AIDS Drug Assistance Program (ADAP) Data Sharing Agreement

User Guide

Version 1.9

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Confidentiality Statement

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INTRODUCTION

This *ADAP Data-Sharing Agreement User Guide* provides information and instructions for the AIDS Drug Assistance Programs (ADAPs) to implement and manage their information-sharing process with the Centers for Medicare & Medicaid Services (CMS). In particular, the information in this user guide will allow data exchange partners to coordinate Medicare Part D drug benefits with CMS, within the requirements 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, partners will be provided with new and up-to-date sections of this guide. Updated versions must replace any older versions of the guide that you might have. Please contact CMS should you have any questions regarding this user guide.

This user guide assumes a fairly comprehensive understanding of the current data sharing 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 data sharing 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@ghimedicare.com, or call 646-458-6740.

If you would like more general information about the current data sharing process, please email vanessa.jackson@cms.hhs.gov, or call 410-786-3276. Remember to provide us with the email address, phone number and other contact information for individuals you would like to have included in the reply.

Chapter 1: Summary of Version 1.9 Changes

The following updates have been made in Version 1.9 of the ADAP Data Sharing Agreement (DSA) User Guide:

To improve point-of-sale/pharmacy processing and plan payments, the criteria for several fields have been changed for users submitting primary and supplemental drug records, specifically for the Rx Insured ID Number, Rx PCN, and Rx BIN Number on the ADAP Input File Layout (Section 3.2.1).

As part of CMS' commitment to the modernization of the Coordination of Benefits & Recovery (COB&R) operating environment, changes have been implemented to move certain electronic file transfer data exchanges to the CMS Enterprise File Transfer (EFT) protocol (Section 4.1).

Chapter 2: Completing and Signing a DSA

To make the CMS relationship operational with an ADAP, the potential data sharing partner and CMS have to sign and exchange completed copies of a DSA.

To complete a DSA, ADAPs must use the online Health Plan Management System (HPMS). HPMS provides a single, secure point-of-contact for ADAP State users when communicating with CMS.

2.1 Using HPMS

Qualified ADAP users will be able to enter into a DSA with CMS through HPMS. These agreements allow data exchanges with CMS to facilitate the coordination of a Medicare beneficiary's prescription drug benefits. Qualified users will be able to review, initiate, and electronically sign the DSA within the HPMS module.

To access HPMS, ADAP users can log in at: https://hpms.cms.gov. From the home page, go to Contract Management / SPAP/ADAP Data.

2.2 Updating Contact Information

Each ADAP is responsible, on an ongoing basis, for communicating any changes in contact information to CMS. Failure to do so will jeopardize the partner's knowledge of, and thus compliance with, key program requirements and deadlines.

To update your contact information, please contact your Electronic Data Interchange (EDI) Representative.

Please direct questions about this guidance to vanessa.jackson@cms.hhs.gov, or call 410-786-3276.

Chapter 3: Standard Data Files

3.1 Standard Reporting Information

Standard Data Files: The data exchanged through the DSA process are arranged in two different files (also referred to as record layouts). A data sharing partner electronically transmits a data file to CMS' Benefits Coordination & Recovery Center, referred to throughout this document as the 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 data sharing partner will submit its covered 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 enrollees who also have Part D.

Current versions of the Standard Data Files immediately follow. Once again, we remind you that the information provided here will likely change from time to time. All updates to the material in this user guide are listed in Chapter 1. Please check our website for the latest edition of this user guide.

3.2 The Input and Response File Data Layouts

Input File: This is the data set transmitted from a data sharing partner to the BCRC on a monthly basis. It is used to report information regarding enrollees—individuals who are eligible for and enrolled in an ADAP 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. Data sharing partners are required to continue to include coverage records for 3 years after the termination date of the coverage.

The business rules for use of the Input File immediately follow the data file layout itself.

If the partner sends more than one Input File in one day, the system will process the files without terminating, or abending, the job. If the first Input File passes its edit checks, it is processed, and a Response File is sent to the partner, per current processes. If second and subsequent input files sent that day pass their edit checks, they are added to a multiple file submissions report for review by the BCRC.

Note: If the first Input File sent is rejected, the subsequent files sent the same day are not processed automatically. In this case, the BCRC will contact the partner regarding file resubmission and processing.

Response File: This is the data set transmitted from the BCRC to the data sharing partner after the information supplied in the partner's 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, indicated by disposition and edit codes which let you know what we did with the record. The Response File will also contain new information for the partner regarding the submitted enrollees, including Medicare enrollment information if a match was found.

3.2.1 ADAP Input File Layout

Table 3-1: ADAP Input File Layout – 249 Bytes

Field	Name	Size	Displacement	Data Type	Description
1.	SSN	9	1-9	Numeric	Social Security Number. Required if Medicare ID is not provided. If unavailable, fill with spaces.
2.	Medicare ID	12	10-21	Alpha-Numeric	Medicare ID, which can be either the Health Insurance Claim Number (HICN) or the Medicare Beneficiary Identifier (MBI). Required if SSN is 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 Coverage - Required CCYYMMDD
8.	Termination Date	8	46-53	Date	Termination Date of Coverage - Required CCYYMMDD *Use all zeros if open-ended
9.	Filler	10	54-63	Alpha-Numeric	Unused field Fill with spaces only.
10.	Rx ID/Policy Number	20	64-83	Text	Covered Individual Pharmacy Benefit ID - Required Provide Policy Number if Coverage Type = V Cannot be blank or all zeros if Coverage Type is U.
11.	Rx Group	15	84-98	Text	Pharmacy Benefit Group Number Provide if Rx Group values assigned; otherwise, fill with spaces.

