Pharmacy Benefit Management

PBM DSA USER GUIDE

December 9, 2005

INTRODUCTON

This Pharmacy Benefit Management Data Sharing Agreement USER GUIDE provides information and instructions Pharmacy Benefit Management (PBM) partners will find useful as they implement and then manage the PBM data sharing process with the Centers for Medicare & Medicaid Services (CMS). In particular, a PBM 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).

FROM TIME TO TIME THE INFORMATION PROVIDED IN THIS USER GUIDE WILL CHANGE. As current requirements are refined and new processes developed, existing and potential PBM DSA partners will be provided with new and up-to-date versions of this Guide. This User Guide assumes a fairly comprehensive understanding of the current PBM Data Sharing Agreement process. Please contact us if you find material that is unclear or not helpful.

PBM DSA partners must replace old versions of this Guide as CMS provides them with changes. All official CMS documentation regarding the Data Sharing process, including up-to-date record layouts and other information (such as Frequently Asked Questions) will originate from the Coordination of Benefits Contractor (COBC). The COBC's Email address is COBVA@GHImedicare.com ; its main phone number is 646-458-6740.

If you have not yet signed a PBM DSA with CMS and would like more general information about the current PBM Data Sharing process, please e-mail COBVA@GHImedicare.com and william.decker@cms.hhs.gov. Remember to provide us with e-mail, phone number, and other contact information, both for you and for other individuals you would like to have added to our distribution list.

SECTION A: COMPLETING AND SIGNING A DATA SHARING AGREEMENT

To make the PBM Data Sharing Agreement (PBM DSA) operational, the PBM and CMS have to sign and exchange completed copies of the PBM DSA. These are the instructions for completing a PBM DSA for signature.

1. In the first paragraph of the PBM 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 PBM DSA partners may prefer to enter the first day of the month in which they expect the PBM DSA to be signed. But bear in mind that if you enter a prospective date, CMS cannot begin full implementation of the PBM DSA until we reach it.

2. Enter the date that is requested on Page 6 of the PBM DSA, in Section C, 1, a. This is the starting date for health plan enrollment information that is entered on the first regular production Input File you provide to CMS.

We normally advise DSA partners to submit historical enrollment data on their first production Input File(s), recommending that the data entered here cover a period starting no later than January 1 of the first full year prior to the execution of the Agreement. Thus, if the effective date of the DSA is October 1, 2006 (for example), the first Input File should include information dating back to at least January 1, 2005. This allows both CMS and our partners to fill in gaps in enrollment information involving coordination of benefits that have not been found through other information exchange activities, such as the IRS/SSA/CMS Data Match questionnaires employers receive each year. We recommend that when submitting data on behalf of a client, a PBM work with the client to include appropriate historical data with early production file submissions.

3. In Section M, (Page 15), enter the partner's Administrative and Technical contact information.

4. Upon receipt of a PBM DSA signed by the partner, the CMS DSA contractor, GHI, will provide the Technical Contact information identified on Page 16. This section does not need to be completed to execute the Agreement.

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

The PBM DSA signature package consists of two documents: The PBM DSA itself, and the PBM DSA Implementation Questionnaire. The PBM DSA Implementation Questionnaire is used to assure both the PBM partner and CMS that agreement on essential operational questions has been reached. PBM partners must complete and

return a copy of the PBM DSA Implementation Questionnaire to CMS with their signed PBM DSA.

The PBM DSA partner will return two signed copies of the PBM DSA and one completed copy of the Implementation Questionnaire to CMS. One copy of the PBM DSA will be signed by CMS and returned to the partner. If it wishes, the partner can ask that CMS sign the PBM DSA first. CMS will then provide two signed copies of the PBM 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 PBM DSA to be in force until the partner has also provided CMS with a completed copy of the Implementation Questionnaire.

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

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

SECTION B: THE PBM DSA DATA FILES – Standard Reporting Information

Standard Data Files: The data regularly exchanged through the PBM DSA process is arranged in two different file schematics (also referred to as record layouts). A PBM DSA partner electronically transmits a data file to CMS. CMS processes the data in this *input file*, and at a prescribed time electronically transmits a *response file* to the partner. In a very few instances (as part of the retiree drug subsidy [RDS] file exchange process, for example) CMS will transmit a record file to a partner without having first received a specific input file, but these are rare exceptions. In ordinary circumstances it will be an input file that will generate a response file.

Additional Data File: The PBM DSA program requires one additional data set from the partner. It is the *TIN* (Tax Identification Number) *Reference File*. This file consists of all business TIN's linked to the health insurance business operations of a PBM DSA partner.

Data Element Keys: Immediately following the Input File is a table that identifies each Input File data element as either M – Mandatory; R – Required if known or possessed by the PBM; O – Optional, or; N/A – Not Applicable. Immediately following the Response File is a table that indicates whether the partner should expect to see active data in a

particular field, indicated by an "X" in the field. If a field is shown with an "N/A," the partner should not expect to see active data filling that field.

Current versions of the two Standard Data Files and the TIN Reference File immediately follow. The Business Rules that apply to these Data Files are at Section II, immediately following the PBM Response File layout.

I. The Input, TIN, and Response File Data Layouts

A – *The Input File: General*

This is the data set transmitted from a PBM to the COB Contractor. It is used to report information about Covered Individuals, in a variety of benefit situations. PBMs have a diverse client base of insurers, employer sponsors of Group Health Plans (GHPs), and various drug assistance programs. The CMS has designed the Input File to fit reporting requirements in the following situations.

- The PBM administers a drug benefit for an insurer or GHP employer sponsor that offers coverage primary to (paying before) Part D and is using this data exchange to satisfy Medicare Secondary Payer (MSP) reporting requirements.
- The PBM administers a drug benefit for an insurer, GHP employer sponsor, or drug assistance program that offers coverage supplemental to (paying after) Part D, and is using this data exchange to identify the Part D Plan as the primary payer and the non-Part D drug coverage as a supplemental payer.
- The PBM administers a drug benefit for a qualified State Pharmacy Assistance Program (SPAP) and is reporting the coverage as supplemental to Part D in order to coordinate benefits.
- The PBM administers a drug benefit for any of the previously mentioned entities. Each also has a data sharing agreement with CMS that obliges it to report its drug coverage and it opts to have the PBM report the information on its behalf.
- The PBM administers the drug benefit of an employer retiree plan, and the employer is claiming the Retiree Drug Subsidy (RDS).
- The PBM must determine the Part D enrollment status of its covered individuals in order to make appropriate decisions on the coverage of those individuals for its clients.

