Voluntary Data Sharing Agreement

USER GUIDE

Non-MSP Reporting Only

Version Effective Date:

March 1, 2016

LIMITED USE RESTRICTIONS

This version of the VDSA User Guide is for the exclusive use of reporting entities that will be using the "D – Non-MSP Only Input File" to do reporting of prescription drug coverage that is secondary to Medicare prescription drug coverage.

All "D – Non-MSP Only Input File" submitters are to ignore any references to MSP reporting. Non-MSP Input File reporters exclusively using this VDSA reporting process are not involved in MSP data reporting.

All "D – Non-MSP Only Input File" submitters are to ignore any references to "Part D Subsidy" reporting. Reporters using the "D – Non-MSP Only Input File" are not permitted to do Part D Subsidy reporting.

RECENT REVISIONS

- This version of the user guide replaces all previous versions.
- Contact information for the Centers of Medicare & Medicaid Services (CMS) has been updated.

INTRODUCTON

This Voluntary Data Sharing Agreement (VDSA) User Guide provides information and instructions VDSA partners will find useful as they manage the VDSA data sharing process with the Centers for Medicare & Medicaid Services (CMS). In particular, a VDSA and the information in this document will allow users to coordinate Medicare Part D drug benefits with CMS under the terms of the Medicare Modernization Act (MMA). From time to time the information in this user guide may change. Please be alert for notices of any such changes.

This VDSA User Guide assumes a fairly comprehensive understanding of the current VDSA process. Please contact us if you find material that is unclear or if you have questions that are not addressed. All official CMS documentation regarding the VDSA process, including up-to-date record layouts and other information (such as Frequently Asked Questions) may also be obtained from the Benefits Coordination & Recovery Center (BCRC). Contact the BCRC by email at COBVA@ehmedicare.com, or call 646-458-6740.

If you have not yet signed a VDSA with CMS and would like more general information about the current VDSA process, please email vanessa.jackson@cms.hhs.gov, or call 410-786-3276. Remember to provide us with the email, phone number, and other contact information for individuals you would like to have added to our distribution list.

SECTION A: COMPLETING AND SIGNING A VOLUNTARY DSA

To make the VDSA relationship operational, the VDSA partner and CMS have to sign and exchange completed copies of the VDSA. These are the instructions for completing these Data Sharing Agreements for signature. The current version of the VDSA is available from CMS in a pdf file format.

1. In the first paragraph of the VDSA, insert all of your specific identifying information where indicated. The date the signature process is completed by both the partner and CMS will be entered here, and will be the "Effective Date." If you wish, the date you enter may be prospective or retroactive. For example, some VDSA partners prefer to enter the first day of the month in which they expect the VDSA to be signed. But bear in mind that if you enter a prospective date, CMS cannot begin full implementation of the VDSA until we reach it.
2. Enter the date that is requested on Page 5 of the VDSA, in Section C, 1. This is the starting date for health plan enrollment information that is entered on the first regular production MSP Input File you provide to CMS.

   We normally advise VDSA partners to submit historical enrollment data on their first production MSP Input File. We recommend that the data entered here cover a period starting no later than January 1 of the first full year prior to the execution of the Agreement. Thus, if the effective date of the VDSA is September 1, 2010 (for example), the first MSP Input File should include information dating back to at least January 1, 2009. This permits CMS and our partners to fill in gaps in enrollment information involving coordination of benefits that have not been found through other information exchange activities.
3. On Page 14, in Section N, enter the partner's Administrative and Technical contact information.
4. Page 15, Section O: Upon receipt of a VDSA signed by the partner, CMS will provide the required Technical contact information. This does not need to be completed to execute the Agreement.
5. In the footer starting on Page 1, and throughout the rest of the document, insert the partner's business name.

The VDSA signature package consists of two documents: The VDSA itself, and the VDSA Implementation Questionnaire. The VDSA Implementation Questionnaire is used to assure both the VDSA partner and CMS that agreement on essential operational questions has been reached. **VDSA partners must complete and return a copy of the VDSA Implementation Questionnaire to CMS with their signed VDSA**. The Questionnaire will be provided to new partners by CMS.

The VDSA partner will return two signed copies of the VDSA and one completed copy of the Implementation Questionnaire to CMS. One copy of the VDSA will be signed by CMS and returned to the partner. If it wishes, the partner can ask that CMS sign the VDSA first. CMS will then provide two signed copies of the VDSA to the partner, and the partner will sign one copy and return it to CMS. But in either case CMS will not consider the VDSA to be in force until the partner has also provided CMS with a completed copy of the Implementation Questionnaire.

To avoid unnecessary processing delays, we strongly recommend that you use an overnight delivery service, and send your VDSA(s) and Implementation Questionnaire to:

Vanessa Jackson
Centers for Medicare and Medicaid Services
Office of Financial Management
Division of Medicare Secondary Payer Operations
Mail Stop: C3-14-16
7500 Security Boulevard
Baltimore, Maryland 21244-1850

SECTION B: THE VDSA DATA FILES – Standard Reporting Information

Standard Data Files: The data exchanged through the VDSA process is arranged in six different file schematics (also referred to as record layouts). A VDSA partner electronically transmits a data file to CMS. CMS processes the data in this Input File, and at a prescribed time electronically transmits a Response File to the partner. In a very few instances CMS will transmit a record layout to a partner without having first received a specific input file, but these are rare exceptions. In ordinary circumstances it will be an input file that will generate a response file.

Current versions of the six Standard Data Files and the TIN Reference File immediately follow. In the VDSA itself, in **Section III, Purpose of this Agreement**, reference is made to Attachments A through G. The Data Files below are those Attachments, still labeled A through G. The Business Rules that apply to these Data Files can be found in Section III of the User Guide.

Please note that headers and trailers are part of the files they start and finish. They are not stand-alone documents and you may not submit headers and trailers as separate files. However, headers and trailers are not to be included when determining the record count in a submission.

Once again we remind you that from time to time the information provided here will change. All significant updates to the material in the most recent version of this User Guide are described on the Cover Page of this document. Always check the Effective Date shown on the Cover Page, on Page 1, and in the footer on each page to be sure you are using the most recent version.

I. The Input and Response File Data Layouts

D – The Non-MSP Input File. This is the data set transmitted from a VDSA partner to CMS that is used to report information regarding the health insurance coverage information of a VDSA partner's Inactive Covered Individuals – people who are currently not working (such as retirees), and a spouse and (or) other dependents, and who are enrolled in a health plan or policy, for which the partner or a subsidiary acts as an insurer, third party administrator, health plan sponsor or any combination thereof – and who cannot be classified as Active Covered Individuals. The Non-MSP Input File is used to report drug coverage information that is secondary to Medicare Part D. The Non-MSP Input File can also be used to query CMS about potential beneficiary Part D coverage.

VDSA Attachment D

D: VDSA Non-MSP Input File Layout – 300 bytes

Table 1: VDSA Non-MSP Input File Layout – 300 bytes

Field	Name	Size	Displacement	Data Type	Description
1.	Beneficiary Social Security Number	9	1-9	Numeric	Covered Individual's Social Security Number. **Required** if HICN not populated. Use any 9 digits, 0-9. Fill with spaces if SSN is not available.
2.	HIC Number (HICN)	12	10-21	Alpha-Numeric	Covered Individual's Health Insurance Claim Number. Required. Populate with spaces if not available.
3.	Covered Individual's Surname	6	22-27	Text	Covered Individual's Last Name – Required.
4.	Covered Individual's First Initial	1	28-28	Alpha	Covered Individual's First Initial – Required.
5.	Covered Individual's Middle Initial	1	29-29	Alpha	Covered Individual's Middle Initial – Optional.
6.	Covered Individual's Date of Birth	8	30-37	Numeric Date	Covered Individual's DOB. (CCYYMMDD). Required.

Field	Name	Size	Displacement	Data Type	Description
7.	Covered Individual's Sex Code	1	38-38	Numeric	Covered Individual's Sex – Valid values: 0 = Unknown 1 = Male 2 = Female Required.
8.	Group Health Plan (GHP) Number	20	39-58	Text	GHP Number assigned by Payer for action type D, or, **Unique Benefit Option Identifier** assigned by Payer for action type S. For use with Action Types D and S. Required for Action Type S when Coverage Type is V, Z, 4, 5 or 6.
9.	Individual Policy Number	17	59-75	Text	Unique Identifier assigned by the payer to identify the covered individual. For use with Action Types D and S. Required for Action Type D when coverage type is V, Z, 4, 5, and 6.
10.	Effective Date	8	76-83	Numeric Date	Start Date of Covered Individual's Primary Coverage by Insurer. (CCYYMMDD) Required for Action Types D and S.
11.	Termination Date**	8	84-91	Numeric Date	End Date of Covered Individual's Primary Coverage by Insurer. (CCYYMMDD). For use with Action Types D and S. **Required** for Action Type S. **All zeros if open-ended.
12.	National Health Plan	10	92-101	Filler	National Health Plan Identifier. (Future Use.)
13.	Rx Insured ID number	20	102-121	Text	Insured's Rx Identification Number. For use with Action Types D and S. **Required** for Action Type D when coverage type = U, W, X, or Y.

Field	Name	Size	Displacement	Data Type	Description
14.	Rx Group Number	15	122-136	Text	Rx Group Health Plan Number assigned by Payer for action type D, or, **Unique Benefit Option Identifier**, as defined by the RDS Center, and assigned by Payer for action type S. **Required** with Action Type S when Coverage Type = U, W, X, or Y.
15.	Rx PCN	10	137-146	Text	Processor Control Number for Medicare Beneficiaries. For use with Action Type D and S when Coverage Type = U, W, X, or Y.
16.	Rx BIN Number	6	147-152	Text	International Identification Number for Medicare Beneficiaries. For use with Action Types D and S. Required for Action Type D when Coverage Type = U, W, X, or Y.
17.	Rx Toll Free Number	18	153-170	Text plus "(" and ")"	Toll Free Number Pharmacist can use to contact Rx Insurer. For use with Action Types D and S.
18.	Relationship Code	2	171-172	Numeric	Covered Individual's Relation to Policy Holder: '01' = Covered Individual is Policy Holder '02' = Spouse or Common Law Spouse '03' = Child '04' = Other '20' = Domestic Partner Or spaces. Required for Action Types D and S.
19.	Partner Assigned DCN	15	173-187	Text	Document Control Number; assigned by the VDSA partner. Required. Each record shall have a unique DCN.

