



# **State Pharmaceutical Assistance Program (SPAP) Data Sharing Agreement**

## **User Guide**

**Version 10.5**

**Rev. 2015/14 December  
COBR-Q1-2016-v10.5**

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**Confidentiality and Disclosures**

Confidentiality and Disclosure of Information Section 1106 (a) of the Social Security Act as it applies to the Centers for Medicare & Medicaid Services (CMS) - (42 CFR Chapter IV Part 401 §§ 401.101 to 401.152) prohibits disclosure of any information obtained at any time by officers and employees of Medicare Intermediaries, Carriers, or contractors in the course of carrying out agreements under Sections 1816 and 1842 of the Social Security Act, and any other information subject to Section 1106 (a) of the Social Security Act. Section 1106 (a) of the Act provides in pertinent part that "Any person who shall violate any provision of this section shall be deemed guilty of a felony and, upon conviction thereof, shall be punished by a fine not exceeding \$10,000, or by imprisonment not exceeding five year, or both." Additional and more severe penalties are provided under Title XVIII (Medicare) USC Section 285 (unauthorized taking or using of papers relating to claims) and under Section 1877 of Title XVIII of the Act (relating to fraud, kickbacks, bribes, etc., under Medicare).

These provisions refer to any information obtained by an employee in the course of their performance of duties and/or investigations (for example, beneficiary identification number, beneficiary diagnosis, social security number, pattern of practice of physicians, etc.). Any unauthorized inspection or disclosure of IRS return information in violation of any provision of Section 6103 may bring damages as described in IRC Sections 7431 and 7213, which include, but are not limited to, a fine of any amount not exceeding \$5,000 or imprisonment.

## INTRODUCTION

This user guide provides the information and instructions that the State Pharmaceutical Assistance Programs (SPAPs) will find necessary and useful as they implement and then manage the SPAP information sharing process with the Centers for Medicare & Medicaid Services (CMS). In particular, an SPAP Data Sharing Agreement (DSA) 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).

Periodically, the information provided in this user guide will change. As current requirements are refined and new processes developed, SPAP partners will be provided with new and up-to-date sections of this Guide. Please contact CMS should you have any questions regarding this User Guide.

If you would like more general information about the current SPAP process, please email [erica.watkins@cms.hhs.gov](mailto:erica.watkins@cms.hhs.gov). Remember to provide us with the E-mail address, phone number and other contact information for individuals you would like to have added to our distribution list.

## **Chapter 1: Summary of Version 10.5 Updates**

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The following represents changes to the State Pharmaceutical Assistance Program (SPAP) Data Sharing Agreement User Guide, v10.5:

SPAPs must now retain eligibility history for all enrollees for 36 months, including for enrollees who are no longer enrolled.

## Chapter 2: Completing and Signing an SPAP DSA

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To make the SPAP DSA relationship operational, the potential SPAP DSA partner and CMS have to sign and exchange completed copies of the SPAP DSA. These are the instructions for completing an SPAP DSA for signature.

In the first paragraph of the SPAP DSA, insert all of your specific identifying information where indicated. The latest date that both the partner and CMS complete the signature process 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 SPAP DSA partners prefer to enter the first day of the month in which they expect the SPAP DSA to be signed. But bear in mind that if you enter a prospective date, CMS cannot begin full implementation of the SPAP DSA until we reach it.

Enter the date that is requested on Page 3 of the SPAP DSA, in Section C, 1. This is the starting date for health plan enrollment information that is entered on the first regular production Initial Input File you provide to CMS.

On Page 8, in Section M, enter the partner’s Administrative and Technical contact information.

Page 10, Section N: Upon receipt of a SPAP DSA signed by the partner, CMS will provide the required Technical Contact information. This item does not need to be completed in order to execute the Agreement.

In the footer starting on Page 1, and throughout the rest of the document, insert the partner’s business name.

In the footer of the Implementation Questionnaire, Attachment C, insert the partner’s business name.

The SPAP DSA signature package consists of two documents: The SPAP DSA itself, and the SPAP DSA Implementation Questionnaire. The SPAP DSA partner will return two signed copies of the SPAP DSA and one completed copy of the Implementation Questionnaire to CMS. One copy of the SPAP DSA will be signed by CMS and returned to the partner. If it wishes, the partner can ask that CMS sign the SPAP DSA first. CMS will then provide two signed copies of the SPAP DSA to the partner, and the partner will sign one copy and return it to CMS. But in either case CMS will not consider the SPAP DSA to be in force until the partner has provided CMS with a signed DSA and 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 SPAP Data Sharing Agreement (s) and Implementation Questionnaire to:

Erica Watkins  
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

## Chapter 3: The SPAP Data Files – Standard Reporting Information

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Standard Data Files: The data exchanged through the SPAP process is arranged in two different file formats (also referred to as record layouts). An SPAP partner electronically transmits a data file to the CMS Benefits Coordination & Recovery Center (BCRC). The BCRC processes the data in this *input file*, and at a prescribed time electronically transmits a *response file* to the partner. The *input file* is the method through which the SPAP data sharing partner will submit its covered SPAP enrollee population. In return, the BCRC will send back a response file to the partner which will contain Medicare Part D enrollment information for all SPAP enrollees who also have Medicare Part D.

Current versions of the Standard Data Files immediately follow. Once again we remind you that periodically the information provided here will change. All updates to the material in this User Guide will be listed on Page 1. To confirm that you are using the most recent version of the Guide, you should check the Version Effective Date on Page 1 and the footer on each page of the document.

### 3.1 The Input and Response File Data Layouts

A – *The SPAP Input File*. This is the data set transmitted from an SPAP partner to CMS (the BCRC) on a monthly basis. It is used to report information regarding the SPAP enrollees – people who are eligible for and enrolled in an SPAP and receive coverage through such a plan. Full file replacement is the method used to update eligibility files. Each month's transmitted file will fully replace the previous month's file. The business rules for use of the SPAP Input File immediately follow the data file layout itself. Please note that the SPAP Data Sharing Agreement makes reference to the SPAP Input File as Attachment A. The layout in this version of the User Guide represents the most current version of this Attachment

### 3.1.1 SPAP Input File Layout – Attachment A

**Table 3-1: State Pharmaceutical Assistance Program Input File Layout – 249 Bytes**

Field	Name	Size	Displacement	Data Type	Description
1.	SSN	9	1-9	Numeric	Social Security Number – Required Populate with spaces if unavailable.
2.	HICN	12	10-21	Alpha-Numeric	Medicare Health Insurance Claim Number Required if SSN not provided. Populate with spaces if unavailable.
3.	Surname	6	22-27	Text	Surname of Covered Individual - Required
4.	First Initial	1	28-28	Text	First Initial of Covered Individual - Required
5.	DOB	8	29-36	Date	Date of Birth of Covered Individual - Required CCYYMMDD
6.	Sex Code	1	37-37	Numeric	Sex of Covered Individual - Required 0: Unknown 1: Male 2: Female
7.	Effective Date	8	38-45	Date	Effective Date of SPAP Coverage - Required CCYYMMDD
8.	Termination Date	8	46-53	Date	Termination Date of SPAP Coverage -Required CCYYMMDD *Use all zeros if open-ended
9.	N-PLAN ID	10	54-63	Filler	Future use for National Health Plan Identifier. Fill with spaces only
10.	Rx ID/Policy Number	20	64-83	Text	Covered Individual Pharmacy Benefit ID for SPAP Rx ID Required if Coverage Type = U Policy Number Required if Coverage Type = V
11.	Rx Group	15	84-98	Text	SPAP Pharmacy Benefit Group Number
12.	Part D RxPCN	10	99-108	Text	Part D specific SPAP Pharmacy Benefit Processor Control Number. Required if Coverage Type = U

