/ • Sec 4.5 of N. Archibald, M. Soper, L. Smith, A. Kruse, J. Wiener. ASPE, Integrating Care Through Dual Eligible Special Needs Plans (D-SNPs): Opportunities and Challenges, April 2019. Available at: https://aspe.hhs.gov/basic-report/integrating-care-through-dual-eligible-special-needs-plans-d-snps-opportunities-and-challenges#investment

Endnotes

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- 13 To learn more about how states can access and use Star Rating data, see this resource from Integrated Care Resource Center: https://www.integratedcareresourcecenter.com/sites/default/files/2020_Medicare_Advantage_Star_Ratings_Guide.pdf
- 14 CMS. "SMDL #18-012 RE: Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare". December 2018. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18012.pdf>
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- 16 The Bipartisan Budget Act of 2018 provided permanent authority for D-SNPs and also included the addition of new minimum integration standards for all D-SNPs. Beginning January 1, 2021, all D-SNPs must either cover Medicaid long-term services and supports and/or behavioral health services or communicate information on certain high-risk members' hospital and skilled nursing facility admissions to a designated entity. Additional requirements were also added formalizing basic care coordination responsibilities of D-SNPs to coordinate Medicaid benefits of their dually eligible members regardless of Medicaid source of coverage.
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- 30 CMS’ State Data Resource Center provides access to public use data, as well as more tailored, state-specific data that must be used specifically for Care Coordination or Program Integrity purposes and approved by CMS. Further detail on requesting data via this process is available in Appendix 1 or online at <https://statedataresourcecenter.com/pages/request-process/>. Other Medicare data sources that are not accessed via this route are outlined in Appendix 1.
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