To support the Part D drug benefit, CMS has leveraged its existing COB activities, particularly its data exchanges. The CMS has added information about drug coverage to its various existing data exchange programs. These data exchanges have retained their original objectives, which were MSP reporting or the enabling of Parts A and B claims crossover, while now incorporating new Part D information into the exchanges. As a result, PBM partners will submit a common set of information about drug coverage, but in a variety of data input formats.

When CMS began developing the PBM data exchange process, CMS recognized that it would need to incorporate elements from all of its existing data exchange programs into the input and response files that would be used by PBMs. As a result, the single PBM Input File layout is standard and can be used in all reporting scenarios. But the business rules the PBM will need to follow are those that were developed for and that apply to other data exchange programs (VDSA, SPAP, etc.). These rules continue to apply to data being reported for partners in these other programs. Nonetheless, certain data elements will always be used in particular situations. For instance, a number of PBM data exchange fields are specific to MSP reporting, and will only be used when the PBM is reporting coverage that is primary to Part D. In all cases, partners should refer to the Data Element Key (see Page 11) which immediately follows the Input File Layout (starting on Page 7) to guide them as they prepare data for submission.

The Input File: Some Specifics

<u>Field 27 in the Input File</u> – labeled "Action Type" – identifies the various reasons for submitting records. This is a mandatory field. The input options for this field are "M," for the reporting of MSP status when the coverage being reported is primary to Part D; "D," for the reporting of other coverage that is supplemental to Part D; "S," for the reporting of information about those individuals being claimed for the Retiree Drug Subsidy; and "N," listing those that are not being reported on, but about whom the COB Contractor will respond with Medicare enrollment information.

The PBM Data Sharing Agreement (PBM DSA) outlines specifically who should be included in various submission types. Following is a summary:

- Records with Action Type "M" (MSP) must include people who are currently working (not carried as retired), and a spouse and (or) other dependents, who are enrolled in and covered by an employer group health plan. At a minimum, we require the partner to include information about all active covered individuals who are 55 years of age and older. CMS views the Input File as a finder file. By using the 55 or older criterion, an input submission can identify most Medicare beneficiaries (almost 97%) and reduce the burden on a PBM of having to identify Part D enrollees prior to submission. A PBM may also include in an input file individuals under the age of 55 if it have reason to believe the individuals are or might be enrolled in Part D.
- Records with Action Types "D" and "S" are for those individuals who cannot be classified as Active Covered Individuals. Action Type "D" is used to report individuals with drug coverage that is supplemental to Medicare Part D. Action Type "S is used to report individuals with retiree drug coverage, and for which the employer client is claiming the Retiree Drug Subsidy. CMS suggests using the age criteria discussed above (55+) when preparing "D" and "S" records.
- Records with Action Type "N" may be used by the PBM to identify Part D enrollees for whom further claim development may be needed. Development may include identifying Part D enrollees to determine MSP status so the PBM can use the appropriate Action Type for an individual.

By signing the PBM Data Sharing Agreement, the PBM has agreed to submit all drug coverage whether primary or supplemental to Part D, in addition to RDS reporting information. The PBM DSA may not be used exclusively for RDS reporting – when both employee and retiree coverage exist, the employee coverage must also be reported to CMS.

CMS recognizes that prior to initiating the DSA process PBMs may not have much (or perhaps any) of this information on hand. For example, a PBM may not need to hold certain information (such as employer size, SSN, or type of supplemental insurance) relating to an employer client's working Medicare beneficiaries. But in order to accurately report data to CMS it will be incumbent upon the PBM to first arrange for the collection of this information from the PBM's client.

Client Identification in the PBM Input File. All CMS data sharing partners are assigned a Data Sharing Agreement ID. The PBM will enter its own PBM DSA ID in Field 2 in the Header record of the Input File.

The insurer, employer or SPAP clients of a PBM can enter into their own Voluntary Data Sharing Agreements (VDSAs), Coordination of Benefits Agreements (COBAs), or SPAP Data Sharing Agreements directly with CMS. Each of these agreements requires the entity to report its prescription drug coverage information to CMS, or to opt to have their PBM report it for them. If the PBM is reporting for a client that has its own Data Sharing Agreement with CMS, the PBM must enter the appropriate client identifiers in Fields 33 and 34 of the Input File.

Matching Partner Data with CMS Data**:** Input File submissions must have a specified set of information that corresponds to data held by CMS in order to effect a data match. For CMS to confirm a Covered Individual's Medicare entitlement, the following minimum set of data elements is always required: The individual's HICN or SSN, the first initial of the first name, the first 6 characters of the last name, the date of birth (DOB), and sex. CMS uses this personal information to match and validate the Medicare entitlement data submitted on your record with the person assigned the HICN or SSN.

The personal information you submit doesn't have to perfectly match the information on Medicare's database in order for that particular HICN or SSN to be considered a match. CMS uses a scoring system to compensate for things such as keystroke errors or receipt of an incorrect date of birth. Again, the additional data elements are:

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

Three out of four of these data elements must match or the system will not be able to confirm an identification. When CMS determines that there is a match, on the response

record CMS will update any non-matching personal information we received on the input record. The PBM DSA partner should store this corrected personal data in its own systems, and from that point forward use it as the individual's official personal identifying information. To ensure that future data updates are accepted by CMS, any updates to that original record should be submitted using the corrected personal information.

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

The Input File: Record Layouts

Data Element Keys: Immediately *following* the MSP Input File is a table that identifies each Input File data element as either M – Mandatory; R – Required if known or possessed by the PBM; O – Optional, or; N/A – Not Applicable.

Input File

PBM Input File Layout: Header Record					
Field	**Name**	**Size**	**Displacement**	**Description**	**Values**
1	Header Indicator	2	1 – 2	Indicates record is a Header Record.	H0
2	PBM ID	4	3 – 6	ID assigned to each PBM	*P'XXX'*
3	Filler	5	7 – 11	For internal use only	Spaces
4	File Type	4	12 – 15	PBM Input file record type	MSPI = *VDSA MSP* *NMSI* = VDSA non-MSP *SPPI* = SPAP *RDSI* = RDS
5	File Date	8	16 – 23	Creation date of file	Format: *CCYYMMDD*
6	RDS Application ID	10	24 – 33	Retiree Drug Subsidy ID number assigned by the RDS contractor that is associated with a particular RDS application.	
7	PBM TIN	9	34 – 42	The TIN of the PBM submitting this file	
8	File Action Type	1	43 – 43	Type of processing action for the file	*C* = Change file *F* = Full replacement
9	Filler	382	44 – 425	Unused	Spaces