Field	Name	Size	Displacement	Data Type	Description
13.	Part D RxBIN	6	109-114	Text	Part D specific SPAP Pharmacy Benefit International Identification Number –Required
14.	Toll-Free Number	18	115-132	Text plus “(“ and “)”	Pharmacy Benefit Toll-Free Number
15.	Document Control Number	15	133-147	Text	Document Control Number Assigned by SPAP- Required
16.	Coverage Type	1	148-148	Alpha-Numeric	Coverage Type Indicator - Required U: Network (electronic, point-of-sale benefit) V: Non-Network (other type of benefit)
17.	Insurance Type	1	149-149	Alpha-Numeric	Insurance Type - Required N: Non-qualified State Program O: Other P: PAP Q: SPAP (qualified i.e. send LIS data) R: Charity S: ADAP
18.	Filler	100	150-249	Alpha-Numeric	Unused Field Fill with spaces only

**Table 3-2: Header Record – All fields required**

Field	Name	Size	Displacement	Data Type	Description
1.	Header Indicator	2	1-2	Alpha-Numeric	Should be: ‘H0’
2.	SPAP-ID	5	3-7	Alpha-Numeric	SPAP Identifier
3.	Contractor Number	5	8-12	Alpha-Numeric	Should be: ‘S0000’
4.	File Date	8	13-20	Date	CCYYMMDD
5.	Filler	229	21-249	Alpha-Numeric	Unused Field Fill with Spaces.

**Table 3-3: Trailer Record – All fields required**

Field	Name	Size	Displacement	Data Type	Description
1.	Trailer Indicator	2	1-2	Alpha-Numeric	Should be: ‘T0’
2.	SPAP-ID	5	3-7	Alpha-Numeric	SPAP Identifier
3.	Contractor Number	5	8-12	Alpha-Numeric	Should be: ‘S0000’
4.	File Date	8	13-20	Date	CCYYMMDD
5.	Record Count	9	21-29	Numeric	Number of records on file

B - *The SPAP Response File*. This is the data set transmitted from the BCRC (CMS) to the SPAP partner after the information supplied in the partner's SPAP Input File has been processed by the BCRC. It consists of the same data elements in the Input File, with corrections applied by the BCRC, and disposition and edits codes, all of which let you know what we did with the records. The response will also contain new information regarding the submitted SPAP enrollees, including Medicare entitlement and Low Income Subsidy (LIS) information, where applicable, if a match occurred. Please note that the SPAP Data Sharing Agreement makes reference to the Input File as Attachment B. The layout in this version of the User Guide represents the most current version of this Attachment.

### 3.1.2 SPAP Response File Layout – Attachment B

**Table 3-4: SPAP Response File Layout – 417 Bytes**

Field	Name	Size	Displacement	Data Type	Description
1.	SSN	9	1-9	Alpha-Numeric	Social Security Number
2.	HICN	12	10-21	Alpha-Numeric	Medicare Health Insurance Claim Number
3.	Surname	6	22-27	Alpha-Numeric	Surname of Covered Individual
4.	First Initial	1	28-28	Alpha-Numeric	First Initial of Covered Individual
5.	DOB	8	29-36	Alpha-Numeric	Date of Birth of Covered Individual CCYYMMDD
6.	Sex Code	1	37-37	Alpha-Numeric	Sex of Covered Individual 0: Unknown 1: Male 2: Female
7.	Effective Date	8	38-45	Alpha-Numeric	Effective Date of SPAP Coverage CCYYMMDD
8.	Termination Date	8	46-53	Alpha-Numeric	Termination Date of SPAP Coverage CCYYMMDD *Use all zeros if open-ended
9.	N-PLAN ID	10	54-63	Alpha-Numeric	Future use for National Health Plan Identifier
10.	Rx ID	20	64-83	Alpha-Numeric	Covered Individual Pharmacy Benefit ID for SPAP
11.	Rx Group	15	84-98	Alpha-Numeric	SPAP Pharmacy Benefit Group Number
12.	Part D RxPCN	10	99-108	Alpha-Numeric	SPAP (Part D specific) Pharmacy Benefit Processor Control Number
13.	Part D RxBIN	6	109-114	Alpha-Numeric	SPAP (Part D specific) Pharmacy Benefit International Identification Number
14.	Toll-Free Number	18	115-132	Alpha-Numeric	Pharmacy Benefit Toll-Free Number

Field	Name	Size	Displacement	Data Type	Description
15.	Original Document Control Number	15	133-147	Alpha-Numeric	Document Control Number Assigned by SPAP
16.	BCRC Document Control Number	15	148-162	Alpha-Numeric	Document Control Number Assigned by BCRC
17.	Coverage Type	1	163-163	Alpha-Numeric`	Coverage Type Indicator U: Network (Electronic, Point-of-Sale Benefit) V: Non-Network (Other type of Benefit)
18.	Insurance Type	1	164-164	Alpha-Numeric	N: Non-qualified State Program O: Other P: PAP Q: SPAP (qualified i.e. send LIS data) R: Charity S: ADAP
19.	Rx Current Disposition Code	2	165-166	Alpha-Numeric	Rx Result from BENEMSTR/MBD (Action taken by BCRC).
20.	Current Disposition Date	8	167-174	Alpha-Numeric	Date of Rx Result from BENEMSTR/MBD (CCYYMMDD)
21.	Edit Code 1	4	175-178	Alpha-Numeric	Error Code
22.	Edit Code 2	4	179-182	Alpha-Numeric	Error Code
23.	Edit Code 3	4	183-186	Alpha-Numeric	Error Code
24.	Edit Code 4	4	187-190	Alpha-Numeric	Error Code
25.	Part D Eligibility Start Date	8	191-198	Alpha-Numeric	Earliest Date that Beneficiary is eligible to enroll in Part D (This date only refers to eligibility for Part D not enrollment in a Part D Plan) -Refer to Field 46 for Part D Plan Enrollment Date CCYYMMDD
26.	Part D Eligibility Stop Date	8	199-206	Alpha-Numeric	Date Beneficiary is no longer eligible to receive Part D Benefits- Refer to Field 47 for Part D Plan Termination Date CCYYMMDD
27.	Medicare Beneficiary Date of Death	8	207-214	Alpha-Numeric	Medicare Beneficiary Date of Death CCYYMMDD
28.	Part D Subsidy Effective Date	8	215-222	Alpha-Numeric	Effective Date of Low Income Subsidy CCYYMMDD

