

Integrating Medicare and Medicaid Data to Support Improved Care for Dual Eligibles

Technical Assistance Brief

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While Medicare and Medicaid generally cover different populations, there are nearly nine million people eligible for both programs. These “dual eligible” beneficiaries represent the most chronically ill and costly segments of both the Medicare and Medicaid populations. Integrating Medicare and Medicaid offers tremendous potential to both improve care and control costs.

Because care for the duals is currently divided between these separate programs, each governed by their own policies and procedures, information on service utilization and expenditures for this population does not reside within a single entity. Thus, identifying ways to link Medicare and Medicaid data is a critical step toward achieving integrated care for adults who are dually eligible. Without access to Medicare data, state Medicaid agencies have only a limited picture of the dual eligible population. This lack of information significantly limits a state’s ability to adequately address the needs of dual eligibles and the poorly coordinated care that results from the current fragmented system. The availability of linked Medicare and Medicaid data can help highlight areas where integration can make a difference, such as identifying ways to reduce service fragmentation and avoidable utilization. Uncovering these opportunities can help build the case to state and federal policymakers for encouraging enrollment of additional dual eligibles into integrated care programs.

This technical assistance brief provides states with practical information about Medicare data and how these data can be accessed, as well as how states can use the information to better understand the dual eligible population and identify opportunities to improve care.

This brief provides information about using Medicare data to identify opportunities to improve care for dual eligibles. The brief:

- Outlines Medicare data available through the Centers for Medicare & Medicaid Services (CMS) and the Research Data Assistance Center (ResDAC);
- Explains the process for obtaining Medicare data from ResDAC;
- Describes the CMS Coordination of Benefits Agreement (COBA) and how it can be used to obtain Medicare claims data;
- Provides an overview of how Medicare and Medicaid data can be linked; and
- Examines the value of integrated data to support improvements in care for duals.

Medicare Data Available through CMS/ResDAC

As the federal agency responsible for Medicare, the Centers for Medicare and Medicaid Services (CMS) is the largest source of program data, including claims and service utilization, enrollment, and eligibility data. These data are generally made available to the public, subject to privacy release approvals, in one or more of three distinct file types as outlined by the Research Data Assistance Center (ResDAC):¹

1. **Research Identifiable Files** (RIFs) contain individual-level data on Medicare beneficiaries and providers. This information includes specific identifiers (e.g., date of birth, age, race, sex, residence information) that can be used to identify a beneficiary or physician.

2. **Limited Data Set Files** (LDS) also contain individual-level health information, but exclude the specific identifiers found in the RIFs. However, LDS data are considered identifiable data sets even though specific identifiers are not included.
3. **Non-Identifiable Data Files** contain aggregate-level information on Medicare beneficiary or provider utilization. All specific identifying information has been removed from these data. As a result, non-identifiable files cannot be linked to Medicaid data to support analysis of Medicare and Medicaid service utilization by dual eligibles.

Within each of these file types, there are a number of subcategories of data files available. Following are examples of files that have the most relevance to achieving improved and integrated care for duals. Additional information on available data can be found in the Appendix.

Research Identifiable Files

Examples of RIFs that offer the greatest potential to provide a fuller picture of duals utilization and costs include:²

- **Standard Analytical Files** (SAFs) contain information that Medicare uses to pay for beneficiary health care services, including institutional (inpatient, outpatient, skilled nursing facility, hospice, or home health agency) and non-institutional (physician and durable medical equipment providers) services.
- **Medicare Provider Analysis and Review Files** (MedPAR) contain data on inpatient hospital and skilled nursing facility (SNF) utilization. Each MedPAR record represents a stay in an inpatient hospital or SNF summarizing all services from the time of admission through discharge.
- **Beneficiary Annual Summary Files** (BASF) contain individual-level information regarding enrollment, eligibility, and service utilization. The file also contains two different diagnosis/condition categories, the Condition Categories and Chronic Condition Warehouse (CCW) flags (see the Appendix for more detail).
- **Part D Drug Event Files** (PDE) contain prescription drug cost and payment data that enable CMS to reimburse prescription drug plans and oversee Part D. The PDE data are not the same as individual drug claims data, but do provide summary information.