PBM Input File Layout					
Field	**Name**	**Size**	**Displacement**	**Description**	**Values**
1	HIC Number	12	1 – 12	Beneficiary’s Health Insurance Claim Number (HICN)	
2	Beneficiary Surname	6	13 – 18	Beneficiary’s Last Name	
3	Beneficiary First Initial	1	19 – 19	Beneficiary’s First Initial	
4	Beneficiary MI	1	20 – 20	Beneficiary’s Middle Initial	
5	Beneficiary DOB	8	21 – 28	Beneficiary’s Date of Birth	Format*: CCYYMMDD*
6	Beneficiary Sex Code	1	29 - 29	Beneficiary’s Gender	*0* = Unknown *1* = Male *2* = Female
7	DCN	15	30 – 44	Unique Document Control Number – to be populated by the PBM partner	
8	Transaction Type	1	45 – 45	Type of Maintenance	*0* = Add Record *1* = Delete Record *2* = Update Record *Space* = Full File Replacement
9	Coverage Type	1	46 – 46	Type of Coverage	*A* = Hospital and Medical *J* = Hospital Only *K* = Medical Only *U* = Drug Only *V* = Drug w/ Major Medical *W* = Comprehensive Cvg - Hosp/Med/Drug *X* = Hospital and Drug *Y* = Medical and Drug *Z* = Health Reimbursement Account
10	Network Indicator	1	47 – 47	Network Indicator	Y = *in network* *N* = not in network
11	Beneficiary SSN	9	48 – 56	Beneficiary’s Social Security Number	
12	Effective Date	8	57 – 64	Start Date of Covered Individual’s Coverage by Insurer	Format: *CCYYMMDD*

PBM Input File Layout					
Field	**Name**	**Size**	**Displacement**	**Description**	**Values**
13	Termination Date	8	65 – 72	End Date of Covered Individual's Primary Coverage by Insurer	Format: *CCYYMMDD* Use all zeroes if insurance coverage is on-going
14	Relationship Code	2	73-74	Covered individual's relation to policy holder	*01* = Covered Individual is Policy Holder *02* = Spouse *03* = Child *04* = Other
15	Policy Holder's First Name	9	75 – 83	Policy Holder's First Name	
16	Policy Holder's Last Name	16	84 – 99	Policy Holder's Last Name	
17	Policy Holder's SSN	9	100 – 108	Policy Holder's Social Security Number	
18	Employer Size	1	109 – 109	Number of employees	*0* = 1 to 19 employees *1* = 20 to 99 employees *2* = 100+ employees Enter '1' if employer has fewer than 20 employees but is part of a multi-employer plan where another employer in that plan has 20 or more employees.
19	GPN	20	110 – 129	Group Policy Number assigned by Primary Payer	
20	Individual PN	17	130 – 146	Individual Policy Number	
21	Employee Coverage Election	1	147 – 147	Whom the Policy Covers	*1* = Policy Holder Only *2* = Policy Holder and Spouse *3* = Policy Holder & Dependents (not spouse)
22	Employee Status	1	148 – 148	Employee Status	*1* = Plan is primary because active employee is in current employment status *2* = Plan is primary for another reason (e.g. active employee is a retiree under age 65, but retains primary coverage through the employer because the Active Employee or covered dependent has ESRD)
23	Employer TIN	9	149 – 157	Employer Tax Identification Number	

PBM Input File Layout					
Field	**Name**	**Size**	**Displacement**	**Description**	**Values**
24	Insurer TIN	9	158 – 166	Insurer Tax Identification Number	
25	National Health Plan ID	10	167 – 176	National Health Plan Identifier; *future*	
26	RX Insured ID Number	20	177 – 196	Insured's Identification Number	
27	Action Type	1	197 – 197	Action Type	*D* = Supplemental Drug Reporting *M* = MSP Drug Reporting *N* = Query(non-reporting) *S* = Subsidy
28	RX Group Number	15	198 – 212	Group Number	
29	RX PCN	10	213 – 222	Process Control Number	
30	RX BIN Number	6	223 – 228	International Identification Number	
31	RX Toll Free Number	18	229 – 246	Toll Free Number	
32	Person Code	3	247 – 249	Person code the plan uses to identify specific individuals on a policy. Values are policy specific	*001* = Self *002+* = Spouse/Other
33	Data Sharing Agreement (DSA) Indicator	1	250 – 250	Identifier Indicator defining who the coverage is being reported for	*C* = COBA ID *P* = PBM *R* = RDS *S* = SPAP *V* = VDSA ID
34	DSA ID Code	10	251 – 260	Plan ID / Contractor #; Identifier for which bytes within field to use. Dependent upon DSA ID Indicator.	**DSA Ind.** – **DSA ID Code** C – *00000 + COBA ID* P – *Plan ID + Contractor Number assigned by GHI* R – *Number assigned by GHI* S – *Plan ID + Contractor Number assigned by GHI* V – *0 + VDSA ID + contractor number (employer = 11105, insurer = 11106, BCBS = 11112)*
35	Supplemental Insurance	1	261 – 261	Type of Insurance (used if this record represents	1 = *Medicaid*

PBM Input File Layout					
Field	Name	Size	Displacement	Description	Values
	Type			supplemental insurance)	2 = *TriCare* *3* = Major Medical Account (pharmacy non-network benefit) *L* = Supplemental *M* = Medigap *N* = Non-qualified state program *O* = Other *P* = PAP *Q* = Qualified SPAP *R* = Charity *S* = ADAP *T* = Federal Government Program
36	Filler	164	262 – 425	Unused	Unused

PBM Input File Layout: Trailer Layout					
Field	Name	Size	Displacement	Description	Values
1	Trailer Indicator	2	1 – 2	Indicates record is a trailer record	T0
2	Filler	4	3 – 6	Unused	Spaces
3	Filler	5	7 – 11	For internal use only	Spaces
4	File Type	4	12 – 15	Record file type	MSPI = *VDSA MSP* *NMSI* = VDSA non-MSP *SPPI* = SPAP *RDSI* = RDS
5	File Date	8	16 – 23	Creation Date of file	*Format* = CCYYMMDD
6	Record Count	9	24 – 32	Number of records on file	
7	Filler	393	33 – 425	Unused	Spaces

Field Placement	FIELD NAME	Qualified SPAPs	Retiree Drug Subsidy	Supplemental	Non-Reporting Query	MSP Reporting
HEADER RECORD	HEADER RECORD	HEADER RECORD	HEADER RECORD	HEADER RECORD	HEADER RECORD	HEADER RECORD
1	Header Indicator	M	M	M	M	M
2	PBM ID	M	M	M	M	M
3	Filler	N/A	N/A	N/A	N/A	N/A
4	File Type	M	M	M	M	M
5	File Date	M	M	M	M	M