Field	Name	Size	Displacement	Data Type	Description
12.	Part D RxPCN	10	99-108	Text	Part D-specific Pharmacy Benefit Processor Control Number. **Note:** If Coverage Type = U, provide the applicable Part D RxPCN that, along with the Part D RxBIN, would denote Supplemental Drug. Must provide if available; otherwise, fill with spaces. Cannot have special characters, except for a non-leading dash, and no leading space.
13.	Part D RxBIN	6	109-114	Text	Part D-specific Pharmacy Benefit International Identification Number – Required if Coverage Type is U. Must be a 6-digit number and digits cannot be all the same number if Coverage Type is U.
14.	Toll-Free Number	18	115-132	Text plus "(" and ")"	Pharmacy Benefit Toll-Free Number – Required
15.	Document Control Number	15	133-147	Text	Document Control Number Assigned by ADAP – 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 S: ADAP (If qualified send Low Income Subsidy [LIS] data.)
18.	Filler	100	150-249	Alpha-Numeric	Unused Field Fill with spaces only

Table 3-2: ADAP Input File Header Record – 249 Bytes

All fields required.

Field	Name	Size	Displacement	Data Type	Description
1.	Header Indicator	2	1-2	Alpha-Numeric	Should be: 'H0'
2.	ADAP-ID	5	3-7	Alpha-Numeric	DSA Identifier ADAPs start with "SD."
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: ADAP Input File Trailer Record – 29 Bytes

All fields required.

Field	Name	Size	Displacement	Data Type	Description
1.	Trailer Indicator	2	1-2	Alpha-Numeric	Should be: 'T0'
2.	ADAP-ID	5	3-7	Alpha-Numeric	DSA Identifier ADAPs start with "SD."
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. Pad with leading zeroes to make 9 digits.

3.2.2 ADAP Response File Layout

Table 3-4: ADAP Response File Layout – 417 Bytes

Field	Name	Size	Displacement	Data Type	Description
1.	SSN	9	1-9	Alpha-Numeric	Social Security Number
2.	Medicare ID	12	10-21	Alpha-Numeric	Medicare ID (HICN or MBI)
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 Coverage CCYYMMDD
8.	Termination Date	8	46-53	Alpha-Numeric	Termination Date of Coverage CCYYMMDD *Use all zeros if open-ended
9.	Filler	10	54-63	Alpha-Numeric	Unused Field
10.	Rx ID	20	64-83	Alpha-Numeric	Covered Individual Pharmacy Benefit ID
11.	Rx Group	15	84-98	Alpha-Numeric	Pharmacy Benefit Group Number
12.	Part D RxPCN	10	99-108	Alpha-Numeric	(Part D specific) Pharmacy Benefit Processor Control Number
13.	Part D RxBIN	6	109-114	Alpha-Numeric	(Part D specific) Pharmacy Benefit International Identification Number
14.	Toll-Free Number	18	115-132	Alpha-Numeric	Pharmacy Benefit Toll-Free Number
15.	Original Document Control Number	15	133-147	Alpha-Numeric	Document Control Number Assigned by ADAP

Field	Name	Size	Displacement	Data Type	Description
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	S: ADAP (If qualified send LIS data)
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 (LIS) CCYYMMDD
29.	Part D Subsidy Termination Date	8	223-230	Alpha-Numeric	Termination Date of Low Income Subsidy CCYYMMDD

Field	Name	Size	Displacement	Data Type	Description
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% FPl); 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
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

Field	Name	Size	Displacement	Data Type	Description
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
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 the current Medicare Part D Plan CCYYMMDD

Field	Name	Size	Displacement	Data Type	Description
47.	Current Part D Plan Termination Date	8	284-291	Alpha-Numeric	Termination Date of Coverage provided by the 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.
49.	Current DEEMED End Date	8	300-307	Alpha-Numeric	(This field is only applicable to people who are deemed eligible for the low-income subsidy). 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”. CCYYMMDD

Field	Name	Size	Displacement	Data Type	Description
50.	Current DEEMED Reason Code	2	308-309	Alpha-Numeric	Code indicating the reason the beneficiary was deemed eligible for LIS. Values: 01=Eligible is entitled to Medicare – QMB only; 2A=Eligible is entitled to Medicare – QMB and Medicaid coverage including RX and FPL>100% 2B= Eligible is entitled to Medicare - QMB and Medicaid coverage including RX and FPL= or <100% 03= Eligible is entitled to Medicare-SLMB only 4A= Eligible is entitled to Medicare - SLMB and Medicaid coverage including RX FPL>100% 4B=Eligible is entitled to Medicare-SLMB and Medicaid coverage including RX FPL= or <100% 06=Eligible is entitled to Medicare-Qualifying Individuals 8A=Eligible is entitled to Medicare-Other full dual eligibles FPL>100% 8B=Eligible is entitled to Medicare-Other full dual eligibles FPL= or <100% 10=SSI 11=MBD 3rd Party (partial dual) 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.