Field	Name	Size	Displacement	Data Type	Description
20.	Action Type	1	188	Alpha	Type of Maintenance: Valid values: ‘D’ = Drug Reporting record ‘S’ = Subsidy Reporting record ‘N’ = Non-Reporting record Required.
21	Transaction Type	1	189	Numeric	Type of Maintenance: Valid values: ‘0’ = Add Record ‘1’ = Delete record ‘2’ = Update record Or space. Required for action type D or S.
22.	Coverage Type	1	190	Alpha-Numeric	Type of Coverage: ‘U’ - Drug Only (network Rx) ‘V’ - Drug with Major Medical (non-network Rx) ‘W’ - Comprehensive Coverage - Hosp/Med/Drug (network Rx) ‘X’ - Hospital and Drug (network Rx) ‘Y’ - Medical and Drug (network Rx) ‘Z’ - Health Reimbursement Account (non-network Rx) ‘4’ = Comprehensive Coverage - Hosp/Med/Drug (non-network Rx) ‘5’ = Hospital and Drug (non-network Rx) ‘6’ = Medical and Drug (non-network Rx). Required for action type D or S.
23.	Person Code	3	191-193	Text	Person code the insurer uses to identify specific individuals on a policy. For use with Action Types D and S. Optional.

Field	Name	Size	Displacement	Data Type	Description
24.	Reserved	10	194-203	Internal use	Reserved for BCRC internal use; Fill with spaces only.
25.	Reserved	5	204-208	Internal use	Reserved for BCRC internal use; Fill with spaces only.
26.	Reserved	1	209	Internal use	Reserved for BCRC internal use; Fill with spaces only.
27.	Rx Insurer Name	32	210-241	Text	Name of Insurance company providing Prescription Drug coverage. For use with Action Types D and S.
28.	Filler	59	242-300	Filler	Unused field.

D: Header Record

Table 2: D: Header Record

Field	Name	Size	Displacement	Data Type	Description
1.	Header Indicator	2	1-2	Alpha	Should be: ‘H0’
2.	VDSA ID	4	3-6	Numeric	‘0001’, ‘0002’, etc. ID number assigned by BCRC. (Previously labeled as “Plan Number.”)
3.	Benefits Coordination & Recovery Center Number	5	7-11	Numeric	‘11105’
4.	File Type	4	12-15	Alpha	‘NMSI’ – non-MSP input file.
5.	File Date	8	16-23	Numeric	CCYYMMDD

Field	Name	Size	Displacement	Data Type	Description
6.	RDS Application Number	10	24-33	Alpha-Numeric	Retiree Drug Subsidy ID number assigned by the RDS Contractor that is associated with a particular RDS application. When populated this field should contain 10 digits (0-9), right justified with leading positions zero filled. This application number will change each year when a new application is submitted. Required for files containing Action Type S. Fill with spaces for Action Types D and N.
7.	Filler	267	34-300	Filler	Unused Field.

D: Trailer Record

Table 3: D: Trailer Record

Field	Name	Size	Displacement	Data Type	Description
1.	Trailer Indicator	2	1-2	Alpha	Should be: 'T0'
2.	VDSA ID	4	3-6	Numeric	'0001', '0002', etc. ID number assigned by BCRC (previously labeled as "Plan Number").
3.	Contractor Number	5	7-11	Numeric	'11105'
4.	File Type	4	12-15	Alpha	'NMSI' – non-MSP input file.
5.	File Date	8	16-23	Numeric	CCYYMMDD
6.	S Record Count	9	24-32	Numeric	Number of Action Type 'S' records on file.
7.	D Record Count	9	33-41	Numeric	Number of Action Type 'D' records on file.
8.	N Record Count	9	42-50	Numeric	Number of Action Type 'N' records on file.
9.	Total Record Count	9	51-59	Numeric	Number of beneficiary records in this file. Do not include the Header and Trailer Records in the Record Count.

Field	Name	Size	Displacement	Data Type	Description
10.	Filler	241	60-300	Filler	Unused Field.

NOTE: Header and Trailer Records are not to be included when determining the record count for a submission.

E – The Non-MSP Response File. This is the data set transmitted from CMS to the VDSA partner after the information supplied in the partner's Non-MSP Input File has been processed. It consists of the same data elements in the Input File, with corrections applied by CMS, disposition and edit codes which let you know what we did with the record, as well as new information for the partner regarding the covered individuals themselves, such as Medicare program coverage details.

This file format is also used to send you unsolicited response files originating from the RDS contractor. These transmissions from the RDS contractor will notify you that significant data you previously submitted has changed. Unsolicited RDS responses are designated by the "RDSU" file type in Field 4 in the header.

VDSA Attachment E

E: VDSA Non-MSP Response File Layout – 500 bytes

Table 4: VDSA Non-MSP Response File Layout – 500 bytes

Field	Name	Size	Displacement	Description
1.	Filler	4	1-4	BCRC use.
2.	SSN	9	5-13	Beneficiary's SSN. Included for action types D, S, and N. Field will contain either the SSN that matched, or a corrected SSN based on a HICN match.
3.	HIC Number	12	14-25	Beneficiary's Health Insurance Claim Number. Included for action types D, S, and N. Field will contain either the HICN that matched, or a corrected HICN based on an SSN match.
4.	Covered Individual's Surname	6	26-31	Beneficiary's Last Name. Included for action types D, S, and N. Field will contain either the name supplied or corrected name from BCRC database.
5.	Beneficiary First Initial	1	32	Beneficiary's First Initial. Included for action types D, S, and N. Field will contain either the value supplied or corrected value from BCRC database.

Field	Name	Size	Displacement	Description
6.	Beneficiary Middle Initial	1	33	Beneficiary's Middle Initial. Included for action types D, S, and N. Field will contain the value supplied.
7.	Beneficiary Date of Birth	8	34-41	Beneficiary's DOB (CCYYMMDD). Included for action types D, S, and N. Field will contain either the value supplied or a corrected value from BCRC database.
8.	Beneficiary Sex Code	1	42	Beneficiary's Sex: 0 = Unknown 1 = Male 2 = Female Included for action types D, S, and N Field will contain either the value supplied or a corrected value from BCRC database.
9.	Group Health Plan Number	20	43-62	GHP Number assigned by Payer for action type 'D,' or, **Unique Benefit Option Identifier**, as defined by the RDS Center, and assigned by Payer for action type 'S.' Included for action types D and S. Field will contain the value supplied on input.
10.	Individual Policy number	17	63-79	Policy Number. Included for action types D and S. Field will contain the value supplied on input.
11.	Effective Date	8	80-87	Start Date of Beneficiary's Insurance Coverage. (CCYYMMDD). Included for action types D and S. Field will contain the effective date applied to the CWF and/or Drug record.
12.	Termination Date	8	88-95	End Date of Beneficiary's Insurance Coverage. (CCYYMMDD) All zeros if open-ended or non-applicable. Included for action types D and S. Field will contain the term date applied to the CWF and/or Drug record.
13.	National Health Plan ID	10	96-105	National Health Plan Identifier. For action types D and S. (For Future Use).
14.	Rx Insured ID number	20	106-125	Insured's Identification Number. Included for action types D and S. Field will contain the value supplied on input.

Field	Name	Size	Displacement	Description
15.	Rx Group Number	15	126-140	Rx Group Health Plan Number assigned by payer for action type 'D,' or **Unique Benefit Option Identifier** assigned by payer for action type 'S.' Included for action types D and S. Field will contain a value supplied on input.
16.	Rx PCN	10	141-150	Processor Control Number. Included for action types D and S. Field will contain the value supplied on input.
17.	Rx BIN Number	6	151-156	Benefit International Number. Included for action types D and S. Field will contain the value supplied on input.
18.	Rx Toll Free Number	18	157-174	Toll Free Number, with extension. Included for action types D and S. Field will contain the value supplied on input.
19.	Person Code	3	175-177	Person Code the Plan uses to identify specific individuals on a policy. Included for action types D and S. Defaults to '001' for D records if not provided.
20.	Relationship Code	2	178-179	Beneficiary's Relation to active employee: '01' = Beneficiary is Policy Holder '02' = Spouse or Common Law Spouse '03' = Child '04' = Other '20' = Domestic Partner Included for action types D and S. Field will contain a value supplied on input.
21.	Partner Assigned DCN	15	180-194	The Document Control Number assigned by the VDSA partner. Included for action types D, S, and N. Field will contain the value supplied on input.
22.	BCRC DCN	15	195-209	BCRC Document Control Number. Included for action types D, S, and N. Field will contain DCN created for this record by the BCRC.

Field	Name	Size	Displacement	Description
23.	Original Action Type	1	210	Type of Maintenance: ‘D’ = Drug Reporting record ‘S’ = Subsidy Reporting record ‘N’ = Non-Reporting record Included for action types D, S, and N. Field will contain the value supplied on input.
24.	Action Type	1	211	Type of Maintenance; applied by BCRC. (BCRC may change an S Action Type to a D if RDS rejects the record due to Part D enrollment): ‘D’ = Drug Reporting record ‘S’ = Subsidy Reporting record ‘N’ = Non-Reporting record Included for action types D, S and N. BCRC supplied value.
25.	Transaction Type	1	212	Type of Maintenance: ‘0’ = Add Record ‘1’ = Delete record ‘2’ = Update record Included for action types D and S. Field will indicate type of maintenance applied.
26.	Coverage Type	1	213	Type of Coverage: ‘U’ = Drug Only (network Rx) ‘V’ = Drug with Major Medical (non-network Rx) ‘W’ = Comprehensive Coverage - Hosp/Med/Drug (network Rx) ‘X’ = Hospital and Drug (network Rx) ‘Y’ = Medical and Drug (network Rx) ‘Z’ = Health Reimbursement Account. (non-network Rx) ‘4’ = Comprehensive Coverage - Hosp/Med/Drug (non-network Rx) ‘5’ = Hospital and Drug (non-network Rx) ‘6’ = Medical and Drug (non-network Rx) Included for action types D and S. Field will contain value supplied on input.
27.	Filler	1	214	Unused Field.