6	RDS Application ID	N/A	M	N/A	N/A	N/A
7	PBM TIN	N/A	N/A	N/A	N/A	M
8	File Action Type	M	M	M	M	M
9	Filler	N/A	N/A	N/A	N/A	N/A
INPUT RECORD	INPUT RECORD	INPUT RECORD	INPUT RECORD	INPUT RECORD	INPUT RECORD	INPUT RECORD
1	HIC Number	R (must have SSN or HICN)	R (must have SSN or HICN)	R (must have SSN or HICN)	R (must have SSN or HICN)	R (must have SSN or HICN)
2	Beneficiary Surname	R	R	R	R	R
3	Beneficiary First Initial	R	R	R	R	R
4	Beneficiary Middle Initial					
5	Beneficiary DOB	R	R	R	R	R
6	Beneficiary Sex Code	R	R	R	R	R
7	DCN	O	O	O	O	O
8	Transaction Type	N/A	M	M (updates)	N/A	M
9	Coverage Type	N/A	N/A	N/A	N/A	M
10	Network Indicator	M	M	M	N/A	M
11	Beneficiary SSN	R (must have SSN or HICN)	R (must have SSN or HICN)	R (must have SSN or HICN)	R (must have SSN or HICN)	R (must have SSN or HICN)
12	Effective Date	M	M	M	N/A	M
13	Termination Date	M	M	M	N/A	M
14	Relationship Code	N/A	M	N/A	N/A	R
15	Policy Holder's First Name	N/A	N/A	N/A	N/A	R
16	Policy Holder's Last Name	N/A	N/A	N/A	N/A	R
17	Policy Holder's SSN	N/A	N/A	N/A	N/A	R
18	Employer Size	N/A	N/A	N/A	N/A	R
19	GPN	M (non-network)	M (non-network)	M (non-network)	N/A	M (non-network)
20	Individual PN	M (non-network)	R (non-network)	M (non-network)	N/A	M (non-network)
21	Employee Coverage Election	N/A	N/A	N/A	N/A	R
22	Employee Status	N/A	N/A	N/A	N/A	R
23	Employer TIN	N/A	N/A	N/A	N/A	R
24	Insurer TIN	N/A	N/A	N/A	N/A	R

25	National Health Plan ID	N/A	N/A	N/A	N/A	N/A
26	RX Insured ID Number	M (network)	R (network)	M (network)	N/A	M (network)
27	Action Type	M	M	M	M	M
28	RX Group Number	R (network)	M (network)	R (network)	N/A	R (network)
29	RX PCN	R (network)	R (network)	R (network)	N/A	R (network)
30	RX BIN Number	M (network)	R (network)	M (network)	N/A	M (network)
31	RX Toll Free Number	R	R	R	N/A	R
32	Person Code	R (network)	R (network)	R (network)	N/A	R (network)
33	Data Sharing Agreement Indicator	M	M	M	N/A	M
34	Data Sharing Agreement ID Code	M	M	M	N/A	M
35	Supplemental Insurance Type	M	N/A	M	N/A	N/A
36	Filler	N/A	N/A	N/A	N/A	N/A
TRAILER RECORD	TRAILER RECORD	TRAILER RECORD	TRAILER RECORD	TRAILER RECORD	TRAILER RECORD	TRAILER RECORD
1	Trailer Indicator	M	M	M	M	M
2	Filler	N/A	N/A	N/A	N/A	N/A
3	Filler	N/A	N/A	N/A	N/A	N/A
4	File Type	M	M	M	M	M
5	File Date	M	M	M	M	M
6	Record Count	M	M	M	M	M
7	Filler	N/A	N/A	N/A	N/A	N/A

B – *The TIN Reference File*

The TIN Reference File consists of a business entity's federal tax identification number and the firm's business mailing address that is linked to the particular TIN. The same firm can have more than one TIN. For example, a company can operate both an HMO and a separate and distinct specialty medical center. Because they are separate business operations each could have its own TIN, and each TIN may be associated with a distinct business mailing address. (Note: The TIN is the same as the federal Employer ID Number, the EIN.) The mailing address associated with each TIN should be the address to which health care insurance coordination of benefits issues should be directed. This mailing address will help CMS and others to direct correspondence to the most appropriate contact at the PBM or at its clients.

A PBM's TIN Reference File should be comprised of all the TINs relevant to the partner's business as it relates to CMS. A PBM must provide complete TIN information about all the employer or insurer clients for which it is reporting MSP information.

TIN Reference File

TIN Reference File Layout : Header Record					
Field	**Name**	**Size**	**Displacement**	**Description**	**Values**
1	Header Indicator	2	1 – 2	Indicates record is a Header Record.	H0
2	PBM ID	4	3 – 6	ID assigned to each PBM	*P'XXX'*
3	Contractor Number	5	7 – 11	ID assigned to PBM by GHI	
4	File Type	4	12 – 15	PBM Input file	*REFR* = PBM Reference
5	File Date	8	16 – 23	Creation date of file	Format = *CCYYMMDD*
6	RDS Application ID	10	24 – 33	Retiree Drug Subsidy ID number assigned by the RDS contractor that is associated with a particular RDS application. This application number will change each year when a new application is submitted	
7	PBM TIN	9	34 – 42	The TIN of the PBM submitting this file	
8	File Type	1	43 – 43	Type of processing action for the file	C = *Change file*
9	Filler	382	44 – 425	Unused	Spaces

TIN Reference File Layout					
Field	**Name**	**Size**	**Displacement**	**Description**	**Values**
1	TIN	9	1 – 9	Tax Identification Number of the entity	
2	Name	32	10 – 41	Name of the entity	
3	Addr1	32	42 – 73	Address Line 1	
4	Addr2	32	74 – 105	Address Line 2	
5	City	15	106 – 120	City	
6	State	2	121 – 122	State	
7	Zip	9	123 – 131	Zip Code	
8	Pseudo ID	1	132 – 132	Indicates Pseudo TIN used for TIN	
9	Filler	294	132 – 425	Unused	Spaces

TIN Reference File Layout : Trailer Record					
Field	**Name**	**Size**	**Displacement**	**Description**	**Values**
1	Trailer Indicator	2	1 – 2	Should be	*T0*
2	Filler	4	3 – 6	Unused	Spaces
3	Contractor Number	5	7 – 11	Contractor ID assigned	
4	File Type	4	12 – 15	Type of file	*REFR* = PBM Reference
5	File Date	8	16 – 23	Creation Date of file	*Format* = CCYYMMDD
6	Record Count	9	24 – 32	Number of records on file	
7	Filler	393	33 – 425	Unused	Spaces

C – *The PBM Response File*. This is the data set transmitted from CMS to the PBM after the information supplied in the PBM's Input File has been processed. It consists of original Input File data (if uncorrected), corrections applied by CMS, disposition and edits codes to tell you what we did with a record, and other relevant new information about the covered individuals.