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	Actions taken from full file replacement include: 0- New Record: New record on input file but not in existing database so record was added. 1- Delete Record: Record was not found on the input file, so the existing record was deleted. 2- Update Record: Existing record updated based on new information on input record. **Note:** If the input record contains exactly the same data as the existing record the transaction type currently on the existing record will be returned.

Field	Name	Size	Displacement	Data Type	Description
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
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: ADAP Response File Header Record – 417 Bytes

All fields required.

Field	Name	Size	Displacement	Data Type	Description
1.	Header Indicator	2	1-2	Alpha-Numeric	Should be: ‘H0’
2.	ADAP-ID	5	3-7	Alpha-Numeric	DSA Identifier ADAPs start with “SD.”
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: ADAP Response File Trailer Record – 417 Bytes

All fields required.

Field	Name	Size	Displacement	Data Type	Description
1.	Trailer Indicator	2	1-2	Alpha-Numeric	Should be: ‘T0’
2.	DSA-ID	5	3-7	Alpha-Numeric	DSA Identifier ADAPs start with “SD.”
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

3.3 Data Type Key

3.3.1 Conventions for Describing Data Values

The following table describes the data types used by the BCRC for its external interfaces (inbound and outbound). The formatting atandards used with each data type correspond to the requirements of the interface layout.

This key is provided to augment the rules prescribing the formatting of data values that are provided within the ADAP Data Exchange Layout fields.

These standards should be used unless otherwise noted in the layouts.

Table 3-7: Data Type Key

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): “MM236 "
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	-

3.4 Data Management Process

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

3.4.1 Processing Requirements

All Partners

1. BCRC receives external files from a data sharing partner through a dedicated T-1 line (AT&T Global Network Services [AGNS]), HTTPS, or Secure File Transfer Protocol (SFTP).
2. The input files are checked to ensure they are in the correct format.
3. A check is performed to detect and bypass duplicate files.
4. Records are edited for required fields and data format.
5. Records received are matched to the exiting BCRC tables.
6. Transactions are created to add new records that were received, update existing records or delete records that were not received on the input file.
7. Transactions are sent to the Medicare Beneficiary Part D Database (MBD).
8. Results from MBD are used to create the response files.
9. Beneficiary Part D eligibility/enrollment information will be retrieved and added to the response files. LIS information will be included for ADAP DSAs.
10. Response files are transmitted to the DSA partner.

3.4.2 Process Description

The purpose of the file process is to enable coordination of information about prescription drug benefit coverage between Medicare Part D plans and the ADAPs. For ADAPs, this process will facilitate the tracking of TrOOP (“true out-of-pocket”) expenses incurred by each Medicare beneficiary.

In order to coordinate benefit information, data must be collected from each ADAP on each of its enrollees. Submission file formats have been created for the partners to use. This input information from a partner will be transmitted to the BCRC where it will be edit-checked, and matched against Medicare data in various eligibility databases. Once a match is found, the BCRC will be able to coordinate the beneficiary’s prescription drug information with the beneficiary’s Medicare Part D information, to create a record of the beneficiary’s prescription drug and Medicare drug benefit coverages.

The combined drug benefit coverage information will be loaded into the Medicare Beneficiary Database (MBD). Data from the MBD will be transmitted to Part D plans. A Response File format has been created to be used to return information to the ADAP. It will contain one status response record for each record initially submitted by the partner to the BCRC. The response record will indicate if the enrollee is a Part D beneficiary, the LIS status of the enrollee, whether or not the BCRC applied the record to the MBD and if the record was not applied to the MBD, why not (e.g., the record contained errors or the record did not provide enough information about the enrollee), what Part D plan the beneficiary is in enrolled in, and other selected Part D enrollment information.

3.4.3 Disposition and Error Codes

3.4.3.1 Disposition Codes

Listed below are the disposition codes that the BCRC may provide in a Response File received by an ADAP. Disposition codes provide information about the general status of the data included in a partner's input files.

Table 3-8: Disposition Codes

Disposition Codes	Description
01	Record accepted by CMS Systems, as an “Add” or a “Change” record.
SP	Transactions edit; record returned with at least one edit. Specific SP (and RX) edits are described below.
50	Record still being processed by CMS. Internal CMS use only; no partner action is required.
51	Beneficiary is not on file with CMS. Record will not be recycled. Beneficiary most likely not entitled to Medicare. Partner should reexamine Medicare beneficiary status based on information in its own files.

3.4.3.2 Error Codes (SP and RX Edits)

The BCRC will perform edit checks on partner input files and will generate the following transaction error codes, as necessary. The BCRC will supply the edit check results to the partner. The ADAP will be expected to correct any errors or update any missing information on its enrollees, and re-transmit the revised data on the following month’s Input File submission. The SP errors that apply to records are as follows:

Table 3-9: SP Error Codes

Error Code	Description
SP 12	Invalid Medicare ID (HICN or MBI) or SSN. 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: 0 = Unknown 1 = Male 2 = Female
SP 18	Invalid Document Control (DC) Number. Field cannot be blank. The ADAP must assign each record a unique DC number in the event questions concerning a particular record arise and need to be addressed.