RIF data can serve as rich sources of information on Medicare utilization and costs for dual eligible beneficiaries (see Figure 1 for a summary of information that can be gleaned through these files). However, states should be aware that these data do not include claims paid by sources other than fee-for-service Medicare. As a result, dual eligibles receiving care through managed care organizations (e.g., Medicare Advantage) and actual Part D claims information are not included in these data.

Figure 1: Medicare Data Available through RIFs

- **Type of Medicare Coverage:** Part A, B, and D coverage; dual eligible status; and end stage renal disease (ESRD) enrollees can be identified.
- **Medicare Utilization:** Utilization by service type is available for Medicare Parts A, B, and D. However, states should be aware that if they use BASF, which contain summary files, service types may be aggregated.
- **Medicare Expenditures:** Expenditures by services are available for Medicare Parts A, B, and D. These data are also available by age range, provider type, highest overall cost per member for specified time period, and highest overall payment per provider for specified time period.
- **Preventable Events** (i.e., emergency department [ED] visits, hospitalization, nursing facility [NF] admissions): It is possible to identify these services in BASF and to use the CCW flags, which indicate if a beneficiary has had any one of 21 pre-identified chronic conditions, to potentially assess whether utilization was preventable.

Limited Data Set

The LDS contains similar data that can be found in RIFs, including SAF and MedPAR files. Unlike RIFs, the LDS files do not include certain specific details. For example, all dates are presented as a quarter and year (e.g., 3rd Quarter of 2006); age is presented as a five-year age range; unique provider identification number (UPIN) is encrypted; and, the lowest level of geographic identification is the county in the LDS SAF and the state in the LDS MedPAR.³ As a result, it is considerably more difficult to use LDS data for individual-level analyses and these data may offer little utility for states interested in linking Medicare and Medicaid data.

Obtaining Medicare Data from ResDAC

In order to access most of the Medicare data described above, a state or researcher must work through ResDAC located at the University of Minnesota.⁴ For example, to access RIFs, an official data request packet must be submitted to ResDAC for review before it is sent to CMS. The requirements of the data request packet may vary depending on the entity requesting the data, but generally include the following:⁵

- Written request letter;
- Synopsis of project;
- Data use agreement;
- Specification worksheet;
- Privacy protected data disclaimer; and
- Evidence of funding.

Data request packets are usually reviewed by ResDAC staff within five to seven days of receipt. Once the data request packet is determined to be complete, ResDAC sends it to CMS for review by the CMS Privacy Board, which generally meets monthly. As previously mentioned, RIFs are subject to an array of federal rules and regulations regarding privacy; as a result, information is usually only released for reasons that are compatible with the purpose(s) for which the data are collected.⁶ Figure 2 outlines CMS criteria for evaluating RIF and LDS data requests.

Figure 2: CMS Criteria for Review of Requests for Research Identifiable Data

- Requested data must be applicable for disclosure under the Privacy Act of 1974 and published as a System of Record.
- Research protocol must outline a strong research design, clearly stating objectives and significance of the study and providing a credible argument for the project's importance.
- Scope and subject matter of the project must assist CMS in monitoring, managing, and improving the Medicare and Medicaid programs or the services provided to beneficiaries. CMS must balance the potential risk to beneficiary confidentiality with the probable benefits gained from the completed research.
- Requestor must demonstrate the expertise and experience to conduct and complete the study.
- Requestor must sign a CMS Data Use Agreement (DUA) that: (1) requires the requestor to obtain permission before attempting to link any other data files to CMS databases; and (2) defines the process that must be followed for the destruction or return of the data to CMS at the conclusion of the study.
- Any tool developed using CMS data must be in the public domain. CMS will review the source of funding to determine if the requestor is independent of the funding organization.
- The publication or public dissemination (including the Internet) of statistics that highlight resident-, beneficiary-, or facility-level data must have prior authorization from CMS to ensure that beneficiary confidentiality is properly maintained. Any statistics developed using CMS data should be made available in the public domain.

