Promoting value to states of more frequent submission of MMA files

Since 2006, states have submitted "MMA" files[1] to CMS to identify all full and partial dual eligible beneficiaries. States must submit the MMA file at least monthly to CMS, but can do so as often as daily. While most states send files weekly or daily, MMCO has identified 13 states[2] that submit monthly.

MMCO is considering reaching out to these states to encourage more frequent submission. We expect that these Medicaid Directors may not be aware of the file or why the state decided to submit only monthly when the data exchange was built a decade ago. We plan to share with states the benefits of more frequent data submission to:

Increase State Efficiencies

1) Faster transition to Medicare drug coverage. The sooner a beneficiary transitioning from Medicaid drug coverage to Medicare Part D drug coverage gets auto-enrolled into a Medicare drug plan, the fewer claims get 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).
2) Faster turnaround to Medicare as primary for other services. More frequent file submission increases the speed of identifying new Medicare Parts A/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.
3) 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.
4) Supports states promoting enrollment in integrated care. Particularly for new duals, more frequent data exchange helps states get people enrolled in integrated products earlier (e.g., D-SNPs, MMPs).

Improve Beneficiary Access to Care

5) Faster access to Medicare subsidies. Dual status on the MMA file prompts CMS to deem individuals for the Medicare Part D low income subsidy (LIS) as well as make changes to that status (e.g., prompted by a move to a nursing home or HCBS) and auto-enroll them into Medicare drug plans back to the start of dual eligible status.
6) More efficient communication to Qualified Medicare Beneficiaries (QMBs) regarding zero liability for Medicare Part A/B cost sharing, and protections from providers billing them for it. A lag in data could cause confusion for the QMBs, as the Medicare Summary Notice they receive would show they are liable and can be billed.

[1] Named for the Medicare Modernization Act of 2003, which created the Part D benefit and necessitated CMS have timely notification of dual status to autoenroll beneficiaries into drug plans, deem them for the Part D low income subsidy, and calculate the state phasedown payment. The timeliness and quality of the data are such that Medicare data is used for Medicare Advantage risk adjustment, and most recently, to notify providers and beneficiaries of Qualified Medicare Beneficiary status in fee for service to prevent inappropriate billing of Medicare A/B cost-sharing.

[2] The thirteen states are: AK, AL, CA, CO, ID, ME, ND, NM, PA, VT, WI, WV, WY.

Reduce Provider Burden

7) 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 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 can cause confusion on the ground for providers and beneficiaries, and possibly increase administratively burdensome inquiries to the state. For example, delays in data can cause problems for those new to QMB.
8) Alleviate the burden on pharmacists. The sooner a beneficiary transitioning from Medicaid drug coverage to Medicare Part D drug coverage gets enrolled into a Medicare drug plan, the fewer claims get 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).