Field	Name	Size	Displacement	Data Type	Description
29.	Part D Subsidy Termination Date	8	223-230	Alpha-Numeric	Termination Date of Low Income Subsidy CCYYMMDD
30.	Part D Premium Subsidy Percent	3	231-233	Alpha-Numeric	Identifies the portion of the Part D Premium subsidized by CMS based on a sliding scale linked to the %FPL. Percentage of Part D Premium Values: 100= 100% of subsidy level (If individual is under 135%FPL); 75=75% of subsidy level (If individual is 136-145% FPL) ; 50=50% of subsidy level (If individual is 141-145%FPI); and 25=25% of subsidy level (If individual is 146-149%FPL)
31.	Part D Subsidy Disapproval Date	8	234-241	Alpha-Numeric	Date of Low Income Subsidy Disapproval (This field is only applicable to people who applied for the low-income subsidy). CCYYMMDD
32.	Basis of Part D Subsidy Denial 1	1	242-242	Alpha-Numeric	Beneficiary is not Part A entitled and/or Part B enrolled (This field is only applicable to people who applied for the low-income subsidy). Y=Yes N=No
33.	Basis of Part D Subsidy Denial 2	1	243-243	Alpha-Numeric	Beneficiary does not reside in USA (This field is only applicable to people who applied for the low-income subsidy). Y=Yes N=No
34.	Basis of Part D Subsidy Denial 3	1	244-244	Alpha-Numeric	Beneficiary has failed to cooperate (This field is only applicable to people who applied for the low-income subsidy). Y=Yes N=No
35.	Basis of Part D Subsidy Denial 4	1	245-245	Alpha-Numeric	Beneficiary resources too high (This field is only applicable to people who applied for the low-income subsidy). Y=Yes N=No
36.	Basis of Part D Subsidy Denial 5	1	246-246	Alpha-Numeric	Beneficiary income too high (This field is only applicable to people who applied for the low-income subsidy). Y=Yes N=No

Field	Name	Size	Displacement	Data Type	Description
37.	Result of an Appeal	1	247-247	Alpha-Numeric	Result of the appeal filed by the beneficiary (This field is only applicable to people who applied for the low-income subsidy). 1=Basis of Appeal 2=Denial 9=N/A Blank=Not based on appeal
38.	Change to Previous Determination	1	248-248	Alpha-Numeric	Change made to a previous subsidy determination: FUTURE (This field is only applicable to people who applied for the low-income subsidy). 1=Yes 2=No 9=N/A
39.	Determination Canceled	1	249-249	Alpha-Numeric	(This field is only applicable to people who applied for the low-income subsidy). 1=Yes 2=No 9=N/A
40.	Part D Subsidy Approved	1	250-250	Alpha-Numeric	Subsidy approved (This field is only applicable to people who applied for the low-income subsidy). 1=Yes 2=No 9=N/A
41.	Basis for Part D Subsidy Determination	1	251-251	Alpha-Numeric	Determines if LIS determination was based on income of an individual or couple. (This field is only applicable to people who applied for the low-income subsidy). 1=Individual 2=Couple 9=N/A

Field	Name	Size	Displacement	Data Type	Description
42.	LIS Determination Source Code	2	252-253	Alpha-Numeric	Code indicating the source of the LIS determination. Allowable sources include State and SSA. (This field is only applicable to people who applied for the low-income subsidy). 'SS' = determination was made through SSA State Code = determination was made through the State (VT, MD etc.)
43.	Part D Premium Amount	9	254-262	Alpha-Numeric	Premium Amount owed by the beneficiary for Part D Plan
44.	Part D Premium Effective Date	8	263-270	Alpha-Numeric	CCYYMMDD
45.	Current Medicare Part D Plan Contractor Number	5	271-275	Alpha-Numeric	Contractor Number of the Current Part D Plan in which the Beneficiary is Enrolled
46.	Current Medicare Part D Plan Enrollment Date	8	276-283	Alpha-Numeric	Effective Date of Coverage Provided by Current Medicare Part D Plan CCYYMMDD
47.	Current Part D Plan Termination Date	8	284-291	Alpha-Numeric	Termination Date of Coverage Provided by Current Medicare Part D Plan CCYYMMDD
48.	Current DEEMED Start Date	8	292-299	Alpha-Numeric	(This field is only applicable to people who are deemed eligible for the low-income subsidy. In the event that there are data in the LIS fields above, the deemed data always prevails.) Effective date of the deeming period. Always the first day of the month the deeming was made. The date will always reflect "01" in data portion of date: CCYYMMDD Deemed status will continue at least until the end of the calendar year in which the basis (Medicaid, MSP, SSI eligibility) for deemed status ends. Deemed status will continue throughout the next calendar year if eligibility for Medicaid, MSP, or SSI ends in a month after August of the current year.

Field	Name	Size	Displacement	Data Type	Description
49.	Current DEEMED End Date	8	300-307	Alpha-Numeric	<p>(This field is only applicable to people who are deemed eligible for the low-income subsidy).</p> <p>Termination date of the deeming period. Always the last day of the year the deeming was made. The month will always reflect “12” and the day always “31”.</p> <p>CCYYMMDD</p>
50.	Current DEEMED Reason Code	2	308-309	Alpha-Numeric	<p>Code indicating the reason the beneficiary was deemed eligible for LIS. Values:</p> <p>01=Eligible is entitled to Medicare – QMB only;</p> <p>2A=Eligible is entitled to Medicare – QMB and Medicaid coverage including RX and FPL&gt;100%</p> <p>2B= Eligible is entitled to Medicare - QMB and Medicaid coverage including RX and FPL= or &lt;100%</p> <p>03= Eligible is entitled to Medicare-,SLMB only</p> <p>4A= Eligible is entitled to Medicare - SLMB and Medicaid coverage including RX FPL&gt;100%</p> <p>4B=Eligible is entitled to Medicare-SLMB and Medicaid coverage including RX FPL= or &lt;100%</p> <p>06=Eligible is entitled to Medicare-Qualifying Individuals</p> <p>8A=Eligible is entitled to Medicare-Other full dual eligibles FPL&gt;100%</p> <p>8B=Eligible is entitled to Medicare-Other full dual eligibles FPL= or &lt;100%</p> <p>10=SSI</p> <p>11=MBD 3rd Party (partial dual)</p> <p>12=EEVS (Eligibility and Enrollment Verification System) Deemed status received through EEVS data in March 2005 without further updates from the deeming state. Individual with this status code would be deemed for CY 2006 as a full dual.</p>

Field	Name	Size	Displacement	Data Type	Description
51.	Dual Status Code	2	310-311	Alpha-Numeric	Dual Status Code: 00 = Eligible is not a Medicare beneficiary 01 = Eligible is entitled to Medicare- QMB only 02 = Eligible is entitled to Medicare- QMB AND full Medicaid coverage 03 = Eligible is entitled to Medicare- SLMB only 04 = Eligible is entitled to Medicare- SLMB AND full Medicaid coverage 05 = Eligible is entitled to Medicare- QDWI 06 = Eligible is entitled to Medicare- Qualifying Individuals (1) 07 = Eligible is entitled to Medicare-Qualifying Individuals (2) 08 = Eligible is entitled to Medicare- Other Dual Eligibles (Non QMB, SLMB,QWDI or QI) with full Medicaid coverage 09 = Eligible is entitled to Medicare – Reason for Medicaid eligibility unknown 99=Eligible's Medicare status is unknown
52.	PBP	3	312-314	Alpha-Numeric	Part D Plan Benefit Package (PBP)
53.	FPL %	3	315-317	Alpha-Numeric	For those individuals who applied and qualified for the low income subsidy, describes income as a specific percent of the Federal Poverty Level (FPL). Not populated for Deemed Individuals.
54.	Transaction Type	1	318	Alpha-Numeric	Type of Maintenance: '0' = Add Record '1' = Delete record '2' = Update record
55.	LIS Co-Pay Level ID	1	319	Alpha-Numeric	Co-payment Level Identifier: 1 = High (Co-Pays of \$2/\$5) 2 = Low (Co-pays of \$1/\$3) 3 = Zero (Institutionalized full dual) 4 = 15% 5 = Unknown