Error Code	Description
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 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 (CCYYMMDD).
SP 32	Invalid Coverage Termination Date. Field must contain numeric characters. Date must correspond with the particular month. Cannot be earlier than the effective date (CCYYMMDD). **Note:** 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. These are standard DSA error, edit, and disposition codes used by the BCRC for processing drug records. Some of these codes are not applicable to all partner data sharing processes.

Table 3-10: 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 07	Missing Part D Effective date
RX 23	NDC-1 Required (Field cannot be left blank.) (Field must be 11-character numeric.)
RX 24	Invalid NDC-2 (Field must be 11-character numeric.)
RX 25	Invalid NDC-3 (Field must be 11-character numeric.)
RX 26	Invalid NDC-4 (Field must be 11-character numeric.)
RX 27	Invalid NDC-5 (Field must be 11-character numeric.)

3.4.4 Data Processing

1. Each month the ADAP submits to the BCRC an electronic Input File of all its enrollees, over the Internet using Secure FTP or HTTPS or via an existing T-1 line.
2. The BCRC edits the Input File for consistency, and attempts to match the enrollees with Medicare Part D enrollment.
3. Where the BCRC determines that an enrollee on the partner's file is a Medicare Part D beneficiary, the BCRC updates that record to the CMS Medicare Beneficiary Database (MBD). The MBD will send daily updates of all prescription drug coverage of Part D beneficiaries to the Transaction Facilitation Contractor and to the Part D plan that the beneficiary is enrolled in.
4. The BCRC then submits a Response File to the ADAP using the same method the Input File was submitted. This file contains a response record for each input record the partner submitted. The

response record shows if the 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, and other Part D enrollment information.

5. The ADAP then examines the Response File to determine whether: The records were applied to CMS systems; the BCRC was not able to match the enrollee in the CMS systems; or the records were not applied because of errors. The partner must correct any defective records so that when they are included in future input files they can be applied to the MBD. Errors have to be corrected because the MBD must have accurate, up-to-date partner coverage information.
6. The ADAP updates its internal records regarding the Part D enrollment of its beneficiaries.
7. When the ADAP submits its next monthly full Input File, it also sends corrections for all the errors found in its previous submission.

3.4.5 Business Rules for Processing

1. The monthly Input File submitted by the partner is a full-file-replacement file. The partner's entire file (participation record) of enrollees must be submitted each month on this file, and it must include any corrections to errors found in the previous month's file. Each month's Input File will fully replace the previous month's Input File.
2. Data-sharing partners are required to continue to include coverage records for 3 years after the termination date of the coverage.
3. A Response File will be returned to each partner, containing a response record for each input record received. This Response File will also contain a response record for each deleted record (i.e., records that were in the previous Input File that are not in the current Input File). The disposition of the input record will be provided on its corresponding response record, including whether the record was accepted.
4. The BCRC will attempt to create one record for each enrollee record received.
5. The BCRC will not send incomplete records to the MBD. Consequently, incomplete drug records will also not get sent to the Transaction Facilitation Contractor (ADAPs and SPAPs only).
6. On all ADAP input files, the fields required are Medicare ID (HICN or MBI) or SSN, Surname, First Initial, Date of Birth, Sex Code, Network Indicator, Effective Date, Termination Date, Coverage Type Indicator, Insurance Type Indicator, and ADAP ID (in both the Header and Trailer).
7. If a new Input File is received by the BCRC, it is compared with the previously submitted Input File. If it is detected that processing the new Input File will delete at least 30% of the records that were accepted in the previous submission, a "threshold error" will be generated and the file will not be processed without additional confirmation from the data-sharing partner. The ADAP will be asked to verify the high number of delete records in the current submission.
8. LIS information will be returned for all qualified ADAP records. Qualified ADAPs are indicated by an Insurance Types of S.
9. Non-qualified ADAP records will not receive LIS information. Non-qualified ADAPS are indicated by an Insurance Type of N.
10. Responses will be returned with enrollment and LIS information regardless of whether this information has changed since the last submission.

11. If the record cannot be matched in the MBD, the BCRC will return a disposition code of "51": Not Found, without any enrollment or LIS data, even if that record is matched on the BCRC's database.
12. 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."

Chapter 4: Working with the Data

4.1 Establishing Electronic Data Exchange

A number of methods of electronic data transmission are available when an ADAP is ready to exchange files with the BCRC in test or production modes. Following is an overview of the most common. The Partner's assigned EDI Representative at the BCRC can address a ADAP's specific questions and concerns.

CMS' preferred method of electronic transmission is with a partner is via programs using either SFTP or HTTPS. We recommend either of these options for partners that anticipate having a relatively low volume of data to transmit.