SOURCE: The above requirements are excerpted from *Criteria for Review of Requests for CMS Research Identifiable Data*. For more information, including the full list of criteria, visit http://www.cms.gov/privprotecteddata/02_criteria.asp.

Requests for LDS data do not require a ResDAC review; however, ResDAC staff are available to review requests for completeness and accuracy prior to submission. Because the LDS does not include the same level of identifiable data as RIFs, the data request requirements are not as rigorous and require only three items:

- Written request letter;
- 2-3 page research application; and
- LDS data use agreement.

While the process for obtaining CMS Medicare data through ResDAC may seem straightforward, it is often a lengthy process requiring an investment in time and resources. As such, some states have chosen to use an external contractor to obtain and analyze data.

Coordination of Benefits Agreement Data

Given the difficulties associated with obtaining identifiable data, CMS has created ways for states to access Medicare data for the purposes of improving the quality of care for dual eligibles. In 2006 CMS developed a model national contract, called the Coordination of Benefits Agreement (COBA), to facilitate the standardized exchange of eligibility and Medicare claims payment information. COBAs permit other insurers and benefit programs (also known as trading partners) to send eligibility information to CMS and receive Medicare paid claims data, along with other coordination of benefits data, from one source, known as the Coordination of Benefits Contractor (COBC).⁷ Historically states have been eligible to enter into a COBA as a trading partner with CMS to receive Medicare Parts A and B data to determine payment liability and coordinate payment (see Figure 3 for available data). In 2008 CMS identified new permissible data uses.

Figure 3: Available Claims Data through COBA

Medicare Part A	Medicare Part B
<ul style="list-style-type: none"> ▪ Hospital inpatient & outpatient ▪ SNF ▪ Clinic ▪ Ambulatory surgical center ▪ Home health ▪ Hospice 	<ul style="list-style-type: none"> ▪ Physician services ▪ Diagnostic tests ▪ Laboratory ▪ Ambulance ▪ Durable medical equipment ▪ Part B drugs

Under the revised COBA, states may seek CMS permission to reuse duals' Parts A and B claims data for quality improvement activities and/or to re-release the data to make treatment disclosures to providers. States can use these data to evaluate practitioner performance, assess and improve the quality of care for individual beneficiaries (for example, by comparing duals' care and outcomes with Medicaid-only beneficiaries), and monitor beneficiaries' utilization and treatment patterns.⁸

Tennessee's Use of Dual Eligible Data under the Revised COBA

In 2009, Tennessee received CMS approval to use Medicare Parts A and B claims data for activities aimed at improving the quality of care for dual eligibles. Most of these activities focus on the use of claims data to evaluate the impact of Medicaid managed care organizations (MCOs) on the services provided to dual eligibles. Because HEDIS measures focus primarily on primary and acute care (e.g., screenings, immunizations, etc.), dual eligibles are often excluded from state HEDIS measurements because of the lack of access to Medicare claims data. Availability of these data will allow Tennessee to use these measures to evaluate quality of care for all beneficiaries — dual and non-dual — using a standardized approach. Tennessee also received CMS approval to provide MCOs with access to Parts A and B claims data to allow care managers to better coordinate Medicaid and Medicare services for duals. The state believes that better coordination will ensure that dual eligible beneficiaries receive the most appropriate and cost-effective care possible. Similarly, the state also received CMS permission to use Medicare claims data to identify duals who are eligible for disease management programs. The data also help the state and its MCO partners track the delivery of appropriate services provided to those with chronic diseases.