Field	Name	Size	Displacement	Description
28.	Reason for Medicare Entitlement	1	215	Reason for Medicare Entitlement: 'A' = Aged 'B' = ESRD 'G' = Disabled Included for action types D and N. BCRC supplied value.
29.	S Disposition Code	2	216-217	Result from RDS processing. Included for records submitted with 'S' action types. RDS supplied value converted to VDSA specific S Disposition Code. Refer to Field 54 (RDS Reason Code) for actual RDS Reason Code as supplied by the RDS Center.
30.	S Disposition Date	8	218-225	Date of BENEMSTR/MBD or RDS Result for S disposition code. (CCYYMMDD). Included for records with an original S action types. RDS supplied value.
31.	Current Medicare Part A Effective Date	8	226-233	Effective Date of Part A Medicare Coverage. (CCYYMMDD) Included for all action types. BCRC supplied value.
32.	Current Medicare Part A Termination Date*	8	234-241	Termination Date of Part A Medicare Coverage. (CCYYMMDD). Included for all action types. BCRC supplied value. * All zeros if open-ended or not applicable.
33.	Current Medicare Part B Effective Date	8	242-249	Effective Date of Part B Medicare Coverage. (CCYYMMDD). Included for all action types. BCRC supplied value.
34.	Current Medicare Part B Termination Date*	8	250-257	Termination Date of Part B Medicare Coverage. (CCYYMMDD). Included for all action types. BCRC supplied value. * All zeros if open-ended or not applicable.

Field	Name	Size	Displacement	Description
35.	Part D Eligibility Start Date	8	258-265	Earliest date that beneficiary is **eligible to enroll** in Part D – Refer to Field 42 for the Part D Plan Enrollment Date. (CCYYMMDD). Included for all action types. BCRC supplied value.
36.	Part D Eligibility Stop Date*	8	266-273	Date the Beneficiary is no longer eligible to receive Part D Benefits – Refer to Filed 43 for the Part D Plan Termination Date. (CCYYMMDD). Included for all action types. BCRC supplied value. * All zeros if open-ended or not applicable.
37.	Medicare Beneficiary Date of Death*	8	274-281	Medicare Beneficiary Date of Death (CCYYMMDD). Included for all action types. BCRC supplied value. * All zeros if not applicable.
38.	Current Medicare Part C Plan Contractor Number	5	282-286	Contractor Number of the current Part C Plan in which the beneficiary is enrolled. Included for all action types. BCRC supplied value.
39.	Current Medicare Part C Plan Enrollment Date	8	287-294	Effective Date of coverage provided by the Beneficiary's current Medicare Part C Plan. (CCYYMMDD). Included for all action types. BCRC supplied value.
40.	Current Medicare Part C Plan Termination Date*	8	295-302	Termination Date of the coverage provided by the Beneficiary's current Medicare Part C Plan. Included for all action types. BCRC supplied value. * All zeros if open-ended or not applicable.
41.	Current Medicare Part D Plan Contractor Number	5	303-307	Contractor Number of the current Medicare Part D Plan in which the Beneficiary is enrolled. Included for all action types.

Field	Name	Size	Displacement	Description
42.	Current Medicare Part D Plan Enrollment Date	8	308-315	Effective Date of coverage provided by the Current Medicare Part D Plan. (CCYYMMDD). Included for all action types. BCRC supplied value.
43.	Current Medicare Part D Plan Termination Date*	8	316-323	Termination Date of coverage provided by the current Medicare Part D Plan. (CCYYMMDD) Included for all action types. BCRC supplied value. * All zeros if open-ended or not applicable.
44.	Error Code 1	4	324-327	Error Code 1 – Contains SP or RX error codes from COC or RDS processing if applicable. COB supplied value for D/N records. RDS supplied value for S records.
45.	Error Code 2	4	328-331	Error Code 2 – Contains SP or RX error codes from COB or RDS processing if applicable. COB supplied value for D/N records. RDS supplied value for S records.
46.	Error Code 3	4	332-335	Error Code 3 – May contain SP or RX error codes from COB or RDS processing if applicable. COB supplied value for D/N records. RDS supplied value for S records.
47.	Error Code 4	4	336-339	Error Code 4 – May contain SP or RX error codes from COB or RDS processing if applicable. COB supplied value for D/N records. RDS supplied value for S records.
48.	D/N Disposition Code	2	340-341	Result from processing of an action type D or N record. This will also be used to provide a disposition for D records converted from S records – in such case, the S disposition (Field 30) will also be populated. Code supplied by the COB.
49.	D/N Disposition Date	8	342-349	Processing date associated with the D/N disposition code. (CCYYMMDD) Supplied by the COB.
50.	RDS Start Date	8	350-357	Start date for subsidy period. RDS supplied value.

Field	Name	Size	Displacement	Description
51.	RDS End Date	8	358-365	End date for subsidy period. RDS supplied value.
52.	RDS Split Indicator	1	366	Indicates multiple subsidy periods within the plan year. Expect multiple records. Values: 'Y' if applicable. Space if not-applicable. RDS supplied value.
53.	RDS Reason Code*	2	367-368	Spaces = Accepted 01=Application deadline missed 02=Invalid application number 03=Invalid Last Name 04=Invalid First Name 05=Invalid Date of Birth 06=Invalid Gender 07=Invalid Coverage Effective date 08= Invalid coverage termination date 09= Invalid benefit option identifier 10= Enrolled in Part D 11= Not eligible for Medicare 12= Beneficiary is deceased 13= Invalid HICN or SSN 14=Termination date less than Effective date 15= Missing Trailer record 16= Not a valid Medicare Beneficiary 17= No coverage period exists for delete transaction 18= Invalid action type 19= Invalid relationship code 20= Beneficiary attempted to enroll in Part D and received an initial rejection. 21= New Medicare information has been received – resend record. *RDS Center supplied codes.
54.	RDS Determination Indicator	1	369	Y = Yes, the retiree qualifies for the RDS subsidy. N = No, the retiree does not qualify for the RDS subsidy. Partner may not always receive this indicator. RDS supplied value.

Field	Name	Size	Displacement	Description
55.	ESRD Coverage Period Effective Date	8	370-377	The date on which the beneficiary is entitled to Medicare in any part because of a diagnosis of End Stage Renal Disease. (CCYYMMDD) Last coverage period will be reported if multiple coverage periods exist.
56.	ESRD Coverage Period Term Date	8	378-385	The date on which the beneficiary is no longer entitled to Medicare under ESRD Provisions (CCYYMMDD) The last coverage period will be reported if multiple coverage periods exist.
57.	First Dialysis Date	8	386-393	The date the beneficiary first started ESRD Dialysis (CCYYMMDD)
58.	ESRD Self-Training Date	8	394-401	A date indicating when the beneficiary participated in ESRD Self Care Training. (CCYYMMDD)
59.	Transplant Date	8	402-409	A date indicating when a Kidney Transplant Operation Occurred. (CCYYMMDD) The latest occurrence will be reported.
60.	Transplant Failure Date	8	410-417	A date that indicates when a Kidney Transplant failed. (CCYYMMDD) The latest occurrence will be reported.
61.	Filler	83	418-500	Unused Field. Filled with spaces.

E: Header Record

Table 5: E: Header Record

Field	Name	Size	Displacement	Description
1.	Header Indicator	2	1-2	Should be: ‘H0’
2.	VDSA ID	4	3-6	‘0001’, ‘0002’, etc. ID number assigned by BCRC. (Previously labeled as “Plan Number.”) Field will contain value supplied on input.
3.	Contractor Number	5	7-11	‘11105’ Field will contain value supplied on input.
4.	File Type	4	12-15	‘NMSR’ – Non-MSP Response file. ‘RDSU’ – Unsolicited RDS Response file.

Field	Name	Size	Displacement	Description
5.	File Date	8	16-23	CCYYMMDD BCRC supplied.
6.	RDS Application Number	10	24-33	Retiree Drug Subsidy ID number assigned by the RDS contractor that is associated with a particular RDS application. This application number will change each year when a new application is submitted. Required for files containing action type S. Field will contain spaces for action types D and N. Field will contain value supplied on input.
7.	Filler	467	34-500	Unused Field. Space filled.

E: Trailer Record

Table 6: E: Trailer Record

Field	Name	Size	Displacement	Description
1.	Trailer Indicator	2	1-2	Should be: 'T0'
2.	VDSA ID	4	3-6	'0001', '0002', etc. ID number assigned by BCRC. (Previously labeled as "Plan Number.") Field will contain value supplied on input.
3.	Contractor Number	5	7-11	'11105' Field will contain value supplied on input.
4.	File Type	4	12-15	'NMSR' – non-MSP response file. Field will contain value supplied on input.
5.	File Date	8	16-23	CCYYMMDD BCRC supplied.
6.	Record Count	9	24-32	Number of beneficiary records in this file. BCRC Supplied.
7.	Filler	468	33-500	Unused Field. Space filled.

II. The Query Only HEW Input and Response File Layouts

F – The Query Only HIPAA Eligibility Wrapper (HEW) Input File. This is a Non-MSP File that is not accompanied by information about drug coverage – it only serves as a query file regarding Medicare entitlement of potential Medicare beneficiaries. If the partner does not use the Non-MSP Input file to report either prescription drug coverage secondary to Medicare, or retiree prescription drug coverage, the partner must use the HIPAA Eligibility Wrapper (HEW) software (provided by CMS) to submit a Query Only HEW Input File. Using this HEW software, the VDSA partner will translate ("wrap") the Non-MSP File into a HIPAA-compliant 270 eligibility query file format.

VDSA Attachment F

F: VDSA Query Only Input File Layout

Table 7: VDSA Query Only Input File Layout

Field	Name	Size	Displacement	Description
1.	HIC Number	12	1-12	Medicare Health Insurance Claim Number (if available).
2.	Surname	6	13-18	Surname of Covered Individual.
3.	First Initial	1	19-19	First Initial of Covered Individual.
4.	DOB	8	20-27	Covered Individual's Date of Birth. (CCYYMMDD)
5.	Sex Code	1	28-28	Covered Individual's Sex: 0 = Unknown 1 = Male 2 = Female
6.	SSN	9	29-37	Social Security Number of the Covered Individual.
7.	Filler	1	38	Filler.

F: Header Record

Table 8: F: Header Record

Field	Name	Size	Displacement	Description
1.	Header Indicator	2	1-2	Should be: 'HO'
2.	VDSA ID	4	3-6	'0001', '0002', etc. ID number assigned by BCRC (previously known as "Plan Number").
3.	Contractor Number	5	7-11	'11105'

Field	Name	Size	Displacement	Description
4.	File Type	4	12-15	‘IACT’ – Inactive.
5.	Cycle Date	8	16-23	File date 'CCYYMMDD'
6.	Filler	15	24-38	Unused Field.