In the Response File, not all fields will be always be populated. The Action Type indicator supplied with the Input File and other results of record processing will dictate what information is returned in the Response File. For instance, data about the Low Income Subsidy status of a Part D eligible individual will be populated only when the PBM is submitting on behalf of a qualified SPAP. Other particular data elements will only be populated if the Input File was an Action Type "M" (MSP) or Action Type "S" (RDS).

PBM partners may find that an Input Record submitted as an Action Type "S" – an employer subsidy record – is returned as an Action Type "D" – drug coverage supplemental to Part D. This will happen when an individual with coverage reported in an "S" record is found to have enrolled in Part D, making his or her employer ineligible to claim the subsidy for that coverage. In such case, the COB Contractor will attempt to convert the "S" to a "D" record. If the employer receiving the subsidy does not terminate coverage because of the beneficiary's Part D enrollment, the employer's coverage will now be supplemental to Part D. NOTE: If the PBM is submitting for a plan sponsor that will automatically terminate coverage if the retiree enrolls in Part D, it would not populate the "D" mandatory fields.

Immediately *following* the Response File is a table that indicates whether the partner should expect to see active data in a particular field, indicated by an "X" in the field. If a field is shown with an "N/A," the partner should not expect to see active data filling that field.

Response File

PBM Response File Layout: Header Record					
Field	**Name**	**Size**	**Displacement**	**Description**	**Values**
1	Header Indicator	2	1 – 2	Indicates record is a Header record	H0
2	PBM ID	4	3 – 6	ID assigned for each PBM	PXXX
3	Filler	5	7 – 11	For internal use only	*Spaces*
4	File Type	4	12 – 15	PBM response file record type	MSPR = *VDSA MSP* *NMSR* = VDSA non-MSP *SPPR* = SPAP *RDSR* = RDS
5	File Date	8	16 – 23	Creation date of file	Format = *CCYYMMDD*
6	RDS Application ID	10	24 – 33	Retiree Drug Subsidy ID number assigned by the RDS contractor that is associated with a particular RDS application.	
7	Filler	767	34 – 800	Unused	Spaces

PBM Response File Layout: Detail Record					
Field	**Name**	**Size**	**Displacement**	**Descriptions**	**Values**
1	Filler	4	1 – 4	For COBC Internal Use	Spaces
2	HIC Number	12	5 – 16	Beneficiary health Insurance Claim Number	
3	Beneficiary Surname	6	17 – 22	Beneficiary's Last Name	
4	Beneficiary First Initial	1	23 – 23	Beneficiary's First Initial	
5	Beneficiary MI	1	24 – 24	Beneficiary's Middle Initial	
6	Beneficiary DOB	8	25 – 32	Beneficiary's Date of Birth (*format = CCYYMMDD)*	Format = *CCYYMMDD*
7	Beneficiary Sex Code	1	33 – 33	Beneficiary's Gender:	*0* = Unknown *1* = Male *2* = Female
8	COBC DCN	15	34 – 48	Document Control Number assigned by COBC	
9	Disposition Code	2	49 – 50	Response Disposition Code from CWF	
10	Transaction Type	1	51 – 51	Type of Maintenance performed	Type of Maintenance: *0* = Add Record *1* = Delete Record *2* = Update Record *Space* = Full File Replacement

PBM Response File Layout: Detail Record					
Field	**Name**	**Size**	**Displacement**	**Descriptions**	**Values**
11	Reason for Medicare Entitlement	1	52 – 52	Reason for Medicare Entitlement	A = *Working Aged* *B* = ESRD *G* = Disabled
12	Coverage Type	1	53 – 53	Type of Insurance (insurer type/policy type):	*3* = Major Medical *A* = Hospital & Medical *J* = Hospital only *K* = Medical only *U* = Drug Only(in-network) *V* = Drug w/ Major Medical (non-network Rx) *W* = Comprehensive (Hosp/Med/Drug – network Rx) *X* = Hospital and Drug (network Rx) *Y* = Medical and Drug (network Rx) *Z* = Health Reimbursement Account
13	RDS Error Code 1	4	54 – 57	Contains SP or RX error codes from COBC or RDS processing if applicable	
14	RDS Error Code 2	4	58 – 61	Contains SP or RX error codes from COBC or RDS processing if applicable	
15	RDS Error Code 3	4	62 – 65	Contains SP or RX error codes from COBC or RDS processing if applicable	
16	RDS Error Code 4	4	66 – 69	Contains SP or RX error codes from COBC or RDS processing if applicable	
17	RDS Split Indicator	1	70 - 70	Indicates multiple subsidy periods within the plan year. A record is created for each subsidy period.	*Y* = Multiple subsidy periods *N* = Not applicable
18	Low Income Subsidy Denial 1	1	71 – 71	Beneficiary is not Part A entitled and/or Part B enrolled	*Y* = Yes *N* = No
19	Low Income Subsidy Denial 2	1	72 – 72	Beneficiary does not reside in the USA	*Y* = Yes *N* = No
20	Low Income Subsidy Denial 3	1	73 – 73	Beneficiary has failed to cooperate	*Y* = Yes *N* = No
21	Low Income Subsidy Denial 4	1	74 – 74	Beneficiary resources too high	*Y* = Yes *N* = No
22	Low Income Subsidy	1	75 – 75	Beneficiary income too high	*Y* = Yes *N* = No

PBM Response File Layout: Detail Record					
Field	Name	Size	Displacement	Descriptions	Values
	Denial 5				
23	Filler	1	76 – 76	Unused	Spaces
24	Low Income Subsidy Appeal Result	1	77 – 77	Result of an appeal	*1* = Basis of appeal *2* = Denial *9* = N/A *Blank* = Not based on appeal
25	Low Income Subsidy CPD	1	78 – 78	Change of previous determination (future use)	Spaces
26	Low Income Subsidy Determination	1	79 – 79	Appeal Determination	*1* = Canceled *2* = Not Canceled *9* = N/A
27	Low Income Subsidy Approval	1	80 - 80	Part D Subsidy Approval Indicator	*1* = Yes *2* = No *9* = N/A
28	Low Income Subsidy Determination Basis	1	81 – 81	Basis for Part D Subsidy Determination	*1* = Yes *2* = No *9* = N/A
29	Filler	3	82 - 84	Unused	Spaces
30	Premium Amount	9	85 – 93	Part D premium amount (received from MBD)	
31	Current DEEMED Start Date	8	94 – 101	Effective date of the deeming period. Always the first day of the month.	Format = *CCYYMM01*
32	Current DEEMED End Date	8	102 – 109	Termination date of the deeming period. When applicable, always the last day of the year.	Format = *CCYY1231*
33	Current DEEMED Reason Code	2	110 – 111	Reason the beneficiary was deemed eligible for LIS	*01* = Full benefit dual *02* = QMB, SLMB, QII *03* = SSI
34	Current DEEMED Split Reason	2	112 – 113	Split Reason Code	
35	PBP	3	114 – 116	Plan Benefit Package	
36	FPL %	3	117 – 119	Federal Poverty Level Income Percent	
37	Filler	45	120 - 164	Unused	Spaces
38	S Disposition Code	2	165 – 166	RDS Disposition Codes	
39	Insurer TIN	9	167 – 175	Insurer's TIN Reference Number	
40	Beneficiary SSN	9	176 – 184	Beneficiary's Social Security Number	
41	MSP Effective Date	8	185 – 192	Start Date of Beneficiary's Coverage by Insurer	Format = *CCYYMMDD*
42	MSP Termination Date	8	193 – 200	End Date of Beneficiary's coverage by Insurer *Use all zeroes if insurance coverage is ongoing*	Format = *CCYYMMDD*