Through COBA, a state has the opportunity to select the type of claims data it would like to receive (e.g., hospital inpatient, skilled nursing facility, home health, etc.) and how often it would like to receive them. For example, states may elect to receive claims as often as daily. In this case, the length of time between when a physician submits a claim and when the state receives it would be roughly two weeks.⁹

States interested in using COBA data should submit requests directly to CMS.¹⁰ In reviewing requests, CMS examines how states intend to use the data, including how quality measures are generated/analyzed; how any outcomes and promising practices will be shared with CMS; and what privacy and security protocols will be utilized in order to protect the data.¹¹

Considerations for Using Medicare Data Available through ResDAC and COBA

As states think about which Medicare data source to use, it is important to recognize key differences regarding ease of obtaining, timeliness, and usability of the types of data available through ResDAC and COBA. Based on discussions with researchers and states, following is a brief summary of potential considerations:

- **Ease of Obtaining:** The process for obtaining data via ResDAC can be somewhat cumbersome; CMS might consider addressing this issue to help streamline state access to data from ResDAC. The process for obtaining COBA data is relatively straightforward.
- **Timeliness:** The most recent data available through ResDAC are for 2008. While there is a few month time lag for COBA data, it is generally much more recent.
- **Usability/Data Cleanliness:** Data available through ResDAC are generally clean and user-friendly. COBA data often require considerable clean-up to be usable, e.g., accounting for retroactive claims adjustments and incomplete data on new enrollees.

Finally, it is important to note that the use of these data sources need not be mutually exclusive. Based on the above differences, states may opt to use both data sources for different purposes, e.g., use data from ResDAC for analyses that do not require time-sensitive data and COBA for targeted analyses that require more current data.

Linking the Data

Once a state receives Medicare data, the next and challenging step is to link these data with Medicaid data. The few states that have accomplished this to date have sought expertise from universities or other researchers to link the data and undertake subsequent analyses.¹² In general, Medicare and Medicaid program beneficiary identification numbers are the first step in linking data on duals.¹³ The next step depends on the types of analyses that the state plans to pursue. For example, if a state is primarily interested in utilization and cost analyses for duals, it might focus on linking Medicare claims to Medicaid crossover data as was done by The Hilltop Institute on behalf of Maryland. To do so, Hilltop matched all Medicaid crossover claims to the corresponding Medicare (RIF/SAF) claims using criteria based on patient identification number, dates of service, and the three Medicare payment fields (amount paid by Medicare, Medicare deductible amount, and Medicare copay amount). Linking the data at the claims level in this way makes it possible to unduplicate service use across Medicare and Medicaid data sources. The resulting file structure highlights the relationships between Medicare-only, Medicaid-only, and cross Medicare and Medicaid service use and costs.¹⁴

CMS Linked Database: Another Source of Medicare Data

In 2009, CMS developed a database of linked Medicare and Medicaid service use and expenditures data using the Medicaid Analytic Extract (MAX) Person Summary Files and the Medicare Beneficiary Annual Summary Files (BASF). The database links all nine million dual eligibles at the beneficiary level for years 2004-2006.

The Medicare Payment Advisory Committee (MedPAC) has contracted with Mathematica Policy Research (MPR) to conduct a variety of analyses using the linked database for 2005 to better understand annual spending for dual eligibles. The MPR analyses look at data state-by-state as well as by service category and distinguish between younger (under 65) people with disabilities and the elderly. The analyses focus on annual service utilization and costs per person for dual eligibles who receive full Medicaid benefits and who are eligible for both Medicare and Medicaid for a full year. MPR has also obtained state-by-state Medicare managed care data from the CMS Medicare Plan Payment Group. While these managed care data are not linked at the individual level, they help provide a fuller picture of dual eligible costs and services. Selected findings from MPR's analysis are available in MedPAC's June 2010 Report to the Congress.¹⁵