F: Trailer Record

Table 9: F: Trailer Record

Field	Name	Size	Displacement	Description
1.	Trailer Indicator	2	1-2	Should be: ‘TO’
2.	VDSA ID	4	3-6	‘0001’, ‘0002’, etc. ID number assigned by BCRC (previously known as “Plan Number”).
3.	Contractor Number	5	7-11	‘11105’
4.	File Type	4	12-15	‘IACT’ – Inactive.
5.	Cycle Date	8	16-23	File date ‘CCYYMMDD’
6.	Record Count	9	24-32	Number of individual query records in this file. Do not include the Header and Trailer Records in the Record Count.
7.	Filler	6	33-38	Unused Field.

NOTE: Header and Trailer Records are not to be included when determining the record count for a submission.

G – The Query Only HIPAA Eligibility Wrapper (HEW) Response File. After CMS has processed the Query Only Input File it will return it to the VDSA partner as a Query Only Response File. The same CMS-supplied software that “wrapped” the Input File will now “unwrap” the Response file, so that it is converted from a HIPAA -compliant 271 eligibility response file format into the Query Only HEW Response File for the partner’s use.

NOTE: This response file does not have a header or trailer.

VDSA Attachment G

G: VDSA Query Only Response File Layout

Table 10: VDSA Query Only Response File Layout

Field	Name	Size	Displacement	Description
1.	HIC Number	12	1-12	Medicare Health Insurance Claim Number.
2.	Surname	6	13-18	Surname of Covered Individual.
3.	First Initial	1	19-19	First Initial of Covered Individual.
4.	DOB	8	20-27	Covered Individual's Date of Birth. (CCYYMMDD)
5.	Sex Code	1	28-28	Covered Individual's Sex: 0 = Unknown 1 = Male 2 = Female
6.	SSN	9	29-37	Social Security Number of the Covered Individual.
7.	Entitlement Reason (Medicare reason)	1	38	Reason for Medicare Entitlement: A = Working Age B = ESRD G = Disabled
8.	Current Medicare Part A Effective Date	8	39-46	Effective Date of Medicare Part A Coverage. (CCYYMMDD)
9.	Current Medicare Part A Termination Date*	8	47-54	Termination Date of Medicare Part A Coverage. (CCYYMMDD) * Blank if ongoing.
10.	Current Medicare Part B Effective Date	8	55-62	Effective Date of Medicare Part B Coverage. (CCYYMMDD)
11.	Current Medicare Part B Termination Date*	8	63-70	Termination Date of Medicare Part B Coverage. (CCYYMMDD) *Blank if ongoing.
12.	Medicare Beneficiary Date of Death	8	71-78	Beneficiary Date of Death. (CCYYMMDD)

Field	Name	Size	Displacement	Description
13.	Current Medicare Part C Plan Contractor Number	5	79-83	Contractor Number of the current Part C Plan in which the beneficiary is enrolled. BCRC supplied value.
14.	Current Medicare Part C Plan Enrollment Date	8	84-91	Effective Date of coverage provided by the beneficiary's current Medicare Part C Plan. (CCYYMMDD)
15.	Current Medicare Part C Plan Termination Date*	8	92-99	Termination Date of the coverage provided by the beneficiary's current Medicare Part C Plan. (CCYYMMDD) *Blank if ongoing.
16.	Disposition Code	2	100-101	01 = Record Accepted. Beneficiary is on File on CMS System. 51 = Beneficiary is not in File on file in CMS System.
17.	CMS Document Control Number	15	102-116	VDSA ID (102-105), Julian Date (106-110), Sequence Counter (111-116).

III. The VDSA Business Rules

The information following describes the data review process used by the BCRC. These are the Business Rules for the four primary Input and Response files. They also apply, by extension, to the Query Only HEW Input files. No Business Rules are needed for the Implementation Questionnaire.

Conventions for Describing Data Values

The table below defines the data types used by BCRC for their external interfaces (inbound and outbound). The formatting standard defined for each data type corresponds to the data type identified for each field within the interface layout. This key is provided to assist in understanding the rules behind the formatting of the data values in the layout fields.

Table 11: Data Type Key. Data Types used by BCRC for their External Interfaces (Inbound and Outbound)

Data Type/Field	Formatting Standard	Examples
Numeric	Zero through 9 (0 to 9) Padded with leading zeroes	Numeric (5): "12345" Numeric (5): "00045"
Alpha	A through Z Left justified Non-populated bytes padded with spaces	Alpha (12): "TEST EXAMPLE" Alpha (12): "EXAMPLE "
Alpha-Numeric	A through Z (all alpha) + 0 through 9 (all numeric) Left justified Non-populated bytes padded with spaces	Alphanum (8): "AB55823D" Alphanum (8): "MM221 "
Text	A through Z (all alpha) + 0 through 9 (all numeric) + special characters: Comma (,) Ampersand (&) Space ( ) Dash (-) Period (.) Single quote (') Colon (:) Semicolon (;) Number (#) Forward slash (/) At sign (@) Left justified Non-populated bytes padded with spaces	Text (8): "AB55823D" Text (8): "XX299Y " Text (18): "ADDRESS@DOMAIN.COM" Text (12): " 800-555-1234" Text (12): "#34 "
Date	Format is field specific Fill with all zeroes if empty (no spaces are permitted)	CCYYMMDD (e.g. "19991022") Open ended date: "00000000"
Filler	Populate with spaces	Populate with spaces
Internal Use	Populate with spaces	Populate with spaces

VDSA Processing: CMS System Requirements

Existing VDSA (Voluntary Data Sharing Agreement) Requirements that apply to the new MSP and Non-MSP files have been modified to assure that data from all VDSA partners is processed consistently.

- The System shall be able to receive an external file from a VDSA partner. The System shall be able to confirm the external VDSA partner file format.
- The System shall be able to match the valid VDSA partner external file to the Eligibility Database.
- The System shall be able to update a CMS record based on differences found between a valid VDSA partner external file and the Eligibility Database.
- The System shall display error descriptions in CHAPS for severe errors identified on BCBS and VDSA files.

New Non-MSP Processing Requirements

- The System shall accept a non-MSP record from a VDSA for reporting of other drug coverage.
- The System shall edit drug records received on the VDSA non-MSP file for the presence of mandatory fields.
- The System shall match drug records received on the VDSA non-MSP file against the drug coverage database.
- The System shall apply RX error codes generated by the BCRC to invalid non-MSP drug records to return them on the Non-MSP Response file.
- The System shall forward validated VDSA non-MSP drug records to MBD.
- The System shall notify VDSA submitters on the Non-MSP Response File of the disposition of supplemental drug records provided.
- The System shall accept lower case characters on a Non-MSP Input File in text fields.
- The System shall forward unsolicited subsidy record updates from RDS to VDSA partners.

Methodological Description

Introduction

The scope of the VDSA process was expanded to include the reporting of prescription drug coverage information to CMS. VDSA partners are now able to report drug coverage that is supplemental to Medicare.

In order to provide a means for participants in VDSAs to report prescription drug coverage to the BCRC, input and response file formats have been developed that include fields for prescription drug plan information about active and inactive beneficiaries.

The old **inactive file** format has been renamed the **Non-MSP File**. VDSA participants are able to report prescription drug coverage information and inquire on beneficiary entitlement status on the Non-MSP File.

Only partners submitting D records may use the Non-MSP File for "N" queries. Those not submitting D records (that is, those wishing to submit nothing but a Non-MSP "N" record) must continue to use the Query Only HEW Input File and accompanying HEW software.

Error Codes

Following is an introduction to the subject of Error Code Reporting in both the MSP and Non-MSP Response Files. A comprehensive listing of all error codes that a partner may encounter can be found in Section IV, The Complete Disposition and Edit Code List. **All D – Non-MSP Only Input filed submitters are to ignore references to MSP reporting.**

Most error reporting can be avoided by completing required fields on the Input File. Required fields include the Surname of Covered Individual, First Initial, Date of Birth, Sex code, a DCN assigned by the VDSA partner, Transaction Type, Coverage Type, Individual's SSN, Effective Date, and Termination Date.

For Non-MSP drug record processing, the BCRC will need to apply error checks and supply the results to the VDSA partner in the response file. The SP errors that will specifically apply for drug records are as follows:

Table 12: SP Errors that specifically apply for Drug Records

Error Code	Description
SP 12	Invalid HIC Number or SSN. At least one of the fields must contain alpha or numeric characters. Both fields cannot be blank or contain spaces.
SP 13	Invalid Beneficiary Surname. Field must contain alpha characters. Field cannot be blank, contain spaces or numeric characters.
SP 14	Invalid Beneficiary First Name Initial. Field must contain alpha characters. Field cannot be blank, contain spaces, numeric characters or punctuation marks.
SP 15	Invalid Beneficiary Date of Birth. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Day of the month must be correct. For example, if month = 02 and date = 30, the record will reject.
SP 16	Invalid Beneficiary Sex Code. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Acceptable numeric characters include the following: 1 = Male 2 = Female
SP 19	Invalid Transaction Type. Field must contain numeric characters. Field cannot be blank, contain alpha characters or spaces. Acceptable numeric characters include the following: 0 = Add Record 1 = Delete Record 2 = Update Record

Error Code	Description
SP 24	Invalid Coverage Type. Field may contain alpha or numeric characters. Field cannot be blank. Valid values are: A, J, K, U, V, W, X, Y, Z, 4, 5, 6 for MSP layout U, V, W, X, Y and Z for Non-MSP layout
SP 31	Invalid Effective Date. Field must contain numeric characters. Field cannot be blank, contain spaces, alpha characters or all zeros. Number of days must correspond with the particular month.
SP 32	Invalid MSP Termination Date. Field must contain numeric characters. Date must correspond with the particular month – CCYYMMDD. For example, 02/27/1997 is acceptable, but not 02/30/1997. Cannot be earlier than the MSP effective date. If there is no termination date (coverage is still active), must use zeros (not spaces) in this field.
SP 34	Invalid Subscriber First Name. Field may contain alpha characters. If field is not used, field must contain spaces. Field cannot be blank or contain numeric characters. Only alpha characters used when subscriber is identified.
SP 35	Invalid Subscriber Last Name. Field may contain alpha characters. If field is not used, field must contain spaces. Field cannot be blank or contain numeric characters. May use spaces instead of apostrophe. Only alpha characters may be used when subscriber is identified.
SP 49	No valid record exists for delete request. Attempt to delete a nonexistent MSP will cause a reject.
SP 52	Invalid patient relationship code
SP 62	Incoming termination date is less than effective date. MSP termination date must be greater than the effective date.