In addition, the ADAP can use Connect: Direct (formerly known as the Network Data Mover or NDM) via the CMS Electronic File Transfer (CMS EFT) protocol. This system provides a direct file transmission connection to the CMS Extranet Network and CMS' private CMSNet. This is the most costly transmission method, and recommended only if a partner will be exchanging very large amounts of data with CMS. For more information on this method of electronic transmission please contact your EDI Representative at the BCRC.

Using hard media (e.g., CDs) for data management is not permitted.

4.2 Testing the Data Exchange Process

Overview: Before transmitting its first Production Input File to the BCRC, the data exchange partner and the BCRC will thoroughly test the file transfer process. Prior to submitting its initial Production Input File, the partner will submit two test Input Files to the BCRC. The first test file should simulate the partner's first full Production Input File. The BCRC will process this file and return a test initial Response File. The partner will then submit a second test input file with some new Adds, some Updates, some Deletes and corrections to errors found in the first test Response File. This should simulate the partner's ongoing monthly Input File. The BCRC will also process this test file and return a second Response File. Testing will be completed when the partner and the BCRC agree that both cycles of testing have been satisfactory.

Details: The partner and the BCRC will begin testing as soon as possible, but no later than 180 days after the date the ADAP DSA is in effect. The population size of a test file will not exceed 1000 records. The partner should use "live" data even in testing (i.e., actual members and their SSNs). All administrative and technical arrangements for sending and receiving test files will be made during the "Preparatory Period." (See "Terms and Conditions" in the partner's Data Sharing Agreement.)

Testing Records: The test file record layouts used will be the regular partner record layouts. Data provided in the test files will be kept in a test environment, and will not be used to update CMS databases.

4.3 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 Medicare Part D cost sharing. ADAP partners that offer an electronic network (real time) managed drug benefit (electronic at point-of-sale) are required to include a unique

TrOOP facilitation RxBIN or unique RxPCN/RxBIN combination ("Part D RxBIN"/"Part D RxPCN") on records in their Input File. These unique code numbers will identify, to the benefits coordination network, the partner's drug benefits which are supplemental to Part D. The partner's use of unique TrOOP Facilitation routing numbers will enable the Transaction Facilitation Contractor (formerly known as the "TrOOP Facilitation Contractor") to capture any paid claims that are supplemental to Part D and to send this information to the Medicare beneficiary's Part D Plan. The Part D Plan will use this supplemental paid claims information in its accounting of the enrollee's TrOOP. To be sure these drug claims are routed through the Transaction Facilitation Contractor, each partner must provide a unique RxBIN or RxPCN/RxBIN combination that is different from the ones used when making Primary Drug payments.

If your program **does not** offer an electronic network (real time) drug benefit (electronic at point-of-sale) and thus has no existing network RxBIN, in order to successfully participate in this data exchange the "non-network" partner is also required to obtain a TrOOP facilitation RxBIN as well as an RxPCN ("Part D RxBIN" and "Part D RxPCN") to include on records in the partner's Input File. As with networked programs, these code numbers will enable the Transaction Facilitator Contractor to correctly transmit needed TrOOP cost sharing information to the appropriate Part D Plan(s).

Talk with your EDI Representative about these networking code requirements. Then, if your program needs to acquire a new RxBIN or RxPCN to use for TrOOP facilitation purposes you may contact either of the following two entities. The organization that issues the BIN 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/.

The National Council for Prescription Drug Programs (NCPDP) manages the PCN coding system. The NCPDP can be contacted through its Web address: www.ncpdp.org.

Note: The NCPDP has informed CMS that an entity needing a new or additional RxPCN is permitted to generate the code number itself, if the new code will be entirely distinct (unlike any other existing) and no more than ten bytes in length.

4.4 File Processing

On a monthly basis, ADAPs will transmit full file submissions in the format specified in their agreement. Full file processing requires the partner to submit a complete file of enrollees every month. Each month's transmitted file will fully replace the previous month's file. (**Note:** ADAPs are required to continue to include coverage records for 3 years after the termination date of the coverage.)

4.4.1 Contact Phone Numbers

ADAPs

Field 14 for the Input File for ADAPs is labeled "Toll-Free Number." Enter the Pharmacy Benefit Toll-Free Number in this field. This is a required field.

4.4.2 File Level Editing

Upon receipt of the ADAP's Input File, the BCRC first performs high-level file edits to verify the format and validity of the Input File, including Header and Trailer data and record counts. The new Input File is compared with the previously submitted Input File. If it is detected that processing the new Input File will delete at least 30% of the records that were accepted in the previous submission, a "threshold error" will be generated and the file will not be processed without additional confirmation from the ADAP. The ADAP will be asked to verify the high number of delete records in the current submission. *With a full file* *replacement, the method for deleting enrollee records is to not include previously submitted enrollee records in the current Input File.* (**Note:** ADAPs are required to continue to include coverage records for 3 years after the termination date of the coverage.)

The Input File is then processed at the record level. The system initially attempts to use an SSN to match to a Medicare ID (HICN or MBI) if a Medicare ID is not submitted on the input file. The system will also determine if an incoming enrollee record is an Add, Update, or Delete, or if no action will be taken.

