VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Interoperability & Patient Access (IPA): Data Exchange

Interoperability & Patient Access (IPA) is a project to implement multiple policies required by CMS in the Interoperability and Patient Access final rule (CMS-9115-F) to improve patient access to their health information. Part of this project requires states to increase the exchange frequency of enrollee data for individuals dually eligible for Medicare and Medicaid, by requiring **MMA**[1] and **Buy-In**[2] file exchanges daily.

Increasing these file exchanges from monthly to daily is expected to improve the dual eligible beneficiary experience by ensuring almost "real time" access to appropriate programs and ensuring services are billed appropriately the first time, eliminating waste and burden. States are required to implement this daily exchange starting April 1, 2022.

IPA: MMA File Data Exchange

Since 2005, states have been submitting files at least monthly to CMS to identify all dually eligible beneficiaries. This includes full benefit and partial benefit dually eligible beneficiaries (i.e., those who get Medicaid help with Medicare premiums, and often for cost-sharing). The file is called the "MMA File" (after the Medicare Prescription Drug, Improvement and Modernization Act of 2003), but is occasionally referred to as the "State Phasedown file." However, federal regulations at 42 CFR 423.910 now require states, effective April 1, 2022, to submit files daily.

State Efficiencies

- **Faster transition to Medicare drug coverage.** The sooner a dual eligible beneficiary transitioning from Medicaid drug coverage to Medicare Part D drug coverage is auto enrolled into a Medicare drug plan, the fewer claims that are paid erroneously by the state and the fewer they must recoup from pharmacists (who then have the burden of reaching out to reconcile with the new Part D plan).
- **Faster turnaround to Medicare as primary for other services**. More frequent file submission increases the speed of identifying new Medicare Parts A and B enrollment, so states can more quickly implement edits, so Medicaid doesn't cover those Medicare services. This also has the benefit of reducing oversight risks related to audits on third-party liability.
- **Streamline error identification/resolution.** A general issue is that if there is some data error (e.g., transposed numbers) and some back and forth is needed to straighten things out, there is a better chance of getting it fixed before the start of the next month if files are transferred more frequently.
- **Supports states promoting enrollment in integrated care**. Particularly for beneficiaries who are newly dually eligible, more frequent data exchange helps states facilitate enrollment into integrated products earlier (Dual Eligible Special Needs Plans, and other Medicare Advantage plans and Medicare-Medicaid plans).

[1] MMA file identifies all people who are dually eligible (fully or partially) for Medicare and Medicaid. MMA is the acronym for the Medicare Prescription Drug, Improvement and Modernization Act of 2003

[2] Buy-In file identifies individuals dually eligible for Medicare and Medicaid for whom the state will pay Part A and/or Part B premiums.

Beneficiary Access to Care

- **Faster access to Medicare subsidies.** Dual eligibility status on the MMA file prompts CMS to deem individuals automatically eligible for the Medicare Part D Low Income Subsidy (LIS), make changes to LIS status (e.g., prompted by a move to a nursing facility or HCBS), and auto-enroll them into Medicare prescription drug coverage back to the start of dual eligibility status. This reduces beneficiary cost-sharing and improves access to Medicare-covered medications.
- **More efficient communication.** To Qualified Medicare Beneficiaries (QMB) regarding zero liability for Medicare Part A and B cost sharing, and protections from providers billing them for it. A lag in data could cause confusion for the QMB, as the Medicare Summary Notice they receive would show they are liable and can be billed. In the worst cases, the beneficiary may limit the need for services due to outstanding financial obligation to the provider.

Reduced Burden on Providers

- **Supports Medicare provider and health plan compliance.** With restrictions on billing QMBs for cost-sharing for services covered by Medicare Parts A and B. CMS notifies fee-for-service (FFS) providers of QMB status via its eligibility query (HETS) and claims processing (provider remittance advice) systems, based on data submitted on the MMA file. Lags in data could cause confusion on the ground for providers and beneficiaries, with a possible uptick in inquiries to the state. For example, delays in data will cause problems for those new to QMB.
- **Alleviate the burden on pharmacists.** The sooner a dual eligible beneficiary transitioning from Medicaid drug coverage to Medicare Part D drug coverage gets enrolled into a Medicare drug plan, the fewer claims that are paid erroneously by the state and the fewer they have to recoup from pharmacists (who then have the burden of reaching out to reconcile with the new Part D plan).

IPA: Buy-In Data Exchange

Medicaid agencies pay for Medicare Part A and or B monthly premiums for most dually eligible individuals. To do so, Medicaid agencies routinely exchange data with CMS on who is enrolled in Medicare and who/what entity is responsible for paying that beneficiary's Parts A and B premiums. These data exchanges support state, CMS, and Social Security Administration (SSA) premium accounting, collections, and enrollment functions.

However, federal regulations at 42 CFR 423.910 now require states, effective April 1, 2022, to submit files daily. Medicaid agencies can send buy-in files to CMS daily and continue to receive one monthly response file or may elect to receive buy-in response files each business day in addition to the monthly file. More frequent buy-in data exchanges benefit dually eligible individuals, Medicaid agencies, and providers.

State Efficiencies

- **Reduced financial impact.** Medicaid agencies can minimize their financial exposure when people lose Medicaid or Medicare Savings Program coverage with a retroactive effective date. While the CMS system will accept any retroactive effective date, states remain liable for months

over the first three months of retroactivity (since beneficiaries can be billed for no more than two months back).

- **More timely decisions.** Daily data exchanges permit states to remove records more quickly from the state's buy-In account, after the state determines the beneficiary is no longer eligible for buy-In.
- **Reduced administrative burden.** Daily exchanges reduce administrative burden of reconciling benefit costs when buy-in is retroactive for beneficiaries already receiving Medicaid.
- **Faster turnaround to Medicare as primary for other services**. Medicaid agencies can effectuate a faster shift to Medicare as primary payer for many health care services. This will also reduce the need to recoup Medicaid reimbursement paid to providers.
- **Streamline error identification/resolution.** Medicaid agencies can avoid spikes in staff workload to resolve processing errors identified on the CMS response file. The CMS response file indicates, for each record submitted by a state, whether the record was accepted or rejected, and if the latter, has reason codes explaining why. This helps the state correct the record prior to resubmitting.

Beneficiary Access to Care

- **Faster access to Medicare coverage.** For beneficiaries who can neither afford Medicare premiums nor qualify for Medicaid, they can more quickly access Medicare A/B services, and providers can more quickly be assured of coverage.
- **Streamline error identification/resolution.** If the state's buy-in transaction request contains an error and CMS rejects the update, CMS will notify the state of the rejection within one business day. This allows the state to correct issues and resubmit quickly, versus waiting for the next monthly file from CMS. This difference may impact an individual's Medicare coverage by several months in some cases.
- **Reduced financial burden.** For beneficiaries who had been paying for the Part B premium themselves, the sooner the Part B buy-in starts, the sooner SSA stops deducting the Part B premium from the beneficiaries' Social Security check. This frees up resources for food, housing, and other necessities that are often critical to maintaining health and independence in the community.

Reduced Burden on Providers

- **Improved billing accuracy.** Greater accuracy in Medicare eligibility increases providers' ability to bill the correct payer the first time. It also reduces the burden of reconciling coverage, i.e., to have money recouped by Medicaid, or for provider to have to re-bill.