Field	Name	Size	Displacement	Data Type	Description
56.	Deemed Co-Pay Level ID	1	320	Alpha-Numeric	Co-payment Level Identifier: 1 = High (Co-Pays of \$2/\$5) 2 = Low (Co-Pays of \$1/\$3) 3 = Zero (Institutionalized full dual) 4 = 15% 5 = Unknown
57.	Co-pay Effective Date	8	321-328	Alpha-Numeric	Co-pay start date CCYYMMDD
58.	Co-pay End Date	8	329-336	Alpha-Numeric	Co-pay end date CCYYMMDD
59.	Filler	81	337-417	Alpha-Numeric	Unused Field.

**Table 3-5: Header Record**

Field	Name	Size	Displacement	Data Type	Description
1.	Header Indicator	2	1-2	Alpha-Numeric	Should be: 'H0'
2.	SPAP ID	5	3-7	Alpha-Numeric	SPAP Identifier
3.	Contractor Number	5	8-12	Alpha-Numeric	Should be: 'S0000'
4.	File Date	8	13-20	Alpha-Numeric	CCYYMMDD
5.	Filler	397	21-417	Alpha-Numeric	Unused Field

**Table 3-6: Trailer Record**

Field	Name	Size	Displacement	Data Type	Description
1.	Trailer Indicator	2	1-2	Alpha-Numeric	Should be: 'T0'
2.	SPAP ID	5	3-7	Alpha-Numeric	SPAP Identifier
3.	Contractor Number	5	8-12	Alpha-Numeric	Should be: 'S0000'
4.	File Date	8	13-20	Alpha-Numeric	CCYYMMDD
5.	Record Count	9	21-29	Alpha-Numeric	Number of records on file
6.	Filler	388	30-417	Alpha-Numeric	Unused Field

## 3.2 The SPAP Data Review Process

The information following describes the data review process used by the BCRC.

### Data Type Key

Conventions for Describing Data Values. The table below defines the data types used by the BCRC for its 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 within the SPAP Data Exchange Layout fields.

**Table 3-7: Data Type Key**

These standards should be used unless otherwise noted in layouts.

Data Type / Field	Formatting Standard	Examples
Numeric	Zero through 9 (0 → 9) Padded with leading zeroes Populate empty fields with spaces	Numeric (5): “12345” Numeric (5): “00045” Numeric (5): “ ”
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	Left justified Non-populated bytes padded with spaces 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 (@)	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	-
Internal Use	Populate with spaces	-

### 3.2.1 CMS SPAP Processing Requirements

1. The Data Processing System shall be able to receive an external file from an SPAP via a dedicated T-1 line ((AT&T Global network Services (AGNS)) or Secure File Transfer Protocol (SFTP).
2. The System shall be able to confirm the external SPAP file format.
3. The System shall pass SPAP input files thru to the appropriate data manipulation process.
4. The System shall retrieve and merge response records from the BCRC Database for each SPAP that has been processed through the Pharmacy Benefit Manager (PBM) / Voluntary Data Sharing Agreement (VDSA) / Drug Engine data process.

5. The System shall merge beneficiary Low Income Subsidy data on the response file for qualified SPAP enrollees.
6. The System shall be able to create a return file to the SPAP in proper format, containing one response record for each SPAP record added, updated or deleted.
7. The System shall display error descriptions in CHAPS for severe errors identified on SPAP files.
8. The System shall maintain the ability to return response files to the SPAP as processed.
9. The System shall be able to process a full-file replacement of SPAP records on a regular basis.
10. The System shall return a response record for every record submitted from an SPAP on their monthly file in the proper SPAP file format.
11. The System shall return Part D enrollment information on the response for all SPAP records matched in the MBD.
12. The System shall return available Part D entitlement information on the response for all SPAP records that have not yet received a response from the MBD with a disposition code of '50'.
13. The System shall return LIS information on the response for all qualified SPAP records matched in the MBD.

### **3.2.2 Process Description**

The purpose of the SPAP process is to coordinate the prescription drug benefits between Medicare Part D plans and the State Pharmaceutical Assistance Programs, which serve as supplemental payers. This collection of all prescription drug related benefits will facilitate the tracking of TrOOP (True Out-of-Pocket) expenses incurred by each Medicare beneficiary.

In order to coordinate benefits information, data must be collected from each SPAP on each of its enrollees. New submission file formats have been created for use by an SPAP to deliver the pertinent information. This information will be transmitted to the BCRC where it will be edit-checked, and matched against the Medicare data in the Eligibility database. Once a match is found, the BCRC will be able to combine a beneficiary's SPAP information with their Medicare Part D specific information to create a complete record of the beneficiary's state and federal drug benefits.

The combined drug benefits information will be loaded into the Master Beneficiary Database (the MBD). Data will be sent from the MBD to the TrOOP Facilitation contractor and Part D plans. An additional file format will be created to send back to the SPAP. This file will contain one status record for each record initially submitted by the SPAP to the BCRC. This response record will indicate if whether or not the SPAP enrollee is a Part D beneficiary; what the SPAP enrollee's Low Income Subsidy status is; whether or not the BCRC applied the record to the Medicare Beneficiary Database; if the record was not applied to the Medicare Beneficiary Database, why, (e.g., the record contained errors or the record did not provide enough information about the enrollee); what Part D plan the beneficiary is enrolled in; whether or not the beneficiary is receiving the Low Income Subsidy; and other Part D enrollment and Low Income Subsidy dates and levels.

### **3.2.3 Error Codes**

The edit checks applied to the SPAP input file will generate the following error codes, as necessary. This is a comprehensive listing of all the error codes that a partner may receive. The SPAP is expected

to correct any errors, or update any missing information on its enrollees, and re-transmit the revised data on the following month's file.

**Table 3-8: Error Codes**

<b>Error Code</b>	<b>Description</b>
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 18	Invalid Document Control Number. Field cannot be blank. Agreeing plan must assign each record a unique number in the event questions concerning a particular record arise and need to be addressed.
SP 24	Invalid Coverage Type. Field must contain alpha characters. Field cannot be blank or contain numeric characters. Valid values are: U: Network V: Non-Network
SP 31	Invalid SPAP Coverage 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 SPAP Coverage 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 SPAP effective date. If there is no termination date (coverage is still active), must use zeros (not spaces) in this field.
SP 62	Incoming termination date is less than effective date.

Additionally, the BCRC will provide RX-specific errors:

**Table 3-9: RX-specific Error Codes**

<b>Error Code</b>	<b>Description</b>
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 07	Beneficiary Does Not Have Part D Enrollment

Listed below are the disposition codes that the BCRC may provide to each SPAP Partner in the Update File Response.