PBM Response File Layout: Detail Record					
Field	**Name**	**Size**	**Displacement**	**Descriptions**	**Values**
43	Relationship code	2	201 – 202	Covered Individual's Relationship to Policy Holder	*01* = Covered Individual is Active Employee *02* = Spouse *03* = Child *04* = Other
44	Policy Holder's First Name	9	203 – 211	Policy Holders First Name	
45	Policy Holder's Last Name	16	212 – 227	Policy Holders Last Name	
46	Policy Holder's SSN	12	228 – 239	Policy Holders Social Security Number *(Left justified)*	
47	S Disposition Date	8	240 – 247	Date of 'S' Disposition code	Format = *CCYYMMDD*
48	RDS Start Date	8	248 – 255	Start date for subsidy period	Format = *CCYYMMDD*
49	RDS End Date	8	256 - 263	End date for subsidy period	Format = *CCYYMMDD*
50	LIS Subsidy Eff Date	8	264 – 271	Effective Date of Low Income Subsidy (LIS)	Format = *CCYYMMDD*
51	Low Income Subsidy Term Date	8	272- 279	Termination Date of LIS	Format = *CCYYMMDD*
52	Filler	8	280 – 287	Unused	Spaces
53	Low Income Subsidy Disapproval Date	8	288 - 295	Date of LIS Disapproval	Format = *CCYYMMDD*
54	Premium Effective Date	8	296 – 303	Effective Date of the Part D Subsidy Premium	Format = *CCYYMMDD*
55	SPAP Effective Date	8	304 – 311	Effective date of coverage	Format = *CCYYMMDD*
56	SPAP Termination Date	8	312 – 319	Termination date of coverage	Format = *CCYYMMDD*
57	State Code	2	320 – 321	Low income subsidy source code	
58	Employer's TIN	9	322 – 330	Employer's TIN Reference Number	
59	Group Policy Number	20	331 – 350	Group Policy Number	
60	Individual Policy Number	17	351 – 367	Individual's Policy Number	
61	Last Query Date	8	368 – 375	Last Date Sent to CWF;	Format = *CCYYMMDD*
62	Current Disposition Code	2	376 – 377	Result from most current CWF transmission	

PBM Response File Layout: Detail Record					
Field	Name	Size	Displacement	Descriptions	Values
63	Current Disposition Date	8	378 – 385	Date of most current CWF transmission	Format = *CCYYMMDD*
64	Previous Disposition Code	2	386 – 387	Result from previous CWF transmission	
65	Previous Disposition Date	8	388 – 395	Date of previous CWF transmission	Format = *CCYYMMDD*
66	First Disposition Code	2	396 – 397	Result from original CWF transmission	
67	Fist Disposition Date	8	398 – 405	Date of original CWF transmission	Format = *CCYYMMDD*
68	Error Code 1	4	406 – 409	SP Error Code 1	
69	Error Code 2	4	410 – 413	SP Error Code 2	
70	Error Code 3	4	414 – 417	SP Error Code 3	
71	Error Code 4	4	418 – 421	SP Error Code 4	
72	Split Entitlement Indicator	1	422 – 422	Entitlement Split Indicator;	Y = *Yes* *N* or *blank* = No
73	Original Reason for Medicare Entitlement	1	423 – 423	Original Reason for Medicare Entitlement	A = *Working Aged* *B* = ESRD *G* = Disabled
74	Original Coverage Effective Date	8	424 – 431	Original coverage effective date sent. This gets populated if a SP31 error occurs.	*Format* = CCYYMMDD
75	Original Coverage Termination Date	8	432 – 439	The original coverage termination date sent. This gets populated if a SP32 error occurs.	*Format* = CCYYMMDD All zeroes if insurance coverage is ongoing
76	Original DCN	15	440 – 454	Original Document Control Number provided by the VDSA partner. It is moved here so we can provide our own unique DCN in Field 7.	
77	Current Medicare Part A Effective Date	8	455 – 462	Effective Date of Medicare Coverage	*Format* = CCYYMMDD
78	Current Medicare Part	8	463 – 470	Termination date of Medicare Coverage	*Format* = CCYYMMDD

PBM Response File Layout: Detail Record					
Field	**Name**	**Size**	**Displacement**	**Descriptions**	**Values**
	A Termination Date				All zeroes if insurance coverage is ongoing
79	Current Medicare Part B Effective Date	8	471 – 478	Effective Date of Medicare Coverage	*Format* = CCYYMMDD
80	Current Medicare Part B Termination Date	8	479 – 486	Termination date of Medicare Coverage	*Format* = CCYYMMDD All zeroes if insurance coverage is on-going
81	Medicare Beneficiary Date of Death	8	487 – 494	Medicare Beneficiary Date of Death	*Format* = CCYYMMDD
82	MA/MA-PD Contractor #	5	495 – 499	Medicare Advantage/Medicare Advantage with Prescription Drug Contractor Number	
83	MA/MA-PD Effective Date	8	500 – 507	Effective date of Medicare Advantage/Medicare Advantage with Prescription Drug Coverage	*Format* = CCYYMMDD
84	MA/MA-PD Termination Date	8	508 – 515	Termination Date of Medicare Advantage/Medicare Advantage with Prescription Drug coverage	Format = *CCYYMMDD* All zeroes if open-ended
85	PDP Contractor Number	5	516 – 520	Prescription Drug Plan Contractor number for use when beneficiary has MA with PDP covered by separate contractor	
86	PDP Effective Date	8	521 – 528	Effective date of Prescription Drug Plan Coverage for use when beneficiary has MA with PDP covered by separate contractor	Format = *CCYYMMDD*
87	PDP Termination Date	8	529 – 536	Termination date of Prescription Drug Plan coverage for use when beneficiary has MA with	Format = *CCYYMMDD* All zeroes if insurance coverage is on-going