4.4.3 Adds

Once a Medicare ID (HICN or MBI) 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 Medicare ID, Effective Date, Insurance Type, and a ADAP ID. If a match of these fields cannot be made on the CMS database, the incoming record is considered an Add – a new record.

4.4.4 Updates

If incoming field matches indicate a record is not an Add, additional fields are compared to determine if the incoming record should be considered an Update. These additional fields include RX ID, RX Group, Part D RxPCN, Part D RxBIN, Toll-Free Number, Coverage Type, and Termination Date. If any of these fields have changed from the previous month's submission the record is considered an Update. If the incoming record matches exactly on these additional fields, no action is taken and the ADAP does not receive a response for this record.

4.4.5 Deletes

Any records contained on the previous month's file that are not included in the current submission are designated as deleted records. You will receive Delete response records in your Response File.

Deletes should only be used to remove records that never should have been included in the CMS database. All ADAP Input files should contain records of enrollees whose enrollment terminated up to thirty-six months (36) prior to the first day of the month in which the current Input File is generated. This is because Medicare Part D regulations require Part D sponsors to coordinate benefits with data-sharing partners and other entities providing prescription drug coverage for a period of 3 years.

4.4.6 Errors

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

4.4.7 Notification to the Medicare Beneficiary Database (MBD)

When processing of incoming data is complete, a file is created and transmitted to the MBD containing the Add, Update, and Delete records generated by the BCRC from the Input File submitted by the ADAP. The MBD returns a file to the BCRC containing Part D enrollment information and LIS data for qualified ADAP enrollees.

4.4.8 Response Files

Within 15 days of the partner's Input File submission, the BCRC generates and transmits a Response File to the ADAP. 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. As a result, the ADAP will receive updated Part D enrollment and LIS status, regardless of whether an input record is new, updated, unchanged, or deleted.

4.5 Distinction Between Part D Eligibility and Enrollment

Some of our data sharing partners have expressed uncertainty regarding the difference between the Part D Eligibility Start and Stop Dates and Current Part D Plan Enrollment and Termination Dates they receive on their response files. While many use these terms interchangeably, these terms have distinct meanings for the CMS data exchange process. To clarify:

Part D Eligibility Start Date: Refers to the first date a beneficiary can enroll in a Part D Plan. It does not mean that the beneficiary actually has coverage, just that because they have current Part A or B coverage they may enroll in a Part D Plan.

Part D Eligibility Stop Date: Refers to the date that the beneficiary is no longer eligible to enroll in and receive coverage from any Part D Plan.

Current Part D Plan Enrollment Date: Refers to the start date of coverage for a Medicare beneficiary that is eligible, has applied for and has current coverage in a Part D Plan.

Current Part D Plan Termination Date: Refers to the date that beneficiary is no longer receiving benefits under the Part D Plan.

In the response files the BCRC sends you, the Current Part D Plan Enrollment Date provides the effective date of coverage for the Part D benefit by the specific Part D Plan listed as the **Current Medicare Part D Plan Contractor Number.** The Current Part D Plan Termination Date is the date that beneficiary is no longer receiving benefits under that Part D Plan.

These dates are the most important for our data sharing partners because they let you know whether the beneficiary has actually elected coverage under Part D and the time period in which the Part D coverage became effective. In summary, a Medicare beneficiary can be **eligible** for Part D, but unless the beneficiary is **enrolled** in a Part D Plan, the beneficiary is not receiving Part D benefits.

4.6 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 your data exchange, the first person to contact is your own EDI Representative at the BCRC. Your EDI Representative 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 Representative, you think your problem could benefit from help at a higher level, please contact the EDI Director, Angel Pagan, at 646-458-2121. His email address is: apagan@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.

Chapter 5: Frequently Asked Questions

5.1 General Questions

Q1. When will an DSA ID be assigned?

A1: The Data Sharing Agreement (DSA) ID will be assigned by the BCRC it has received a copy of the signed DSA from the ADAP data-sharing partner. ADAP IDs start with “SD.”

Q2. Is there a possibility of receiving overlapping enrollment or multiple Prescription Drug Plan (PDP) information on a beneficiary?

A2: CMS will not send multiple records on a beneficiary. ADAPs will receive one record, containing the most recent information available for that beneficiary. If a beneficiary is with one PDP at the beginning of the month, then changes to another PDP mid-month, CMS will send information about the most recent PDP enrollment.

Q3: The BCRC-ADAP 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?

A3: The file receipt schedule is agreed to by the ADAP and the BCRC. All ADAPs do not need to be on the same schedule. The BCRC will work with each ADAP partner during the Preparatory Period to set up a reporting and data production schedule.

Q4: Why is it necessary for the ADAP to send records on beneficiaries for up to 36 months after eligibility has been terminated in the ADAP?

A4: If a record is sent one month, but not the next, the record of that beneficiary will be deleted from the CMS databases. Recall that the ADAP should only delete a record that should not have been added in the first place. 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.

Q5: In our state we have two ADAPs, 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 ADAP - CMS data sharing agreement?

A5: Yes, for administrative efficiency you could combine the two programs into one data exchange program. For the actual data exchange, however, we will assign you two different ADAP IDs, so that a Part D Plan can differentiate between the two programs if it needs to. We can take the files from the same source at the same time, but both sets would need to be separated from each other with unique headers and trailers.