**Table 3-10: Update File Response Disposition Codes**

Disposition Codes	Description
01	Record accepted by CMS System as an “Add” or a “Change” record.
SP	Transaction edit: Record returned with at least one edit (specific SP edits described below).
50	Record still being processed by CMS. Internal CMS use only; <i>no Agreeing Partner action is required.</i>
51	Beneficiary is not in file on CMS System. Record will not be recycled. Beneficiary most likely not entitled to Medicare. <i>Agreeing Partner should re-verify beneficiary status based on information in its files.</i>

NOTE: These are the standard error, edit and disposition codes used by the BCRC for processing drug records. However, not all of these codes are applicable in the SPAP data sharing process.

### 3.3 SPAP Data Processing

1. Each month the SPAP submits an electronic input file of all enrollees to the BCRC via an existing T-1 line or over the Internet using Secure FTP.
2. The BCRC edits the input file for consistency, and attempts to match those enrollees with Medicare Part D entitlement.
3. Where the BCRC determines that an enrollee on the SPAP file is a Medicare Part D beneficiary, the BCRC updates that record to the CMS Medicare Beneficiary Database (MBD), which holds prescription drug coverage and low-income subsidy information on all Medicare Part D beneficiaries. The MBD will send daily updates of all prescription drug coverage of Part D beneficiaries to the TrOOP facilitation contractor and to the Part D plan that the beneficiaries are enrolled in.
4. The BCRC then submits a response file to the SPAP via the same method the input file was submitted, i.e., via a dedicated T-1 line or Secure FTP. This file contains a response record for each input record the SPAP submitted. The response record shows if the SPAP enrollee is a Part D beneficiary, if the BCRC applied the record to the MBD, if the record was not applied to the MBD, and why (e.g., the record contained errors or the record did not provide enough information about the enrollee), in which Part D plan the beneficiary is enrolled, whether the beneficiary is receiving the Low Income Subsidy, and other Part D enrollment and Low Income Subsidy dates and levels.
5. The SPAP examines the response file to determine whether: the records were applied; the BCRC was not able to match the SPAP enrollee in the CMS systems; or the records were not applied because of errors. The SPAP must correct any records, so that in future input file submissions the corrected or updated records can be applied in the MBD. All errors need to be corrected because the MBD must have accurate, up-to-date coverage information in order for the TrOOP facilitation process to work.
6. The SPAP also updates its internal records on the Part D enrollment of its enrollees.

When the SPAP submits the next monthly full input file, it includes the corrections of all the errors from the previous submission.

### 3.4 SPAP Data Management Business Rules

1. The monthly file submitted by SPAPs is a full-file replacement. The entire base of enrollees must be submitted on this file each month. The submission will include any corrections from the previous month's file. Each month's input file will fully replace the previous month's input file.
2. One response file will be returned to each SPAP, containing one response record for each input record received. The disposition of each input record will be provided on the corresponding response record, indicating if the record was accepted.
3. The BCRC will attempt to create one drug record for each SPAP enrollee record received.
4. The BCRC will not send incomplete drug records to the MBD. Therefore, incomplete drug records will not be sent to the TrOOP facilitator.
5. Required fields for SPAP records are Social Security Number (SSN) or HICN, Surname, First Initial, Date of Birth, Sex Code, Network Indicator, SPAP Effective Date, SPAP Termination Date, Coverage Type Indicator, Insurance Type Indicator, and SPAP ID.
6. Low Income Subsidy information will be returned for all Qualified SPAP records. Qualified SPAPs are indicated by an Insurance Type of Q.
7. Non-qualified SPAP records will not receive Low-Income Subsidy information. Non-qualified SPAPs are indicated by an Insurance Type of N, O, P, R, or S.
8. If an SPAP input file submission is received by the BCRC with less than 70% of the number of records sent on the SPAP's previous input file submission, a "severe error" will be generated and the file will not be processed without additional confirmation from the plan. A file with this severe error can only be released for production if confirmation is received from the SPAP that the file is okay to process.
9. Responses will be returned with enrollment and LIS information regardless of whether this information has changed since the last submission.
10. If the record cannot be matched in the MBD, the BCRC will return a disposition of 51: Not Found, without any enrollment or LIS data, even if that record is matched on the BCRC's database.
11. When a response file is created that includes records that have responses still pending from the MBD, those records will be returned with the enrollment and LIS information, but with a disposition code of 50.

### 3.5 SPAP Implementation Questionnaire

The SPAP Implementation Questionnaire asks a series of questions of the data sharing partner that assists the BCRC and the partner in setting up the data sharing exchange process. These questions are intended to help you think through some of the issues which need to be addressed before you begin the data exchange and to assure that both the CMS and the SPAP partner are in agreement as to the operational process involved. **SPAP partners must fill out, sign and return a copy of the Questionnaire to the CMS with their signed SPAP Data Sharing Agreement.** The Questionnaire is also identified as Attachment C in the materials that new SPAP data sharing partners will acquire at the start of the implementation process.

## Chapter 4: Working with the Data

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### 4.1 Updates to the SPAP Process

#### “ID” Disposition Code

Some partners have seen an “ID” value in the Rx Current Disposition Code field (Field 19) for some records in their Response files. The “ID” Disposition Code is being caused by an identification error (an “ID” error) at the MBD, one of the systems feeding data to the BCRC.

The records on Input Files from our partners are matched against MBD records. The ID Disposition Code problem arises in some cases because the BCRC tries to apply an incoming record to the MBD, but the MBD does not find any existing record for that particular beneficiary, even though the MBD has already told the BCRC that the record exists. Fortunately, while this is only happening in a very limited number of cases an SPAP might still get some records with the “ID” code, seeming to show that the MBD matching process does not identify the incoming record. However, response records transmitted to the SPAP do include whatever Medicare information the BCRC had already received from MBD and stored for that beneficiary in the BCRC’s own database. While the beneficiary’s data cannot yet be validated absent a confirmation of acceptance from MBD, CMS staff continues to work to resolve this data reporting problem.

#### LIS Co-Pay Level ID and Deemed Co-Pay Level ID: Fields 55 and 56

The MBD feed to the BCRC includes Co-Pay Level ID data for both the LIS and Deemed categories. Field 55 shows LIS Co-Pay Level ID information. Field 56 shows Deemed Co-Pay Level ID information.

Partners should note that it is possible for an individual to have both LIS and Deemed Co-Pay Level ID information. For such individuals, the Deemed Co-Pay Level ID information in Field 56 takes priority over the LIS Co-Pay Level ID information in Field 55. Please review Fields 55 and 56 on the SPAP Response File layout, located on Pages 13 and 14.

### 4.2 Obtaining a TrOOP Facilitation RxBIN or RxPCN

TrOOP is the acronym for “true out-of-pocket” – spending by or on behalf of a Medicare beneficiary that counts toward the beneficiary’s Part D cost sharing. SPAP partners that provide their drug benefit using electronic data interchange networks (electronic at point-of-sale) are required to obtain unique electronic routing codes, referred to as their TrOOP facilitation Rx Bank Identification Number (RxBIN). RxBIN and Rx Processor Control Number (RxPCN) (also known as the Part D RxBIN and RxPCN). Within the data management network these unique codes will identify the SPAP partner’s drug benefits that are supplemental to Part D.