Additionally, the BCRC will provide RX-specific error codes:

Table 13: BCRC Provided RX-Specific Error Codes

Error Code	Description
RX 01	Missing RX ID
RX 02	Missing RX BIN
RX 03	Missing RX Group Number
RX 04	Missing Group Policy Number
RX 05	Missing Individual Policy Number
RX 06	Missing/Invalid Retiree Drug Subsidy Application Number
RX 07	Beneficiary does not have Part D enrollment
RX 09	Invalid action code
RX 10	Record not found for delete
RX 11	Record not found for update

Error Code	Description
RX 12	Invalid Supplemental Type

Non-MSP Processing

VDSA partners can use the new non-MSP record layout for three purposes. They are identified on the input record by action type:

- Drug Coverage Reporting (D) – To allow reporting of other drug coverage to MBD for TrOOP to utilize.
- Non-Reporting (N) – To determine entitlement to Medicare.

An Action Type of D or N will always be required to determine the purpose of the submission.

For Non-Reporting records the following fields are required in addition to action type:

- HICN or SSN
- Surname
- First initial
- Date of birth
- Sex

(DCN and middle initial can be populated if available.)

When a non-MSP 'D' record is received with a coverage type that indicates there is prescription drug coverage (U, V, W, X, Y, Z, 4, 5, 6), the BCRC will attempt to create an RX transaction. The record will go through the beneficiary matching process first to establish that beneficiary data is valid. Records that aren't matched with an active beneficiary will be rejected by the BCRC system.

The drug record will be compared to the BCRC's existing drug coverage table for matches for HICN, effective date, patient relationship, coverage type, and VDSA ID. If these fields all match the record will the considered an update. Otherwise the record will be added to the data table and forwarded to MDB.

Business Rules

Non-MSP Processing

1. Action type will be required on all non-MSP records.
2. Required fields for non-Reporting records are HICN or SSN, surname, first initial, date of birth, and sex. DCN and middle initial can be populated if available.
3. Required fields for drug records are HICN or SSN, surname, first initial, date of birth, sex, effective date, relationship code, transaction type, and coverage type plus Policy number for coverage type 'V, Z, 4, 5, or 6'. Rx ID and RxBIN are required for coverage type 'U, W X, or Y.' DCN, middle initial, termination date, RxPCN, Rx Group ID and person code should be provided if available.

4. Only other drug records for current beneficiaries will be sent to MBD.
5. BCRC will not send incomplete other drug records to MBD.
6. Although lower case characters will be accepted in the non-MSP file, the text in the response file will be returned in upper case since the BCRC will need to convert the text to upper case in order to process the file.
7. BCRC will zero fill termination date fields instead of leaving the field blank for open -ended coverage or where the date is not applicable.
8. Drug records passed to the Drug Engine from the VDSA non-MSP files will include an indicator that the coverage is supplemental coverage.
9. BCRC will add all the entitlement information that is available (Part A, B and D) into all the response records regardless of whether the submitted record was a D or N.
10. BCRC will pass the split indicator to the VDSA partner on the response.
11. In cases were a split indicator is used, the BCRC will include the entitlement information in both records. Each record will contain its individual status and errors if applicable.
12. Drug coverages sent on the non-MSP file will be sent to MBD using the plan dates submitted.
13. Drug coverages sent on the non-MSP file will be sent to MBD for matched beneficiaries that have a Part D enrollment date.

IV. The Complete Disposition and SP Edit Code List

For your reference, we are including the codes that constitute the complete set of Disposition and SP Edits. These are all the edit and disposition codes that the Centers for Medicare & Medicaid Services (CMS) may use in an Update File Response forwarded to an Agreeing Partner. Subsets are shown elsewhere in the business rules, above.

Keep in mind that not all these codes will apply to all response files you can receive from the Benefits Coordination & Recovery Center (BCRC). Please contact the BCRC if you have questions about any of the Disposition or SP Edit codes.

NOTES: Codes marked with an asterisk (*) are "front end" consistency edits. These codes show conditions on the face of the record that are unrecognizable or unallowable for that field (e.g., the field requires numeric characters but the submitted record contains alpha characters).

Codes that do not have an asterisk (*) show discrepancies that result from information on the submitted record conflicting with or not matching the information on CMS's Systems.

DISPOSITION AND SP EDIT CODE LIST

Table 14: Disposition Codes CMS May Use in an Update File Response Forwarded to an Agreeing Partner

Disposition Code	Description
01	Record accepted by Common Working File (CWF) as an "Add" or a "Change" record.
SP	Transactions edit; record returned with at least one SP or RX edit (specific SP and RX edits are described below).
50	Record still being processed by CMS. Internal CMS use only; **no Agreeing Partner action is required.**
51	Beneficiary is not in file on CMS System. Record will not be recycled. Beneficiary most likely not entitled to Medicare. **Agreeing Partner should re-verify beneficiary status based on information in its files**.
52	Record still being processed by CMS. Internal CMS use only; **no Agreeing Partner action is required.**
53	Record in alpha match at CMS. Internal CMS use only; **no Agreeing Partner action is required.**
55	Name/Personal Characteristic Mismatch. Name or personal characteristic of beneficiary does not match the Health Insurance Claim Number (HICN) on Medicare's files**. Agreeing Partner** needs to re-verify name, HICN, date of birth and sex based on information in its files; then resubmit on next exchange file.
61	Cross-Reference Data Base Problem. Internal CMS use only**; no Agreeing Partner action is required.**
AB	CWF problem that can only be resolved by CWF Technician. Internal CMS use only; **no Agreeing Partner action is required**.

Disposition Code	Description
CI	Processing Error. Internal CMS use only; **no Agreeing Partner action is required.**
ID	Drug Record Processing Error. Internal CMS use only; **no Agreeing Partner action is required.** Partner should re-submit record on next file.

Drug Records

For Non-MSP drug processing, the BCRC will apply error checks and provide the results to the Partner in the response file. The SP edits that would be generated as a result of errors on drug records are as follows:

Table 15: SP Edits that Would be Generated as a Result of Errors on Drug Records

Error Code	Description
*SP 12	Invalid HIC Number. Field must contain alpha or numeric characters. Field cannot be blank or contain spaces.
*SP 13	Invalid Beneficiary Surname. Field must contain alpha characters. Field cannot be blank, contain spaces or numeric characters.
*SP 14	Invalid Beneficiary First Name Initial. Field must contain alpha characters. Field cannot be blank, contain spaces, numeric characters or punctuation marks.
*SP 15	Invalid Beneficiary Date of Birth. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Day of the month must be correct. For example, if month = 02 and date = 30, the record will reject.
*SP 16	Invalid Beneficiary Sex Code. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Acceptable numeric characters include the following: 1 = Male 2 = Female
*SP 19	Invalid Transaction Type. Field must contain numeric characters. Field cannot be blank, contain alpha characters or spaces. Acceptable numeric characters include the following: 0 = Add Record 1 = Delete Record 2 = Update Record
*SP 24	Invalid Coverage Type. Field may contain alpha or numeric characters. Field cannot be blank. Applicable values are: A, J, K, U, V, W, X, Y, Z, 4, 5, 6 for MSP layout; U, V, W, X, Y, Z, 4, 5, 6 for Non-MSP layout.
*SP 31	Invalid Effective Date. Field must contain numeric characters. Field cannot be blank, contain spaces, alpha characters or all zeros. Number of days must correspond with the particular month.

Error Code	Description
*SP 32	Invalid MSP Termination Date. Field must contain numeric characters. Date must correspond with the particular month – CCYYMMDD. For example, 02/27/1997 is acceptable, but not 02/30/1997. Cannot be earlier than the MSP effective date. If there is no termination date (coverage is still active), must use zeros (not spaces) in this field.
*SP 34	Invalid Subscriber First Name. Field may contain alpha characters. If field is not used, field must contain spaces. Field cannot be blank or contain numeric characters. Only alpha characters used when subscriber is identified.
*SP 35	Invalid Subscriber Last Name. Field may contain alpha characters. If field is not used, field must contain spaces. Field cannot be blank or contain numeric characters. May use spaces instead of apostrophe. Only alpha characters may be used when subscriber is identified.
SP 49	No valid record exists for delete request. Attempt to delete a nonexistent MSP record will cause a reject.
*SP 52	Invalid patient relationship code
SP 62	Incoming termination date is less than effective date. MSP termination date must be greater than the effective date.

Additionally, the BCRC will provide specific RX coding errors:

Table 16: BCRC-Provided Specific RX Coding Errors

Error Code	Description
*RX 01	Missing RX ID
*RX 02	Missing RX BIN
*RX 03	Missing RX Group Number
*RX 04	Missing Group Policy Number
*RX 05	Missing Individual Policy Number
*RX 06	Missing or Invalid Retiree Drug Subsidy Application Number
*RX 07	Beneficiary does not have Part D enrollment
*RX 09	Invalid action code
*RX 10	Record not found for delete
*RX 11	Record not found for update
*RX 12	Invalid Supplemental Type

NOTES: Codes marked with an asterisk (*) are "front end" consistency edits. These codes show conditions on the face of the record that are unrecognizable or unallowable for that field.

Codes that do not have an asterisk (*) show discrepancies that result from information on the submitted record conflicting with or not matching the information on CMS's Systems.

V. The VDSA Implementation Questionnaire

The VDSA Implementation Questionnaire is not a file layout like those above. Instead, the Implementation Questionnaire is a document to be filled out by the VDSA partner that provides information to be used to assure both the VDSA partner and CMS that agreement on essential operational questions has been reached. **VDSA partners must complete and return a copy of this document to CMS with their signed VDSA**. The VDSA Implementation Questionnaire is available from CMS.

SECTION C: WORKING WITH THE DATA

I. The Distinction between Part D Eligibility and Part D Enrollment

In your response files you will get information about beneficiary Part D eligibility and Part D enrollment. We know that the distinction between an individual's benefit eligibility and benefit **enrollment** can be confusing. While it sometimes appears that the two terms are used interchangeably, for CMS they have very different and distinct meanings.

Once an individual is a Medicare beneficiary, he or she is then eligible to participate in Medicare's benefit programs, including Part D. Usually, the Medicare beneficiary can choose to participate, and if he or she does, the first day the beneficiary's participation is effective is **the date of enrollment** in the benefit program. For example, individuals who have aged into Medicare Part A are then eligible to enroll in Medicare Parts B and D, if they so choose. Once an application for enrollment is accepted, the beneficiary's effective date of enrollment is determined.