Q6: With regard to the Administrative and Technical contacts needed for the ADAP -CMS data exchange, must either or both of these contacts be "State" staff or may they be "Contractor" staff?

A6: The State can designate whomever they wish to be the administrative and technical contacts, including contractor staff, but only a duly authorized representative of the State can sign the actual ADAP Data Sharing Agreement.

Q7: What are the requirements that must be met in order to successfully complete the testing of the ADAP data sharing exchange?

A7: For the ADAP partner the minimum CMS requirements are 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 the authority to determine whether or not the ADAP partner has successfully completed testing and can move on to production data exchange.

5.2 Data-Specific Questions

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

A1: Yes, you would send a complete full file replacement.

Q2: Should we exclude previously matched records?

A2: No, you <u>must include</u> previously matched records.

Q3: Are "errors" just data discrepancies (e.g., a mismatched Medicare ID (HICN or MBI) and SSN)?

A3: Errors encompass a number of anomalies. They can be data that is intrinsically defective or that contains an invalid value, such as an alpha character in a field requiring a numeric, or the error could be due to a programming mistake. In such case, the Response File will identify the particular error for the ADAP, using our standard error codes.

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

A4: You will receive only Medicare Part D enrollment information for your ADAP clients. We are not permitted to identify other sources of coverage.

Q5: What field identifies Medicare D enrollment?

A5: The Current Medicare Part D Plan Effective Date (field 46 in the ADAP Response File Layout) provides current Medicare Part D enrollment information.

Q6: What field identifies the Medicare D insurer?

A6: The Current Part D Plan Contractor Number (field 45 in the ADAP Response File Layout) identifies the particular Part D plan the beneficiary is enrolled in.

Q7: We currently do not mandate collection of an SSN from the participant, although most of our participants have an SSN. In the cases where we do not have a SSN, should we just send the other information we have on the input file? If so, do we zero fill the SSN data field or leave it blank?

A7: We must have either the Medicare ID (HICN or MBI) or the SSN for every individual you submit in order to be able to determine their Medicare entitlement information. If you do not have either one of these numbers to include on a particular individual's record you should not submit that record.

Q8: Is the Part D RxBIN and RxPCN the information that is identifying the Part D Plan (carrier) or is it being used to identify other insurance as well?

A8: This information does not identify the Part D Plan. The Part D RxPCN and Part D RxBIN – usually known as the TrOOP RxBIN or TrOOP RxPCN – are code numbers used to enable electronic routing of network pharmacy benefit information. While an ADAP might already have a standard RxBIN or RxPCN to help electronically pay network claims, a Part D-specific RxBIN and RxPCN is required for the support of the TrOOP facilitation process. These Part D-specific code numbers are used to permit the TrOOP Facilitator to capture and route claims that have been paid secondary to Part D.

Q9: What does "network" refer to? Is it a type of coverage, such as a (Preferred Provider Organization [PPO] or Health Maintenance Organization [HMO])?

A9: "Network" in this context refers to computerized "real time" electronic data interchange (EDI). Specifically, it is the EDI system that providers and payers use to move claims information. The health care billing transaction site – often at the point of sale, such as a pharmacy – is a common entry point to the claims transaction network.

Q10: What does the "disposition code" identify? Is this simply a "Yes or No" indication of something like coverage on the MBD?

A10: The disposition code lets you know what action the BCRC has taken regarding a submitted record. For instance, if the record is not found on CMS databases, the BCRC will provide the ADAP partner with a disposition code that indicates that fact. Additionally, if a record is not applied because it contains errors, the cause is shown in the disposition code.

Q11: You've added Plan Benefit Package (PBP) to the Response File. Is the three-byte PBP code unique? Also, we have determined that we will need the PBP enrollment start and end dates. We request that this information be added to the data exchange Response file.

A11: PBP information (Field 52 of the ADAP Response File Layout) is now provided. There is no intrinsic logic to the PBP number and it cannot be used alone as an identifier. It is only useful when used in conjunction with the PDP's contractor number. We cannot provide a start and stop date for the PBP. If the PBP code changes, ADAPs will receive the new PBP number to be used with the original PDP contractor number, but the PDP coverage dates will not change. ADAPs can program to note the changed PBP ID number and then input the new PBP start date.

Q12: Will the BCRC ADAP response files include retroactive eligibility/enrollment information for a beneficiary?

A12: Yes, but the earliest that a Part D Plan enrollment date can be is 01/01/06.

Q13: What is the difference: COBA ID vs. ADAP ID vs. Contractor ID?

A13: The ADAP ID is your own DSA ID number. A COBA ID is used by our COB partners that have claims processing "crossover" agreements with us. A state agency (usually Medicaid) that has both a COBA and ADAP DSA with CMS would have both a COBA ID and an ADAP ID, but the two IDs could not be used interchangeably. The Contractor ID number (Field 45 in the ADAP Response File) is the code number (ID) assigned by CMS to approved Part D Plans.

Q14: The data layout indicates space for four Rx error codes, yet the user guide lists six Rx error codes, and several error codes starting with SP.