Using a TrOOP RxBIN and RxPCN will also support the pharmacy point-of-sale coordination system for TrOOP facilitation. The SPAP’s use of a unique TrOOP network routing code will allow the TrOOP Facilitation Contractor to capture the paid claims data of payers supplemental to Part D (including SPAPs) and send a copy of this data to the Part D Plan in which the Medicare beneficiary is enrolled. The Part D Plan will use the supplemental paid claims information it receives from the TrOOP Facilitation Contractor to update the calculation of the beneficiary’s TrOOP. To route these claims through the TrOOP Facilitation Contractor, partners may use a new, separate and unique RxBIN by itself, or a unique TrOOP RxPCN in addition to their existing non-TrOOP network RxBIN.

The organization that issues the RxBIN is the American National Standards Institute, or ANSI. (Note that a BIN is sometimes referenced as an IIN; an IIN is a BIN.) ANSI can be contacted through its Web address: [www.ansi.org](http://www.ansi.org).

The National Council for Prescription Drug Programs (NCPDP) issues the RxPCN. For TrOOP Facilitation routing, you can use a new RxPCN or obtain and use an additional RxPCN in lieu of an additional RxBIN. The NCPDP can be contacted through its Web address: [www.ncdp.org](http://www.ncdp.org).

### 4.3 Testing the Data Exchange Process

**Overview:** Before transmitting its first “live” (full production) input file to the BCRC, the partner and the BCRC will thoroughly test the file transfer process. Prior to submitting its initial Input Files, the partner will submit a test initial Input File to the BCRC. The BCRC will return a test initial Response File. The BCRC will correct errors identified in the partner’s test files. Testing will be completed when the partner adds new enrollees in test update Input Files, the BCRC clears these transmissions, and the partner and the BCRC agree all testing has been satisfactorily completed.

**Details:** The partner and the BCRC will begin testing as soon as possible, but no later than 180 days after the date the SPAP Data Sharing Agreement is in effect. 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 B, of the SPAP Data Sharing Agreement).

*Testing SPAP records:* The test file record layouts used will be the regular SPAP record layouts. Data provided in the 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, the BCRC will provide the partner with a response for every record found on it, usually within a 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.

After all file transmission testing has been completed to the satisfaction of both the SPAP Data Sharing partner and CMS, the partner may begin submitting its regular production files to the BCRC, in accordance with the provisions of Sections C and D of the SPAP Data Sharing Agreement.

In order to test the process for creating an Update File, a test “Update” shall be prepared by the partner and include data regarding individuals identified in the Test File. The partner shall submit the test Update data within ninety (90) days after receipt of the test Response File. The Test File Update shall include any corrections made in the previous Test Response File sent to the partner by the BCRC. For full file replacement, any corrections made to a file will fully replace what was previously submitted by the Partner. Upon completion of its review of the test update, the BCRC shall provide the partner a Response for every record found on the Test Update File. The BCRC shall provide a Test Update Response File to the partner, within a week, but no longer than forty-five (45) days after receipt of the partner’s Test Update File.

Once the BCRC and the SPAP partner have completed all file transmission testing to the satisfaction of both parties, the partner may begin submitting its regular production files to the BCRC.

### 4.4 SPAP File Processing

Using a transfer technology such as Secure File Transfer Protocol (SFTP) or Connect:Direct (formerly NDM), each month SPAPs will transmit *full file* submissions in the specified format. (For a fuller explanation of available data methods, see Chapter 5.2.) Full file processing requires the SPAP to submit a complete file of all current enrollees every month. Each month’s new Input File will fully replace the previous month’s Input File.

### 4.4.1 File Level Editing

Upon the BCRC's receipt of the SPAP Input File, high-level file edits are performed to verify the Input File's format and validity. Header and Trailer data and record counts are verified. The size of the SPAP Input File (number of records contained in the file) is compared to the size of the previous monthly file submitted. If the new file size is less than 70% of the previous month's file, a "severe error" will be produced, processing of the current Input File will be placed on hold, and the SPAP partner will be notified. Since the method for deleting existing enrollees in full file replacement processing is to not include them in a newly submitted file, if a new file is less than 70% of the size of the previous file the SPAP partner will be asked to verify what appear to be the high number of "delete" records in the new submission.

The new Input File is then processed at the record level to determine if each incoming enrollee record is an add, update, or delete, or if no action will be taken. The system also initially attempts to convert any SSN to a HICN if a HICN is not submitted on the input record.

### 4.4.2 Adds

Once a HICN is identified, the incoming record is compared to the CMS database to attempt to match it against previously submitted records. The initial matching criteria data set consists of the *HICN*, *Effective Date*, *Insurance Type*, and *SPAP ID*. If a match of these fields cannot be made on the CMS database, the incoming record is considered an add – a new record.

### 4.4.3 Updates

If the incoming record matches an existing record, additional fields are compared to determine if the incoming record should be considered an update. These fields include *RX ID*, *RX Group*, *Part D RxPCN*, *Part D RxBIN*, *Toll-Free Number*, *Coverage Type*, and *Termination Date*. If data in any of these fields has changed from the previous submission the record is considered an update.

### 4.4.4 Deletes

Any records contained on the previous month's file that are not included in the current submission are designated as deleted records. In your Response File you will receive a notice that the record submitted and accepted by CMS on the previous month's file has now been deleted from CMS' data system.

#### NOTES:

**A deletion should only be used to remove a record that never should have been included in the CMS database. All Input files should contain records of all SPAP Enrollees whose SPAP enrollment terminated up to thirty-six months (36) prior to the first day of the month in which the current Input File is generated, or whose SPAP enrollment terminated after December 31, 2005, whichever date is most recent. Failure to continue submitting these older valid records will cause them to be erroneously deleted from the CMS database, as if the records should never have been posted to begin with.**

**While Medicare claims filing deadlines are 12 months after the date of service, it is important that you continue to send the record for 36 months after the beneficiary is no longer enrolled in the SPAP. This is because Medicare Part D regulations require Part D sponsors to coordinate benefits with SPAPs and other entities providing prescription drug coverage for a period of 3 years.**

**This is also especially important to remember now that the One for One response system has been instituted. (See "Response Files," below.)**

#### 4.4.5 Errors

Records containing errors are returned to the SPAP with the error code contained in the error number field on the response record. It is expected that the SPAP will correct the error and resubmit the record in the next month's file.

#### 4.4.6 Notification to the MBD

Once processing is completed, a file is created and transmitted to MBD containing the adds, updates, and delete records generated by the BCRC from the Input File submitted by the SPAP. MBD returns a file to the BCRC containing Part D enrollment information and LIS data for qualified SPAP enrollees.

#### 4.4.7 Response Files – “One for One” Responses

Within 15 days of the SPAP input file submission, the BCRC generates and transmits a response file to the SPAP. A response record is generated for each input record as well as responses indicating which records were deleted because they were not included in the current file – it is a “one for one” response system. As a result, the SPAP will receive updated Part D enrollment or LIS status regardless of whether an input record is new, changed or deleted. And an input record that has already been applied in a previous full file submission and that is contained in the current submission unchanged will also generate a response record.