In summary, an eligible Medicare beneficiary may participate in Medicare program benefits beginning on his or her date of enrollment in the benefit program. For beneficiaries who choose to participate in the Part D program, the date of enrollment is, usually, the first day of the following month.

In the VDSA Response Files there are five related fields that can have information about current Medicare Part D eligibility and enrollment.

Part D Eligibility Start Date. This will be the first date a Medicare beneficiary has the right to enroll in Part D. It is almost always the effective date of coverage for the beneficiary's Part A or Part B participation. Information in this data field does not show that a beneficiary has enrolled in Part D. It simply gives the date the beneficiary became eligible to enroll. It is Field 35 in the Non-MSP Response File.

Part D Eligibility Stop Date. This is the date that a Medicare beneficiary has lost the right to enroll in Part D, for any reason. It is Field 36 in the Non-MSP Response File.

Current Medicare Part D Enrollment Date. This is the effective date of a Medicare beneficiary's most recent enrollment in Part D. It is the current first date the beneficiary can receive Part D benefit coverage. It is Field 42 in the Non-MSP Response File.

The beneficiary's current Part D Plan is identified in **Current Medicare Part D Plan Contractor Number**. It is Field 41 in the Non-MSP Response File.

Current Medicare Part D Plan Termination Date. This is the last date a Medicare beneficiary can receive Part D benefit coverage from the beneficiary's current Part D provider. After this date the beneficiary is no longer enrolled, and can no longer receive benefit coverage from the (most recent former) Part D plan. It is Field 59 in the MSP Response File; Field 43 in the Non-MSP Response File.

Non-MSP Fields 42 and 43 tell you whether a beneficiary has actually chosen Part D coverage, and the period of time the current benefit coverage is in force. For most VDSA partners, on a routine basis these two fields are the most immediate Indicators of Part D coverage.

II. Establishing Electronic Data Exchange

A number of methods of electronic data transmission are available when a partner is ready to exchange files with the Benefits Coordination & Recovery Center (BCRC) in test or production modes. Following is an overview of the most common. The Partner's assigned Electronic Data Interchange Representative (EDI Rep) at the BCRC will address a Partner's specific questions and concerns. Data exchange using hard media (e.g., CD) is not permitted.

CMS' preferred method of electronic transmission is Connect:Direct (formerly known as Network Data Mover [NDM]). This system provides a direct file transmission connection to the BCRC mainframe using the CMS Extranet Network and CMS's private CMSNet. Use of either SNA or TCP/IP is available to submitters connected to Connect:Direct.

In addition, CMS has available two secure Internet transmission options. We recommend either of these options for Partners that anticipate having a relatively low volume of data transmissions, and that might find it is a burden to secure a Connect:Direct connection

- SFTP: Using SFTP permits automated data transmission and management. A Partner may use any SFTP client as long as it is SSH v2 capable.
- HTTPS: There is no additional cost associated with using this method as long as the Internet Explorer browser is used. However, use of HTTPS does not permit automated data management.

If a Partner is contemplating a method of data transmission that has not been discussed above, the Partner will need to establish specific alternative data transmission procedures with the BCRC.

Establishing Connect: Direct Connectivity with the BCRC

Electronic submitters that currently do not have an existing Connect: Direct account and plan to send and receive information using this telecommunications link should contact the BCRC as early as possible in order to quickly comply with the BCRC's technical requirements.

III. Testing the Data Exchange Process

Overview: Before transmitting its first "live" (full production) input file to CMS, the partner and CMS will thoroughly test the file transfer process. Prior to submitting its initial Non-MSP Input Files, the partner will submit a test initial Non-MSP Input File to

CMS. CMS will return a test initial Non-MSP Response File. CMS will correct errors identified by CMS in the partner's test files. Testing will be completed when the partner adds new enrollees in test update Non-MSP Input Files, CMS clears these transmissions, and the partner and CMS agree all testing has been satisfactorily completed.

Details: The partner and CMS will begin testing as soon as possible, but no later than one hundred and eighty (180) days after the date the VDSA is in force. The population size of a test file will not exceed 1000 records. All administrative and technical arrangements for sending and receiving test files will be made during the "Preparatory Period" (see "Terms and Conditions," Section A, of the VDSA).

Testing Non-MSP records: The test file record layouts used will be the regular non-MSP record layouts. Data provided in test files will be kept in a test environment, and will not be used to update CMS databases. Upon completion of its review of a test file, CMS will provide the partner with a response for every record found on it, usually within week, but no longer than forty-five (45) days after receipt of the test file. After receiving the test Response File in return, the partner will take the steps necessary to correct the problems that were reported on it.

In order to test the process for creating an Update File, a test "Update" shall be prepared by the partner, to include data regarding individuals identified in the Test File. The partner shall submit the test Update, and an updated TIN test Reference File, within ninety (90) days after receipt of the test Response File. The test Update File shall also include an agreed upon number of newly reported Covered Individuals ("adds") that were previously sent to the partner, previously Covered Individuals who have become Medicare eligible as reported by CMS in its Response File to the Test File ("adds"), and deletions for individuals who were erroneously included on the Test File ("deletes"). Upon completion of its review of the test update, CMS shall provide to the partner a Response for every record found on the Test Update File. CMS shall provide a test Update Response File to the partner, usually within with a week, but no longer than forty-five (45) days after receipt of the partner's Test Update File.

After all file transmission testing has been completed to the satisfaction of both the VDSA partner and CMS, the partner may begin submitting its regular production files to CMS, in accordance with the provisions of Sections B through E of the VDSA.

Testing Non-MSP Query Only HEW Files: The partner will provide CMS a test file of the data elements in Attachment F, the Non-MSP Query Only HEW Input File. The HIPAA mandates that partners must be able to transmit and receive HEW "wrapped" Query Only files following the HIPAA 270/271 (Health Care Medicare Entitlement/Benefit Inquiry and Information Response) transaction code set rule and standards. See Section A, II above for more details regarding HEW wrapped files.

The Query Only HEW Input Test File shall contain a maximum of 1000 records of actual data on Covered Individuals. The Test File will allow CMS to review the data prior to receiving the partner's first Covered Individual File submission and identify any defects. The partner will provide this Test File to CMS as soon as possible, but no later than one hundred and eighty (180) days after the date the VDSA is in force.

After processing the Test File, CMS will provide to the partner a Response File identifying those Covered Individuals that have Medicare coverage, and those Individuals not found in the database. CMS will return the Response File to the partner within forty-five (45) days of receipt of the Test File. CMS has the right to request that the partner submit another Non-MSP Query Only HEW Input Test File if CMS finds it necessary. After both the partner and CMS are satisfied with the results of the testing, the partner may begin submitting regular production files to CMS, in accordance with the provisions of Section D, 4 of the VDSA.

IV. Transaction Types: Definitions of "Add," "Update" And "Delete"

From time to time a VDSA partner will have to update non-MSP information it has previously supplied to CMS. To make any such changes the partner will use the Non-MSP Input File (see Section I, A).

- There are two important conditions that apply throughout this section:
- The only record “Action Type” that will **never** have an “Add,” “Update,” or “Delete” Transaction Type applied to it is an ‘N’ Record.
- Files submitted subsequent to the first production files (the initial Input Files) are deemed Update Files.

Add: An Add is a new data set. It is a new record of coverage information the partner gives CMS that CMS has never posted to its database. The Update File is used to “add” an individual to a CMS database.

Example: Information about Mr. John Jones was included on a previous Update File as an "add," but the partner did not include enough of Mr. Jones’ required personal identification data elements. CMS could not determine whether the name and SSN submitted belonged to a Medicare beneficiary, and so this attempt to add Mr. Jones was rejected. With its next Update File, the partner resubmits Mr. John Jones’ information (in an “Add” record) and now includes enough data elements for CMS to confirm that he is a beneficiary. NOTE: If rejected again, the record would continue to be submitted as an "add" until a), the partner received a response file from CMS indicating the individual is a Medicare beneficiary or ‘b’), the individual no longer satisfies the definition of Active Covered Individual.

Update: A change to a subset of the existing data in a Covered Individual’s record that has already been posted to CMS. An Update changes current information about an individual that is already in a CMS database.

Example: The partner provided CMS an "add" record for Mr. John Smith that was accepted by CMS. However, the partner did not originally include some of the non-required data elements such as the "Rx Toll-free Number." The partner subsequently obtains the Rx Toll-free Number for Mr. Smith’s record and resubmits the original record with the additional information to CMS. This information would be noted as an “update” Transaction Type on the record.

Delete: Removal of a record that was erroneously sent to and subsequently processed by CMS. A Delete removes all information about an individual from an existing CMS database.

Example: A record was previously sent to CMS stating that a GHP was a primary payer based on current employment status. Recently the partner discovered that the individual did not have current employment status and that Medicare should have been a primary payer. The partner sends this information in the next update tape and CMS "deletes" the incorrect record from its files.

Matching Partner Data with CMS Data: To add a new beneficiary record, or change one that already exists, certain data elements supplied by the VDSA partner must match data CMS already has.

"Add" Records: Establishing Medicare Entitlement Using Matching Criteria.

In CMS's personal identification matching process, we first look for a valid Medicare Health Insurance Claim Number (HICN). If there is no HICN or the HICN does not match to a known Medicare beneficiary, we then look for a valid Social Security Number (SSN). If the SSN results in a match, we will provide you with the beneficiary's valid HICN. If you provide a HICN and we match that number to a Medicare beneficiary, we will also return the beneficiary's valid SSN.

For CMS to confirm a Covered Individual's Medicare entitlement, the following minimum set of data elements is **always** be submitted by the VDSA partner: The individual's HICN or SSN, plus the following personal information:

- The first initial of the first name;
- The first 6 characters of the last name;
- The date of birth (DOB);
- The sex indicator.

CMS uses this personal information to match and validate the Medicare entitlement data submitted on your record with the person assigned the HICN or SSN in Medicare's database. The personal information you submit doesn't have to perfectly match the information on Medicare's database in order for that particular HICN or SSN to be considered a match. CMS uses a scoring algorithm that compensates for things such as keystroke errors or receipt of an incorrect date of birth. But three of the four personal information data elements must match, or it is not considered a match by the system.