PBM Response File Layout: Detail Record					
Field	**Name**	**Size**	**Displacement**	**Descriptions**	**Values**
				PDP covered by separate contractor	
88	Current Part D Effective Date	8	537 – 544	Effective date of Medicare Part D Coverage	Format = *CCYYMMDD*
89	Current Part D Termination Date	8	545 – 552	Termination Date of Medicare Part D Coverage	Format = *CCYYMMDD* All zeroes if insurance coverage is on-going
90	National Health Plan ID	10	553 – 562	National Health Plan Identifier (*future requirement)*	
91	RX Insured ID Number	20	563 – 582	Insured's Identification Number	
92	RX Group Number	15	583 – 597	Group Number	
93	RX PCN	10	598 – 607	Processor Control Number	
94	RX BIN Number	6	608 – 613	International Identification Number	
95	RX Toll Free Number	18	614 – 631	Toll Free Number	
96	Person Code	3	632 – 634	Person code	
97	Rx Disposition Code	2	635 – 636	Rx result from BENEMSTR/MBD	
98	Rx disposition Date	8	637 – 644	Date of Rx result from BENEMSTR/MBD	Format = *CCYYMMDD*
99	Rx Error Code 1	4	645 – 648	Rx Error Code 1	
100	Rx Error Code 2	4	649 – 652	Rx Error Code 2	
101	Rx Error Code 3	4	653 – 656	Rx Error Code 3	
102	Rx Error Code 4	4	657 – 660	Rx Error Code 4	
103	ESRD Data	88	661 – 748	Future use	Spaces
104	Part D Premium Subsidy %	3	749 – 751	Percent of Part D Premium	
105	DSA ID Code	10	752 – 761	Plan ID / Contractor # ; DSA indicator determined from PBM input file	**DSA Ind.** / **DSA ID Code** C / *00000 + COBA ID* P / *Plan ID + Contractor Number assigned by GHI* R / *Number assigned by GHI* S / *Plan ID +*

PBM Response File Layout: Detail Record					
Field	**Name**	**Size**	**Displacement**	**Descriptions**	**Values**
					S: *Plan ID + Contractor Number assigned by GHI* V: *0 + VDSA ID + contractor number (employer = 11105, insurer = 11106, BCBS = 11112)*
106	DSA Indicator	1	762 – 762	Identifier Indicator defining who the coverage is being reported for	*C* = COBA ID *P* = PBM *R* = RDS *S* = SPAP *V* = VDSA ID
107	Supplemental Insurance Type	1	763 – 763	Type of Insurance (used if this record represents supplemental insurance)	*1* = Medicaid *2* = TriCare *3* = Major Medical Account (pharmacy non-network benefit) *L* = Supplemental *M* = Medigap *N* = Non-qualified state program *O* = Other *P* = PAP *Q* = Qualified SPAP *R* = Charity *S* = ADAP *T* = Federal Government Program
108	Filler	37	764 – 800	Unused	Spaces

PBM Response File Layout: Trailer Record					
Field	**Name**	**Size**	**Displacement**	**Description**	**Values**
1	Trailer Indicator	2	1 – 2	Indicates Record is a trailer record	T0
2	PBM ID	4	3 – 6	ID assigned to each PBM	*P'XXX'*
3	Filler	5	7 – 11	For internal use only	Spaces
4	File Type	4	12 – 15	*PBM Response file record type*	MSPR = *VDSA MSP* *NMSR* = VDSA non-MSP *SPPR* = SPAP RDSR = *RDS*

PBM Response File Layout: Trailer Record					
Field	**Name**	**Size**	**Displacement**	**Description**	**Values**
5	File Date	8	16 – 23	Creation Date of file	*Format* = CCYYMMDD
6	Record Count	9	24 – 32	Number of records on file	
7	Filler	768	33 – 800	Unused	Spaces

Field Placement	FIELD NAME	Qualified SPAPs	Retiree Drug Subsidy	Supplemental/N Record	MSP Reporting
HEADER RECORD	HEADER RECORD	HEADER RECORD	HEADER RECORD	HEADER RECORD	HEADER RECORD
1	Header Indicator	X	X	X	X
2	PBM ID	X	X	X	X
3	Filler	N/A	N/A	N/A	N/A
4	File Type	X	X	X	X
5	File Date	X	X	X	X
6	RDS Application ID	N/A	X	N/A	N/A
7	Filler	N/A	N/A	N/A	N/A
RESPONSE RECORD	RESPONSE RECORD	RESPONSE RECORD	RESPONSE RECORD	RESPONSE RECORD	RESPONSE RECORD
1	Filler	N/A	N/A	N/A	N/A
2	HIC Number	X	X	X	X
3	Beneficiary Surname	X	X	X	X
4	Beneficiary First Initial	X	X	X	X
5	Beneficiary Middle Initial	X	X	X	X
6	Beneficiary DOB	X	X	X	X
7	Beneficiary Sex Code	X	X	X	X
8	COBC DCN	X	X	X	X
9	Disposition Code	N/A	N/A	N/A	X
10	Transaction Type	N/A	X	X	X
11	Reason for Medicare Entitlement	N/A	X	X	X
12	Coverage Type	X	X	X	X
13	RDS Error Code 1	N/A	X	N/A	N/A

14	RDS Error Code 2	N/A	X	N/A	N/A
15	RDS Error Code 3	N/A	X	N/A	N/A
16	RDS Error Code 4	N/A	X	N/A	N/A
17	RDS Split Indicator	N/A	X	N/A	N/A
18	LIS Denial 1	X	N/A	N/A	N/A
19	LIS Denial 2	X	N/A	N/A	N/A
20	LIS Denial 3	X	N/A	N/A	N/A
21	LIS Denial 4	X	N/A	N/A	N/A
22	LIS Denial 5	X	N/A	N/A	N/A
23	Filler	N/A	N/A	N/A	N/A
24	LIS Appeal Result	X	N/A	N/A	N/A
25	LIS CPD	X	N/A	N/A	N/A
26	LIS Determination	X	N/A	N/A	N/A
27	LIS Approval	X	N/A	N/A	N/A
28	LIS Determination Basis	X	N/A	N/A	N/A
29	Filler	N/A	N/A	N/A	N/A
30	Premium Amount	X	N/A	N/A	N/A
31	DEEMED Start Date	X	N/A	N/A	N/A
32	DEEMED End Date	X	N/A	N/A	N/A
33	DEEMED Reason Code	X	N/A	N/A	N/A
34	DEEMED Split Reason	X	N/A	N/A	N/A
35	PBP	X	N/A	N/A	N/A
36	FPL %	X	N/A	N/A	N/A
37	Filler	N/A	N/A	N/A	N/A
38	S Disposition Code	N/A	X	N/A	N/A
39	Insurer TIN	N/A	N/A	N/A	X
40	Beneficiary SSN	X	X	X	X
41	MSP Effective Date	N/A	N/A	N/A	X
42	MSP Termination Date	N/A	N/A	N/A	X