A14: The Response File has space for only four error codes. These fields may contain either the SP or the RX error code. CMS does not anticipate that an ADAP partner will ever receive more than 4 error codes for a particular individual.

Q15: Is the new TrOOP RxBIN and TrOOP 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?

A15: We need your Part D specific RxBIN and or RxPCN in order to pass TrOOP data on to the TrOOP facilitator and the Part D Plan. Since you will not necessarily know which of your enrollees are Medicare beneficiaries, we are asking you to populate the TrOOP RxBIN and RxPCN fields with the Part D specific TrOOP RxBIN or RxPCN for those individuals as if they were Part D beneficiaries. As described earlier, you have to designate your TrOOP Rx BIN and TrOOP RxPCN to the BCRC in the Implementation Questionnaire.

Q16: Are we to send all of the ADAP enrollees in the input file (including non-Medicare clients), or only those who have told us that they have Medicare and therefore are eligible for a Part D plans?

A16: You send all of your enrollees. We respond with data indicating: Those that Medicare matched on and that we applied to our databases; those we matched on but didn't apply because of errors in the record you supplied; or those who we could not match on and who therefore are not Medicare beneficiaries. We do not expect you to know who among your clients are Medicare beneficiaries or enrolled in a Part D Plan. Essentially, the files you send us are finder files.

Q17: Is there any indictor on the Response File that tells us if a person is ineligible for Part D and a reason? I think that there are various reasons for being ineligible. There would be some that do not have Medicare Parts A or B but there would also be those whose employers accepted the subsidy and they cannot enroll. How would we determine this?

A17: Generally, someone who is a Medicare beneficiary and enrolled in Part A or Part B (or both) is eligible to enroll in Part D. Even if the beneficiary is part of a group for which an employer is claiming the employer subsidy the beneficiary is still permitted to enroll in a Part D Plan – although that beneficiary would then almost surely lose his or her employer-sponsored coverage.

Appendix A: Acronyms

Table A-1: Acronyms

Term	Definition
AGNS	AT&T Global Network Services
ADAP	AIDS Drug Assistance Programs
AIDS	Acquired Immune Deficiency Syndrome
BCRC	Benefits Coordination & Recovery Center
CMS	Centers for Medicare & Medicaid Services
CR	Change Request
DC	Document Control (Number)
DOB	Date of Birth
DSA	Data Sharing Agreement
EDI	Electronic Data Interchange
FPL	Federal Poverty Level
HICN	Health Insurance Claim Number
HPMS	Health Plan Management System
LIS	Low Income Subsidy
MBD	Medicare Beneficiary Database
MBI	Medicare Beneficiary Identifier
MMA	Medicare Modernization Act
MSP	Medicare Secondary Payer
NDC	National Drug Code
PAP	Patient Assistance Program
PBM	Pharmacy Benefit Manager
PDP	Part D Plan
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

Versioh 1.8

Starting April 5, 2021, the following changes will become effective:

To improve point-of-sale/pharmacy processing and plan payments, the criteria for several fields will be changed for users submitting primary and supplemental drug records, specifically for the Rx Insured ID Number, Rx PCN, and Rx BIN Number on the ADAP Input File Layout (Section 3.2.1).

Version 1.7

The details regarding Deletes and the contacts for the data exchange escalation process have been updated (Section 4.4.5).

The ADAP Response File Transaction Type field (column 318) has been clarified (Table 3-4). Additionally, a business rule has been clarified to confirm that a response record is returned even if the input record is unchanged (Section 3.4.5.

Since Health and Human Services (HHS) has eliminated the regulatory requirement for health plans to obtain and use a health plan identifier (i.e., N Plan ID), references to it have been removed from this guide (Section 5.2).

Version 1.6

ADAP partners are required to continue to include coverage records for 3 years after the termination date of the coverage (Sections 3.2, 3.3.6, and 4.3).

The EDI Director has been updated for the data exchange escalation process (Section 4.5).

Version 1.5

To reduce administrative overhead for health plans and state-run entities, CMS has launched an automated attestation and DSA submission process through the Health Plan Management System (HPMS) for use by State Pharmaceutical Assistance Programs (SPAPs) and AIDS Drug Assistance Programs (ADAPs) (Chapter 2).

Version 1.4

As part of the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act (MACRA) of 2015, all Health Insurance Claim Number (HICN) fields have been renamed as "Medicare ID" and have been configured to accept either the HICN or the new Medicare Beneficiary Identifier (MBI). Specifically, the AIDS Drug Assistance Program (ADAP) data exchange systems have been modified to accept the MBI on submitted files in addition to the HICN and SSN, and they will return the MBI on Response Files under appropriate conditions.

Version 1.3

If a plan sends more than one ADAP Input File in one day, the system will process the files without terminating. If the first file sent passes its edit checks, it is processed, and a response file is sent per current processes. Second and subsequent files sent the same day are added to a multiple file submissions report for review by the BCRC (Section 3.1).

Version 1.2

Contact information for the Centers for Medicare & Medicaid Services (CMS) has been updated.

Version 1.1

Reformatted document to CMS user guide standards.

Version 1.0

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