The Value of Integrated Data

Regardless of the source, Medicare data, when linked with a state's Medicaid data, can provide the state with valuable information about dual eligible beneficiaries. Following are four key areas for duals data analysis that a state could pursue using linked Medicare and Medicaid data (note, this is not meant to be an exhaustive list, rather four broad areas for potential analysis):

1. **Basic Utilization and Cost Information.** Linked data can provide service use and cost information for both Medicaid and Medicare for the major service categories, including inpatient and outpatient hospital; physician and related services; nursing facility (both Medicare skilled nursing facility and Medicaid nursing facility); waiver and related home- and community-based services; pharmacy; home health; hospice, and durable medical equipment. These data should also be broken out by age (under 65 vs. over 65) and/or eligibility given the difference in utilization and expenditures for older duals and younger dual eligible consumers with disabilities.
2. **Diagnostic Snapshot.** Linked Medicare and Medicaid data may be used to identify utilization and costs by certain diagnostic categories/comorbidities. In particular states may choose to focus on mental health diagnoses given the prevalence of mental illness among beneficiaries with multiple chronic conditions and those receiving long-term supports and services (LTSS).¹⁶ This will help states identify high-need, high-cost beneficiaries who might benefit from more targeted case management.
3. **Care Opportunities.** In addition to the general needs and service use of the population, states can use the linked data to identify opportunities for streamlining and/or improving care for dual eligible beneficiaries. These types of analyses can be used to help make the case for further integration of Medicare and Medicaid services. To that end, states might look for areas of high overlap between Medicaid and Medicare utilization or potentially avoidable utilization, including:
 - Home health service overlaps between the two programs that may be proxies to show utilization driven by cost shifting.
 - Service overlaps between Medicare skilled nursing facility and Medicaid nursing facility that may highlight where cost shifting may occur.
 - Pharmacy utilization and spending broken out by institutionalized beneficiaries vs. non-institutionalized beneficiaries that may highlight concerns around polypharmacy and contra-indications.
 - Avoidable hospitalizations for both institutionalized and community-based duals that may be identifiable using inpatient hospital data.

4. **Dual Subsets and Care Opportunities.** Analyses could be structured to identify opportunities to improve care and reduce costs by population subsets. For example, the dual eligible population could be broken down into three categories based on whether their service utilization is driven more by LTSS or acute care needs. For each category, hypotheses would be developed and analyses conducted. Sample hypotheses/analyses are listed in Figure 4.

Figure 4: Potential Opportunities to Improve Utilization and Control Costs	
Population Subset*	Hypotheses to be Tested
LTSS Institutionalized Beneficiaries	Avoidable hospitalizations and improved medication management
LTSS Community-Dwelling Beneficiaries	Effect of home- and community-based services (HCBS) on institutionalization, especially NF utilization
Acute-Comorbid Beneficiaries	Avoidable inpatient admissions, readmits, and ED visits; effectiveness of care transitions

*Categorized by primary driver of need/utilization.

Despite the significant opportunities for analysis outlined above, there are limitations to what the data available through ResDAC and COBA can provide. For example, while service utilization that occurred can be identified, utilization that should have occurred but did not (i.e., gaps in care) cannot be readily identified except indirectly or by inference. Similarly, it is possible to identify services that enrollees received from both programs — home health, for example — but it is far more difficult to determine whether this represented duplication of services.

It is also worth reiterating that utilization and claims data for duals who receive Medicare services through Medicare Advantage (MA) organizations are not available through these data sources. States may consider working with MA organizations directly to try to obtain such information. In addition, the data do not include several other factors that may be of importance to states, including: actual Part D claims; information related to Medicare administrative expenditures; and rates paid to Medicare providers for specific services.

Conclusion

Accessing Medicare data can be challenging and few states have attempted it to date. States that have done so have found that obtaining Medicare data can significantly inform efforts to improve and, ultimately, integrate care. By linking Medicare and Medicaid data, a Medicaid agency can better understand the varied needs of its dually eligible beneficiaries and areas where services can be improved. States can apply this understanding to develop programs focused on ensuring that beneficiaries receive the right care at the right time and in the right setting. And lastly, states can use this powerful information to influence stakeholders at every level — state, federal as well as consumers — regarding the potential of integration to improve care and control costs.