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 SPAP Response File 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 25 in the SPAP 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 26 in the SPAP Response File.

The beneficiary's current Part D Plan is identified in Current Medicare Part D Plan Contractor Number. It is Field 45 in the SPAP Response File.

Current Medicare Part D Plan 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 46 in the SPAP Response File.

Current 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 47 in the SPAP Response File.

Fields 46 and 47 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 SPAP partners, on a routine basis these two sets of fields are the most immediate indicators of Part D coverage.

## Chapter 5: SPAP Frequently Asked Questions

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### 5.1 General Questions

**Q1: Will we receive other “other coverage” information for SPAP enrollees who are not enrolled in a Medicare Part D Plan?**

**A1:** The BCRC will provide a response to you indicating which SPAP Enrollees are Medicare Part D enrolled, and which have been approved for the LIS. The CMS is not permitted to share information about other insurers with its partners.

**Q2: Will we receive LIS information for people who have not yet selected a plan?**

**A2:** Yes, you will receive LIS information regarding those individuals who qualify. However, CMS will not have Part D enrollment information until the individual enrolls (or is auto-enrolled) into the program.

**Q3: What are considered CMS’ acceptable methods for transmitting data when conducting the SPAP data exchange process?**

**A3.** If you are a state agency (or affiliated with a state agency) that has access to a dedicated AGNS T-1 line to the CMS, you can use existing programming with this line to send and receive your files. Alternatively, any of our partners may establish its own T-1 connection with CMS. To use this data transmission method please contact your EDI Representative (EDI Rep).

An option in broad use by our other partners is to submit and receive files over the Internet through SFTP. Another Internet-based transmission option is Hypertext Transfer Protocol Secure (HTTPS). There is no additional cost associated with using SFTP or HTTPS as long as the Internet Explorer browser is used. However, use of HTTPS does not permit automated data management.

File transfer using physical media is not permitted.

Other options may be mutually available. If a partner is contemplating a method of data transmission that has not been discussed above, you will need to work with your technical representative at the BCRC directly to establish an alternative data transmission procedure, if one is possible. But in any case, starting April 1, 2007, no partner will any longer be permitted to use hard media for data transmission.

**Q4: Will data transfer via a T-1 line be passed through without any “parking” at CMS so that it does not interfere with the timeliness of the monthly transmissions to BCRC?**

**A4:** The data transfer will be a pass-through.

**Q5: When will an SPAP ID be assigned?**

**A5:** The SPAP ID will be assigned once the BCRC has received confirmation from CMS that a SPAP Data Sharing Agreement has been executed by CMS and the SPAP.

- Q6: Is there the possibility of receiving overlapping enrollment or multiple Prescription Drug Plan (PDP) information on a beneficiary?**
- A6:** CMS will not send multiple records on a beneficiary. Partners will only receive the most recent information for that beneficiary. If a beneficiary starts with one PDP at the beginning of the month, then changes to another PDP mid-month, CMS will report the most recent PDP enrollment.
- Q7: The BCRC SPAP data exchange is a monthly process. What is the schedule for this process? Will the data exchange happen at the beginning, middle or end of month?**
- A7:** The BCRC will work with each SPAP partner during the Preparatory Period to set up a data production schedule. Each state needs not and will not have the same schedule.
- Q8: Why is it necessary for the SPAP to send records on beneficiaries for up to 36 months after eligibility has been terminated in the SPAP?**
- A8:** Medicare claims filing time limits allow claims to be filed up to 12 months after the date of service on the claim. Thus, it is important that payer data remain on CMS' systems for up to 36 months after payer coverage ends so that, in the event an additional claim is filed after the date of service, Medicare and other payers can make the proper payment (and payment order) determination. If an SPAP record is sent one month, but not the next, the BCRC will delete the record, as though it was never supposed to have been posted to begin with. To keep records active in the database, they obviously cannot be deleted. Also, while 12 months is the period of time a Medicare claim can be filed after the last date of service, Medicare Part D regulations require Part D sponsors to coordinate benefits with ADAPs and other entities providing prescription drug coverage for a period of 3 years.
- Q9: In our state we have two SPAPs, one that has about 7,200 clients while the other has fewer than 600 clients. For the sake of minimizing paperwork and maximizing efficiency, can we combine these two programs for the purposes of the SPAP-CMS data sharing agreement?**
- A9:** Yes, you could combine the two programs for the sake of administrative efficiency. However, we will mutually have to sign two separate SPAP DSA signature pages, one for each SPAP. Then, for the data exchange we will need to assign you two different SPAP IDs. We can take the files from the same source, but they would have to be separated by the appropriate ID, with unique headers and trailers for each.
- Q10: With regard to the Administrative and Technical contacts needed for the SPAP-CMS data exchange, must either or both of these contacts be "State" staff or may they be "Contractor" staff?**
- A10:** The State can designate whomever it wants as the administrative and technical contacts, including staff with a contractor. But only a State official with signature authority can sign the actual SPAP Data Sharing Agreement.
- Q11: What are the requirements that must be met in order to successfully complete the testing phase of the SPAP data sharing exchange process?**
- A11:** At a minimum CMS requires the SPAP partner to be able to (1) submit an initial test Input File that can be processed to the satisfaction of the BCRC, (2) receive and process a test Response File from the BCRC, and (3) be able to submit a test update file to the BCRC. The BCRC has

been delegated the authority to determine whether or not the SPAP partner has successfully completed the testing process to the satisfaction of CMS.

## 5.2 Data Elements

**Q1: When the SPAP submits the next monthly input file, it also sends the corrections of all the errors from the previous submission. Are we sending the full file (all SPAP eligible enrollees)?**

**A1:** Yes, you would send a full file.

**Q2: Should we exclude previously matched records?**

**A2:** No, you should include previously matched records. If you don't, the previously submitted records will be deleted from CMS's data system. The only previously submitted records that should not be included in your current full file submission are ones you had sent in error, and that you want completely deleted from CMS' data systems.

If a record is sent one month, but not the next, the BCRC will delete the record. Medicare claims filing time limits allow claims to be filed up to 27 months after the final date of service. "Other payer" data must remain on CMS' systems for up to 27 months after coverage ends so that, in the event a claim is filed after the final date of service, Medicare and other payers can still make correct payment determinations.

**Q3: Are "errors" just data discrepancies (e.g., a mismatched SSN)?**

**A3:** Errors can include data that is defective or that contains an invalid value, such as an alpha character in a field requiring a numeric date. The error could also result from faulty programming. In any case, your Response File will identify the type of error using the CMS' standard error codes.

**Q4: Will we be receiving only Medicare Part D enrollment information, or will we receive information on all the other prescription coverage carried by the enrollee?**

**A4:** You will only receive Medicare Part D enrollment information for the SPAP enrollees you submitted to the BCRC.

**Q5: What field on the Response File indicates Medicare D enrollment?**

**A5:** The Current Medicare Part D Plan Enrollment Date – Field 46 in the SPAP Response File layout – identifies current Medicare Part D enrollment information.

**Q6: What field identifies the Medicare D insurer?**

**A6:** The Current Medicare Part D Plan Contractor Number – Field 45 in the SPAP Response File Layout – gives the ID number of the Part D plan a beneficiary is enrolled in.