When CMS determines that there is a match, on the response record CMS will update any non-matching personal information we received on the input record. The Data Sharing Agreement partner should store this corrected personal data in its own data systems, and from that point forward use it as the individual's official personal identifying information. To ensure that future data updates are accepted by CMS, any updates to that original record should be submitted under the corrected personal information.

"Update" and "Delete" Records: Additional Matching Criteria

Situation: A partner has had a record previously accepted by CMS (the partner received an "01" Disposition Code on the response record from CMS). The partner wishes to update the record previously accepted by CMS by sending an Update record. In addition to the standard Matching Criteria (SSN or HICN, first initial of the first name, first 6 characters of the last name, DOB and sex), for Update records we also match against the effective date of the coverage, the insurance coverage type, and the patient relationship

code. If there is not a match on all of them, we treat the record as an "add" and build a new record, while leaving the original record unmodified on CMS's database. If a partner attempts to "delete" a previously accepted record and the fields listed above don't match, the record will error out.

V. Protocols for 'D,' 'S,' and N' Records

'D' – Other Drug Coverage Reporting for TrOOP Record and Response

The 'D'Action Type in **either** an MSP or a Non-MSP Input File signals that the record contains information about an individual's prescription drug benefit coverage.

'D' records will require all of the standard matching criteria required in an 'N' record. ('N' records are described at the end of this section, below.) In addition, in a 'D' record VDSA partners should also anticipate providing:

Group Health Plan Number – Number assigned by claim processor identifying the Group Health Plan.

Policy Number – Plans are required to populate this field if the Coverage Type is V, Z, 4, 5, or 6.

Effective and Termination Dates – These fields are populated in the same way they are on the MSP file.

Plan ID – This field is populated in the same way as on the MSP file.

Rx ID - This is the ID for the individual's drug coverage. It may be the same as the hospital/medical individual ID. This field is required when the Coverage Type is U, W, X, and Y.

Rx Group - This is the group policy number for the drug coverage. It may be the same as the hospital/medical group policy number.

RxBIN - Pharmacy Benefit International Identification Number used for pharmacy routing. All network pharmacy payers have an RxBIN. This field is required when the Coverage Type is U, W, X, and Y.

RxPCN - Pharmacy Benefit Processor Control Number used for pharmacy routing. Some, but not all, network pharmacy payers use this for network pharmacy benefit routing along with the BIN. This number, if it is used, is required when the Coverage Type is U, W, X, and Y.

Toll-free Number- This is the toll-free telephone number commonly found on an insurance card. CMS asks for this so that if there is confusion at the point of sale, the pharmacist or the covered individual can call the Plan for assistance.

Person Code – This is the code the Plan uses to identify specific individuals on a policy. It is policy specific.

Relationship Code – this is the Covered Individual's relationship to the Policy Holder.

Coverage Type – The coverage type codes used on the non-MSP file will be consistent with those used on the MSP file, but not all MSP file coverage types will be relevant. CMS needs supplemental drug coverage on the non-MSP file. If the partner is describing

a network (EDI) pharmacy benefit, the coverage type will be U, W, X, or Y. If the partner is describing a non-network pharmacy benefit the coverage type will be V, Z, 4, 5, or 6.

Insurer Name- This is the name of the private insurer providing prescription drug coverage. CMS asks for this to facilitate proper billing at point of sale.

The 'D' record in the Non-MSP Response File will also contain whatever information was provided in the incoming file, i.e. SSN or HICN, DOB, Rx ID, etc. The Non-MSP Response File will also contain the Rx Disposition Code and Rx Error Codes that will be contained in the MSP Response record for the same reasons and according to the same rules as described in the MSP File section above.

Special Note about the "ID" Disposition Code

Partners may see the term "ID" as a value in the Rx Disposition Code field in the D/N Disposition Code field on their Non-MSP Response Files (Field 48). This "ID" Disposition Code is being caused by an identification error at the CMS Medicare Beneficiary Database (the MBD).

Response records you get that have an "ID" code in an Rx Disposition Code field are those that have not yet been accepted by the MBD. However, these response records returned to you do include whatever Medicare information the BCRC had received, if any, from the MBD and stored for that beneficiary in the BCRC's own database. But without a confirmation of acceptance of a record from the MBD, the record's data can not be considered validated. To confirm acceptance of such records Partners should include them as part of their next quarterly submission.

'N' – Non-Reporting Query Record and Response

Non-MSP Input Files with an 'N' Action Type (that is, a "query only" filing) will require the following minimum data set: HIC Number (HICN) or SSN, last name, first initial, date of birth, and sex. All are included as part of the current Non-MSP Input File. In response, CMS will provide the Medicare Part A and B entitlement information it now provides in other non-MSP responses, as well as the new Medicare Part D entitlement information, which is described above in the Non-MSP Response File layout.

Note that an 'N' Action Type (a "query only" input file) includes and is related to information about drug coverage benefits. If a partner wishes to submit a "query only" file not accompanied by information about drug coverage, the file type to use is the Query Only HEW Input File (see A, 2 above).

VI. Obtaining a TrOOP Facilitation RxBIN or RxPCN to Use with Non-MSP Records

VDSA partners will need to obtain a TrOOP Facilitation RxBIN or RxPCN to route claims through the TrOOP Facilitator. The TrOOP Facilitation RxBIN or RxPCN are routing numbers used to flag claims for coverage supplemental to Medicare Part D that will be paid by VDSA partners or their agents. As it is being routed to the pharmacy, the TrOOP Facilitation RxBIN or RxPCN will enable the TrOOP Facilitation Benefits Coordination & Recovery Center to identify a Part D supplemental claim, capture it, and transmit the supplemental paid claim amount to the appropriate Part D Plan to support the

Plan's TrOOP calculation responsibilities. To route these claims through the TrOOP Facilitation Contractor, partners may use a separate and unique RxBIN by itself, or a unique RxPCN in addition to their existing RxBIN.

The organization that issues the original RxBIN is the American National Standards Institute, or ANSI. ANSI can be contacted through its Web address: www.ansi.org.

A different organization, the National Council for Prescription Drug Programs (NCPDP) issues the Processor Control Number, or RxPCN. For TrOOP routing you can use a new or additional RxPCN in lieu of an additional RxBIN. The NCPDP can be contacted through its Web address: www.ncpdp.org .

VII. Beneficiary Lookup

When a partner has an immediate need to access Medicare entitlement information, an online, real-time query capability will be provided via secure web site. This new Beneficiary Lookup action will provide a real time response as to whether information supplied for a covered individual can be matched to a Medicare beneficiary. This solution will provide entitlement information for Parts A, B, C and D of Medicare.

VIII. Contact Protocol for Data Exchange Problems

In all complex electronic data management programs there is the potential for an occasional breakdown in information exchange. If you have a program or technical problem involving VDSA data exchange, the first person to contact is your own EDI Representative at the BCRC. Your EDI Rep should always be sought out first to help you find solutions for any questions, issues or problems you have.

If after working with your EDI Rep, you think your problem could benefit from help at a higher level, please contact the EDI Supervisor, Jeremy Farquhar, at 646-458-6614. His email address is: jfarquhar@ehmedicare.comail.

If you feel further escalation is necessary, contact the EDI Manager, William Ford, at 646-458-6613, Mr. Ford's email address is: wford@ehmedicare.com.

The BCRC Project Director, with overall responsibility for the EDI Department, is Jim Brady. Mr. Brady can be reached at 646-458-6682. His email address is: JBrady@ehmedicare.com.

Non-MSP VDSA User Guide

FREQUENTLY ASKED QUESTIONS

GENERAL

Q1: Give me a high level explanation of the kinds of health plan coverage information you are capturing in order to better coordinate benefits between my health plan and Medicare?

A1: VDSA partners and CMS exchange databases on a regular basis.

The Non-MSP File (Non-Medicare secondary payer file) is used to capture and report drug coverage that is secondary to Medicare (such as benefits for covered retirees and their covered spouses and dependents). We need this specific drug coverage data to help the Part D plans calculate the beneficiaries' True Out-Of-Pocket costs and to help pharmacies bill in the correct payer order at the pharmacy point of sale.

TERMS OF THE VOLUNTARY DATA SHARING AGREEMENT

Q1: We are currently in the process of getting a signed agreement with CMS to participate in the Voluntary Data Sharing Agreement process. Do we need to have this agreement in place before a certain deadline?

A1: No. However, the VDSA must be signed before we can begin accepting files.

We provide you new and updated written VDSA materials as they are published.

Q2: What functions does the Non-MSP file support?

A2: Use the Non-MSP record layout when reporting information about Medicare eligible people for whom Medicare is not a secondary payer. VDSA partners can use the Non-MSP Input File layout: To report drug coverage information that is supplemental to Medicare and to support the TrOOP facilitation process and to query CMS in order to obtain Medicare entitlement information. These various purposes are identified on the Non-MSP Input File Layout by the Action Type designation in Field 20, namely as 'D' and 'N' records.

Q3: We do not know whether to submit individuals on the Non-MSP Input File. We would like to develop information regarding the work status of all of our enrollees. Can we use the "N" record submission process to query for Medicare entitlement data so that we can focus our development activities toward the percent of our enrollment population that has Medicare?

A3: Yes, under two conditions. First, CMS expects all new VDSA partners to fully test their required Non-MSP file submission processes before we will allow for the exchange of any production data, including 'N' Action Type data. Second, when CMS provides Medicare entitlement data in response to an 'N'-type query, CMS expects the VDSA partner to complete its development (coverage analysis)

within a commercially reasonable time, and to begin reporting on found individuals, as appropriate, using the Non-MSP Input File. Failure to meet these two conditions will result in termination of the VDSA by CMS.

Q4: Would you clarify for me what inactive means. Does this mean inactive as in cancelled members?

A4: No. “Inactive” means that a covered individual is not working. He or she has health insurance benefit coverage but does not meet the regulatory definition of an “Active” (working) covered individual. (What used to be called the “Inactive File” is now the Non-MSP File.)

Q5: What does CMS consider to be a successful completion of the data exchange testing process?

A5: At a minimum CMS requires the VDSA partner to be able to (1) submit an initial test Non-MSP Input File that can be processed to the satisfaction of the BCRC contractor, (2) receive and process a test Non-MSP Response File from the BCRC contractor, and (3) be able to submit a test Update Non-MSP file to the BCRC contractor. We have delegated the authority to determine whether or not the VDSA partner has successfully completed the testing process to the BCRC contractor.

Q6: How long does the testing process take?