Resources from the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS is leading work with states, health plans, and federal policymakers to advance programs that integrate care for adults who are dually eligible. To learn about CHCS' *Transforming Care for Dual Eligibles* initiative or to download resources from "Designing Integrated Care Programs: An Online Toolkit," visit www.chcs.org.

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Appendix: Medicare Data Available through CMS/ResDAC

There are a number of advantages and disadvantages to using the various Medicare data files that are available. Research identifiable files (RIFs) allow a state to match Medicare and Medicaid utilization data for individual dual eligible beneficiaries to get a full picture of the services that a particular person may have used over a period of time. However, because identifiable data is governed by a number of federal laws, rules, and regulations, it can be difficult to access. The limited data sets (LDS) are much easier to obtain but a number of variables (e.g., age, service dates, zip code, etc.) are either encrypted, grouped into ranges, or left blank, making it difficult to use for individual-level analyses.

More detail on the various data provided through each of these file types can be found below. Data descriptions come directly from the Research Data Assistance Center that is the liaison for obtaining these data from CMS.¹⁷

Research Identifiable Files

- **Standard Analytical Files (SAFs):** contain information that Medicare uses to pay for beneficiary health care services, including institutional (inpatient, outpatient, skilled nursing facility, hospice, or home health agency) and non-institutional (physician and durable medical equipment providers) services.
- **Medicare Provider Analysis and Review Files (MedPAR):** contain data on inpatient hospital and SNF utilization. Each MedPAR record represents a stay in an inpatient hospital or SNF summarizing all services from the time of admission through discharge.
- **Denominator Files:** contain demographic and enrollment information about Medicare beneficiaries, including the beneficiary unique identifier, state and county codes, zip code, date of birth, date of death, sex, race, age, whether they are eligible for Medicare Parts A and/or B, eligibility information, and whether they are enrolled in managed care. The Denominator File can be used to determine beneficiary demographic characteristics, entitlement, and beneficiary participation in Medicare managed care organizations.
- **Beneficiary Annual Summary Files (BASF):** contain individual-level information regarding enrollment, eligibility, and service utilization. The file also contains two different diagnosis/condition categories, the Condition Categories and the Chronic Conditions Data Warehouse flags (CCW flags).
- **Part D Denominator Files:** contain demographic and enrollment information about Medicare beneficiaries, including a derived race/ethnicity code, whether a beneficiary has Other Creditable Drug Coverage or is enrolled in MA-PD/PDPs, whether a beneficiary receives a Low Income Subsidy or Retiree Drug Subsidy, and State Reported Dual Eligibility Status.
- **Part D Drug Event (PDE) Files:** contain prescription drug costs and payment data that enable CMS to make payments to prescription drug plans and otherwise administer the Part D benefit. The PDE data are not the same as individual drug claim transactions but do provide summary information.
- **Chronic Conditions Summary Files:** contain a Chronic Conditions Warehouse (CCW) flag to indicate if a beneficiary has had any one of the 21 predefined chronic conditions by year.¹⁸

Limited Data Set

- **LDS Standard Analytical Files (SAF):** contain information that Medicare uses to pay for beneficiary health care services, including institutional (inpatient, outpatient, skilled nursing facility, hospice, or home health agency) and non-institutional (physician and durable medical equipment providers) services. All dates are presented as a quarter and year (e.g., 3rd Quarter 2008); age is presented as a five-year age range; physician identification number is encrypted; and, the lowest level of geographic identification in the LDS SAF is the county.
- **LDS MEDPAR Files:** contain data on inpatient hospital and SNF utilization. Each MedPAR record represents a stay in an inpatient hospital or SNF summarizing all services from the time of admission through discharge. The lowest level of geographic identification in the LDS MedPAR File is the state.
- **LDS Denominator Files:** contain demographic and enrollment information about Medicare beneficiaries, including the beneficiary unique identifier, state and county codes, zip code, date of birth, date of death, sex, race, age, whether they are eligible for Medicare Parts A and/or B, eligibility information, and whether they are enrolled in managed care. The Denominator File can be used to determine beneficiary demographic characteristics, entitlement, and beneficiary participation in Medicare managed care organizations.