**Q7: If other additional other insurer information is being sent, what field will have it?**

**A7:** The SPAP data exchange only provides Medicare Part D enrollment information on your clients. However, it also gives LIS information, if applicable, for an individual. The data exchange does not provide you with any other insurer information.

- Q8: We currently do not mandate collection of an SSN from a participant, although most of our participants have an SSN. In the cases where we do not have an SSN, do we send what information we have on the input file? If so, do we zero fill the SSN field or leave it blank?**
- A8:** Either the SSN or the Medicare Health Insurance Claim Number (HICN) is our primary identifier for determining Medicare entitlement. If you do not have either one of these numbers, you should not submit the record, at all. We cannot perform our matching process without one ID number or the other. However, if the information you are sending does not require finding a match, and you don't have the SSN or HICN, you should zero-fill those fields.
- Q9: Is the Part D RxBIN and RxPCN the information that is identifying the Part D carrier or is it being used to identify other insurance as well?**
- A9:** This information does not identify the Part D carrier. The Part D RxBIN and Part D RxPCN are numbers used to electronically route network pharmacy benefit information. While an SPAP might already have an RxBIN or RxPCN to electronically move network claims, a *Part D specific* RxBIN (or RxPCN) is necessary to support the Part D TrOOP Facilitation process. One of these code numbers will be used as the primary means of capturing claims paid secondary to Part D. The Current Medicare Part D Plan Contractor Number (ID) is in Field 45 of the SPAP Response File.
- Q10: What does “network” refer to? Is it the coverage type? Is it what determines if a person has network coverage ((Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO))?)**
- A10:** No. In this program “network coverage” refers to the nationwide system of electronic routing of prescription drug claims, starting at the point-of-sale.
- Q11: What does the disposition code identify? Is this simply a “Yes or No” indication of coverage on the MBD?**
- A11:** No. The disposition code lets you know what action the BCRC has taken regarding the submitted record. For instance, if the record is not found, the BCRC will provide the data sharing partner with a disposition code that indicates that the record provided was not found. Additionally, if a record is not applied to the database due to errors in the record, the disposition code provides you with that information.
- Q12: In the latest Response File specifications, you’ve added the Plan Benefit package (PBP) (Field 52). Is the 3 byte PBP code unique without considering the PDP? In addition, we have determined that we will need the PBP enrollment start and end dates. We request that this information be added to the SPAP Response file.**
- A12:** The PBP code number must be used in conjunction with the PDP's contractor number. There will not be a start and stop date for the PBP in the Response File. If the PBP changes, states will receive the same PDP ID number and the new PBP ID number. The PDP effective (Enrollment) date will not change. States should note the changed PBP number and input a new PBP start date. The CMS is considering adding the PBP enrollment start and end dates in the future.

**Q13: Are PDP's eligible for the NplanID?**

A13: The NplanID field is there as a place-holder (for future use). All payers of health care coverage, including Medicare HMOs and Part D Plans, will be assigned an NplanID when the numbering system is implemented.

**Q14: Will either the BCRC SPAP or MMA response files contain retroactive eligibility/enrollment for a beneficiary?**

A14: Yes. But the earliest Part D Plan enrollment effective date is 01/01/06.

**Q15: What is the SPAP ID?**

A15: The SPAP ID number is a code assigned by the BCRC which identifies a particular SPAP.

**Q16: The data layout indicates space for 4 Rx error codes, yet the user guide lists 7 Rx error codes and several error codes starting with SP?**

A16: The file has space for only 4 error codes. These fields may contain either the SP or the RX error code. CMS does not anticipate a state having more than 4 error codes for an individual and any one time.

**Q17: Q18: Is the new RxBIN/RxPCN for our Medicare Part D claims payments the RxBIN/RxPCN that we will always be sending in the monthly input? In what circumstances would we not know what the correct RxBIN/RxPCN would be? Would your system ever correct the RxBIN/RxPCN and send the new number back to us?**

A18: We only need the Part D specific RxBIN (or RxPCN) in order to pass it on to the Part D Plan and TrOOP facilitator. Because you will not necessarily know those of your enrollees who are beneficiaries, we are asking you to routinely populate the RxBIN and RxPCN fields with your Part D specific RxBIN or RxPCN. You need to provide us with your Part D specific RxBIN or RxPCN.

**Q19: Are we to send all of the SPAP enrollees in the input file, or only those who have told us that they have Medicare and therefore are eligible for Part D Plans?**

A19: We do not expect you to know of all of your enrollees who are Medicare beneficiaries. Your file submissions are, essentially, finder files. You send all of your enrollees, and we return a file indicating: Those we matched on and applied; those we matched on but didn't apply, because of errors in the record; and those we did not match on as beneficiaries.

**Q20: Is there any indicator on the response file that tells us if a person is ineligible for Part D and a reason? I know that there are various reasons for being ineligible. Some may not have Medicare A or B, but there could also be those whose employers accepted the Part D subsidy and thus they cannot enroll in Part D. How would we determine this?**

A20: Such information can't be supplied by CMS at this time. The information is something you will have to develop for with your enrollees.

**Q21: If the Co-Pay Level ID value changes, will the Co-Pay Effective date be updated also?**

A21: Yes.

- Q22: If the Co-Pay Level ID changes, will an SPAP partner receive 2 records (one record with an end date on the old level value and one with the new level and effective date)?**
- A22:** No. You will receive the current record with the new level and effective date.
- Q23: What is the difference between Contract Number and Plan Benefit Package (PBP) Number?**
- A23:** The Contract Number identifies the Part D plan the beneficiary is enrolled in. The PBP identifies which benefit package within that plan the beneficiary is enrolled in.
- Q24: What does EEVS stand for under value 12 of the Current Deemed Reason Code?**
- A24:** EEVS stands for Eligibility and Enrollment Verification System. This code is assigned to cases deemed from March 2005 data with no later state MMA file submissions. If a beneficiary is identified as deemed based on code 12, they were deemed for calendar year 2006 as a full dual.

## Appendix A: Acronyms

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**Table A-1: Acronyms**

<b>Term</b>	<b>Definition</b>
AGNS	AT&T Global Network Services
BCRC	Benefits Coordination & Recovery Center
CHAPS	Community Health Accreditation Program
CMS	Centers for Medicare & Medicaid Services
CR	Change Request
DSA	Data Sharing Agreement
FPL	Federal Poverty Level
HICN	Health. Insurance Claim Number
HMO	Health Maintenance Organization
LIS	Low Income Subsidy
MBD	Medicare Beneficiary Database
MMA	Medicare Modernization Act
PBM	Pharmacy Benefit Manager
PBP	Plan Benefit Package
PDP	Prescription Drug Plan
PPO	Preferred Provider Organization
RxBIN	Rx Bank Identification Number
RxPCN	Rx Processor Control Number
SFTP	Secure File Transfer Protocol
SPAP	State Pharmaceutical Assistance Program
SSN	Social Security Number
TrOOP	True Out-of-Pocket
VDSA	Voluntary Data Sharing Agreement

## **Appendix B: Previous Version Updates**

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### **Version 10.4**

The document had been reformatted to CMS user guide standards.

### **Version 10.3**

Section C, Part IV: Using BASIS for Queries, and related references, has been removed.