A6: Testing can begin as soon as a VDSA is executed by both Parties, and it takes place on a scheduled weekly basis. Under ideal circumstances, each testing cycle takes about a full week before the VDSA partner can be ready to submit the next test file. Testing will take place at the VDSA partner's preferred pace and can take a month or more to complete, depending on how quickly the VDSA partner can gather the necessary resources to meet the implementation requirements. VDSA partners should note that CMS's goal throughout the testing and implementation process is to ensure that the VDSA partner's first real production file is as accurate as possible. The accuracy of data on the first production file is more important then how quickly the VDSA partner can produce it.

Q7: Other than stating that files can be exchanged quarterly with the option of exchanging non-MSP files on a monthly basis, there is no mention of the actual reporting schedule we would use.

A7: The Benefits Coordination & Recovery Center will work with each VDSA partner during the Preparatory Period to set up reporting and data production schedules.

Q8: Are there any implementation or maintenance fees charged by CMS to VDSA partners?

A8: There are no fees charged by CMS to participate in the VDSA process.

Q9: In addition to the ability to send data via Connect:Direct, what Internet-based Secure FTP protocol will VDSA partners be offered by CMS?

A9: CMS has available two secure Internet transmission options. We recommend either of these options for VDSA partners that anticipate having a low volume of

data transmissions, that have access to the Internet, and that find it is a burden to secure an AGNS connection.

SFTP: Using SFTP permits automated data transmission and management. For this transmission method, a Partner may use any client program as long as it is SSH v2 capable.

HTTPS: There is no additional cost associated with using this method as long as the Internet Explorer browser is used. However, use of HTTPS does not permit automated data management.

If a potential VDSA partner is contemplating a method of data transmission that has not been discussed above, the partner will need to discuss and establish specific alternative data transmission procedures directly with the BCRC.

RECORD LAYOUT AND FILE SUBMISSIONS

Q1: Why does CMS insist we fill the "DCN" field on Input Files?

A1: The "Document Control Number" (DCN) is an ID number assigned by the VDSA partner, for its own use as a tracking code. While other information in an input record may have changed in the response record, the DCN will not. Consequently, using the DCN will always allow a VDSA partner to match and link an input record with its corresponding response record. Supplying a DCN on an input record is mandatory. On the Non-MSP Input File record layout the DCN field is Number 19.

Q2: Throughout the record layouts there is a field for HIC Number (HICN). Some of the data field descriptions state that the HICN is not required if the SSN is provided. This is not explicitly stated in others. Please confirm that an SSN is an acceptable substitute for the HICN in all the layouts.

A2: For VDSA reporting the Medicare HIC Number (HICN) is the "gold standard". A correct HICN will always identify a Medicare beneficiary. More generally, to confirm a beneficiary data match we always need either the HICN or the SSN. Having one of these numbers is necessary to determine if a Covered Individual you submit is also entitled to Medicare. We encourage you to send us both numbers in case one or the other contains an error.

Q3: We don't have all of the SSNs for all of our covered individuals. Should we include a record with no SSN or HICN on the file anyway?

A3: No. Without either the HICN or SSN, do not submit a record for that individual. The HICN or SSN are the primary identifiers we use to confirm Medicare entitlement. Without one or both of those numbers, a record will not process.

Q4: What should we do for records that do not have the SSN?

A4: See if you have a HICN for that individual. If you do not, don't send the record.

Q5: Is just the SSN enough to make a match in your database?

A5: Almost. Using an SSN to confirm that the individual on a submitted record is a Medicare beneficiary requires the SSN, the first 6 characters of the person's surname, first name initial, date of birth, and gender.

Q6: What if we have the SSN but not all of the personal identifying information (first 6 characters of the person's surname, first name initial, date of birth, and sex code) that you need to confirm Medicare entitlement?

A6: You should include as much of the personal identifying information as possible. It is often possible to find Medicare entitlement even if not all of the personal identifying information exists or is correct on the record you submit. We use a matching algorithm that accepts a match when at least 3 of the 4 personal identifying pieces of information for the submitted SSN or HICN are correct.

Q7: Many of our enrollees are concerned about identity theft and are wary about giving us their Social Security Numbers (SSNs). How can we assure them that an individual's SSN will be protected and used appropriately?

A7: The collection and use of individual SSNs is now limited by an evolving body of federal and state law and regulation. When an SSN is to be used as personal health information, management of the SSN (who can collect it; for what reason; with what other entity or person can it be shared) is directed by regulations required by the federal Health Insurance Portability and Accountability Act (HIPAA). These are called the HIPAA privacy rules. They are quite strict, and after they were fully implemented in 2004, measures to protect personal health information have become stronger. Collection of SSNs for purposes of coordinating benefits with Medicare is a legitimate use of the SSN under Federal law.

Q8: Don't state laws prohibit the use and collection of SSNs?

A8: There are state laws that restrict when SSNs can be collected and how they can be used. But these state initiatives do not preempt the provisions of the Medicare Secondary Payer (MSP) or Medicare Modernization Act (MMA) regulations or the "permitted use" provisions of the HIPAA privacy rules. These federal laws allow the collection and use of SSNs to help providers and insurers manage their operations. However, state laws frequently augment the federal regulations. Some states now restrict how SSNs may be displayed, prohibiting a health plan from including an SSN on an individual's plan ID card for example. These state initiatives are not affected by the federal rules.

Q9: The Non-MSP Input File has an "Action Type" code field (Field 20) with values of 'D' for Drug Reporting Record, 'S' for Subsidy Reporting Record, and 'N' for Non-Reporting Record. Please clarify when a partner would submit an 'N' (non-reporting) record.

A9: The 'N' record is a query record where you are merely asking for Medicare entitlement information. We do not store the information you submit on an 'N' record, which is why we call it a non-reporting record.

Q10: Can we submit 'N' records for our retirees or other "Non-MSP" covered individuals?

A10: Yes. You can submit 'N' records about any of your Covered Individuals. Because data submitted on 'N' records is not used or stored by CMS, when necessary you must still submit information about your Covered Individuals on either the MSP Input File or as a 'D' record on the Non-MSP Input File.

Q11: Would you clarify for me what inactive means? Is someone who is "inactive" a cancelled (former) plan member?

A11: No. For VDSA reporting, "Inactive" means only that a covered individual is not working. He or she has health insurance benefit coverage but does not meet Medicare's definition of an "Active" (working) covered individual.

Q12: What is the difference between the "Relationship Code and the "Person Code?"

A12: The Relationship Code is required by CMS, and references the cardholder, spouse, and dependents. It is a two digit code. (See Field 18 on the Non-MSP Input File Layout.) The Relationship Code is independent of the Person Code. Submitting a Person Code is optional. Person Codes are assigned by insurers and are not defined by CMS. The insurer is always the source of the Person Code. They identify family members and consist of three digits: Cardholder is usually "001"; Spouse is usually "002"; dependents are usually numbered "003" to "099".

Q13: I got back a match on one of my records in the response file but the date of birth I originally submitted was changed. Why? Should I store this changed information?

A13: The birth date CMS had on its Medicare Beneficiary Database conflicted with the birth date you submitted, but the rest of the information you provided was enough to make a match to a Medicare beneficiary. It is common to receive a data element that doesn't result in a 100% match but find that the whole data set is still accurate enough to be considered matching; this can happen for a number of reasons. In any case, using our data we can correct your records and return them to you. The corrected data originates from the Social Security Administration (SSA), and is linked to a particular beneficiary's HICN or SSN. This SSA data set constitutes the Federal Government's official set of beneficiary identifiers. Consequently, we expect you to update and store the corrections in your own records, to better ensure that they will match again when you have to update the same individual's record. Incidentally, CMS cannot update SSA data. Only a beneficiary has the authority to seek corrections in his or her own SSA data.

Q14: What are the benefits of submitting the Non-MSP file every month versus every quarter?

A14: Many entities may wish to receive Medicare entitlement data on a frequent basis. These partners can choose to submit Non-MSP Files monthly. Conversely, there are VDSA partners that will want to have a longer time to evaluate Non-MSP Response Files and more time to build their next submission files. They may be concerned that the extra resources needed to perform a monthly exchange will be

cost prohibitive, or that rushing to meet a monthly deadline may produce erroneous or incomplete data. They can choose to submit Non-MSP files on a quarterly basis.

The bottom line is that deciding on the submission interval for Non-MSP Files is a business decision each partner evaluates and makes for itself.

Q15: We do not find a header or trailer record for the Query Only HEW Response File. Did we overlook it or is one not needed?

A15: The Query Only HEW Response File has no header or trailer. For this particular response file neither a header nor trailer is necessary, and so we don't include them. VDSA partners do provide include a header and trailer as part of the Input File submission since the header/trailer allows us to identify the sender. We can then route our response back to the DSN specified by the partner.

PART D AND VDSAs

Q1: In the Implementation Questionnaire, why do you ask for a list of the TrOOP RxBINs and RxPCNs, when we include those data on the individual record?

A1: The BCRC contactor will use that RxBIN and RxPCN list to perform informal edits of the data you submit on both the Non-MSP Input File, to ensure that we are receiving the appropriate RxBIN and RxPCN data in the records you forward to us.

Q2: You state that all reporters will have to get a TrOOP Facilitation RxBIN and RxPCN for reporting and coordinating drug coverage that is secondary to Medicare Part D coverage. It will ensure that these drug claims are routed through the TrOOP Facilitator. If so, do we have to apply for the RxBIN and RxPCN numbers?

A2: Yes, you will have to acquire TrOOP Facilitation RxBIN and RxPCN code numbers. These TrOOP Facilitation RxBIN and RxPCN codes are for supplemental drug benefit coverage that has to be reported to Part D Plans. A benefit manager can apply for an RxBIN or RxPCN for TrOOP Facilitation through ANSI or the NCPDP. Please refer to "VI. Obtaining a TrOOP Facilitation RxBIN or RxPCN to Use with Non-MSP Records," in the User Guide, above.

Q3: In the Non-MSP Input File (Field 17) there is a data field for "Rx Toll Free Number." How is this information used? Is this a required field? If I don't provide a toll free number, will I get an edit notification?

A3: An "Rx Toll Free Number" is often included on a pharmacy benefit insurance card. It is the number a pharmacist can call if he or she has questions about a prescription or about coverage issues, and it can be useful information to have available at point-of-sale. We encourage all VDSA partners to provide this number. However, it is not a required data element. If this data field is filled with spaces no edits are generated.