Endnotes

¹ For information about the Research Data Assistance Center, visit <http://www.resdac.umn.edu>.

² Medicare Identifiable Data Descriptions. Research Data Assistance Center: http://www.resdac.umn.edu/Medicare/Data_File_Descriptions_RIF.asp.

³ Medicare Limited Data Set File Descriptions, Research Data Assistance Center: http://www.resdac.umn.edu/Medicare/Data_File_Descriptions_LDS.asp

⁴ Through a contract with CMS, ResDAC provides free assistance to academic, government, and nonprofit researchers interested in using Medicare and/or Medicaid data for their research. In addition to providing technical assistance to interested parties on topics ranging from the conversion of raw data into usable data sets to possible applications of Medicare/Medicaid data, ResDAC also provides assistance in the process of obtaining RIFs and LDS files from CMS. For more information on ResDAC, see <http://www.resdac.umn.edu/AboutUs/Index.asp>

⁵ For more information on specific elements required as part of the data request packet by type of requestor, see CMS website: <http://www.cms.gov/privprotecteddata/tor/list.asp>.

⁶ A. Tucker, K. Johnson, A. Rubin, S. Fogler. *A Framework for State-Level Analysis of Duals: Interleaving Medicare and Medicaid Data*. The Hilltop Institute, September 2008. http://www.hilltopinstitute.org/publication_view.cfm?pubID=169&st=tbl_Publications

⁷ *Coordination of Benefits Agreement Implementation Users Guide*. Centers for Medicare and Medicaid Services. November 2009. <http://www.cms.hhs.gov/COBAgreement/Downloads/COBAGuide.pdf>

⁸ *The New COBA Agreement: Obtaining CMS Permission to Reuse Duals' Claims for Quality Improvement Activities and to Make Treatment Disclosures to Providers Frequently Asked Questions*. Centers for Medicare and Medicaid Services.

⁹ Ibid.

¹⁰ States should submit requests via email to: MedicaidQuality@cms.hhs.gov. CMS anticipates that obtaining approval for such a request will take approximately 90 days from the initial written submission by the state to the CMS determination. During this timeframe, CMS may submit questions back to the state for their response, which would reset the 90-day clock.

¹¹ The New COBA Agreement, op. cit.

¹² For an example of what a state might request in terms of data linkage and analysis, see Vermont's 2010 Request for Proposals.

¹³ Tucker, et al., op. cit.

¹⁴ Ibid.

¹⁵ http://www.medpac.gov/chapters/Jun10_Ch05.pdf

¹⁶ States should note that the diagnostic information available in Medicare data is generally limited to the Chronic Condition Warehouse (CCW). While the CCW includes 21 predefined conditions including Alzheimer's and depression, some of the most prevalent mental health diagnoses (such as schizophrenia or other psychoses) are not included. Because the BASF also contain the CCW flags, states using these files should be aware of the limitations.

¹⁷ <http://www.resdac.umn.edu>

¹⁸ The 21 predefined chronic conditions are: acute myocardial infarction; Alzheimer's disease; Alzheimer's disease, related disorders, or senile dementia; atrial fibrillation; cataract; chronic kidney disease; chronic obstructive pulmonary disease; depression; diabetes; glaucoma; heart failure; hip/pelvic fracture; ischemic heart disease; osteoporosis; rheumatoid arthritis/osteoarthritis (RA/OA); stroke / transient ischemic attack; female breast cancer; colorectal cancer; prostate cancer; lung cancer; and endometrial cancer.