43	Relationship code	N/A	N/A	X	X
44	Policy Holder’s First Name	N/A	N/A	N/A	X
45	Policy Holder’s Last Name	N/A	N/A	N/A	X
46	Policy Holder’s SSN	N/A	N/A	N/A	X
47	S Disposition Date	N/A	X	N/A	N/A
48	RDS Start Date	N/A	X	N/A	N/A
49	RDS End Date	N/A	X	N/A	N/A
50	LIS Effective Date	X	N/A	N/A	N/A
51	LIS Termination Date	X	N/A	N/A	N/A
52	Filler	N/A	N/A	N/A	N/A
53	LIS Disapproval Date	X	N/A	N/A	N/A
54	Premium Effective Date	X	N/A	N/A	N/A
55	SPAP Effective Date	X	N/A	N/A	N/A
56	SPAP Termination Date	X	N/A	N/A	N/A
57	State Code	X	N/A	N/A	N/A
58	Employer’s TIN	N/A	N/A	N/A	X
59	Group Policy Number	N/A	X	X	X
60	Individual Policy Number	N/A	X	X	X
61	Last Query Date	N/A	N/A	N/A	X
62	Current Disposition Code	N/A	N/A	N/A	X
63	Current Disposition Date	N/A	N/A	N/A	X

64	Previous Disposition Code	N/A	N/A	N/A	X
65	Previous Disposition Date	N/A	N/A	N/A	X
66	First Disposition Code	N/A	N/A	N/A	X
67	Fist Disposition Date	N/A	N/A	N/A	X
68	Error Code 1	N/A	X	N/A	X
69	Error Code 2	N/A	X	N/A	X
70	Error Code 3	N/A	X	N/A	X
71	Error Code 4	N/A	X	N/A	X
72	Split Entitlement Indicator	N/A	N/A	N/A	X
73	Original Reason for Medicare Entitlement	N/A	N/A	X	X
74	Original Coverage Effective Date	N/A	N/A	N/A	X
75	Original Coverage Termination Date	N/A	N/A	N/A	X
76	Original DCN	X	X	X	X
77	Current Medicare Part A Effective Date	N/A	X	X	X
78	Current Medicare Part A Termination Date	N/A	X	X	X
79	Current Medicare Part B Effective Date	N/A	X	X	X
80	Current Medicare Part B Termination Date	N/A	X	X	X
81	Medicare Beneficiary Date of Death	X	X	X	X

82	MA/MA-PD Contractor #	N/A	X	X	X
83	MA/MA-PD Effective Date	N/A	X	X	X
84	MA/MA-PD Termination Date	N/A	X	X	X
85	PDP Contractor Number	X	X	X	X
86	PDP Effective Date	X	X	X	X
87	PDP Termination Date	X	X	X	X
88	Current Part D Eligibility Effective Date	X	X	X	X
89	Current Part D Eligibility Termination Date	X	X	X	X
90	National Health Plan ID	N/A	N/A	N/A	N/A
91	RX Insured ID Number	X	X	X	X
92	RX Group Number	X	X	X	X
93	RX PCN	X	X	X	X
94	RX BIN Number	X	X	X	X
95	RX Toll Free Number	X	X	X	X
96	Person Code	N/A	X	X	X
97	Rx Disposition Code	X	X	X	X
98	Rx Disposition Date	X	X	X	X
99	Rx Error Code 1	X	X	X	X
100	Rx Error Code 2	X	X	X	X
101	Rx Error Code 3	X	X	X	X
102	Rx Error Code 4	X	X	X	X
103	ESRD Data	N/A	N/A	N/A	N/A

104	LIS Premium Subsidy %	X	N/A	N/A	N/A
105	Data Sharing Agreement ID Code	X	X	X	X
106	Data Sharing Agreement Indicator	X	X	X	X
107	Supplemental Insurance Type	X	N/A	X	N/A
108	Filler	N/A	N/A	N/A	N/A
TRAILER RECORD	TRAILER RECORD	TRAILER RECORD	TRAILER RECORD	TRAILER RECORD	TRAILER RECORD
1	Trailer Indicator	X	X	X	X
2	PBM ID	X	X	X	X
3	Filler	N/A	N/A	N/A	N/A
4	File Type	X	X	X	X
5	File Date	X	X	X	X
6	Record Count	X	X	X	X
7	Filler	N/A	N/A	N/A	N/A

II. PBM Data Management Specifications

The information following describes the data review and response process used by the CMS data management contractor, the COBC. Included are the Business Rules for the two primary Input and Response files. The TIN reference file has no codified Business Rules at this time. No Business Rules are needed for the Implementation Questionnaire.

I. Conventions for Describing Data Values

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

Data Type Key

Data Type / Field	***Formatting Standard***	***Examples***
Numeric	• Zero through 9 (0 → 9) • Padded with leading zeroes	• Numeric (5): "12345" • Numeric (5): "00045"
Alpha	• A through Z • Left justified • Non-populated bytes padded with spaces	• Alpha (12): "TEST EXAMPLE" • Alpha (12): "EXAMPLE "

Alpha-Numeric	• A through Z (all alpha) + 0 through 9 (all numeric) • Left justified • Non-populated bytes padded with spaces	• Alphanum (8): "AB55823D" • Alphanum (8): "MM221 "

Text	• A through Z (all alpha) + 0 through 9 (all numeric) + special characters:
	  • Comma (,)
	  • Ampersand (&)
	  • Space ( )
	  • Dash (-)
	  • Period (.)
	  • Single quote (')
	  • Colon (:)
	  • Semicolon (;)
	  • Number (#)
	  • Forward slash (/)
	  • At sign (@)
	• Left justified
	• Non-populated bytes padded with spaces
		• Text (8): "AB55823D"
		• Text (8): "XX299Y "
		• Text (18): "ADDRESS@DOMAIN.COM"
		• Text (12): " 800-555-1234"
		• Text (12): "#34 "

Date	• Format is field specific • Fill with all zeroes if empty (no spaces are permitted)	• CCYYMMDD (e.g. "19991022") • Open ended date: "00000000"
Filler	• Populate with spaces	
Internal Use	• Populate with spaces	
The above standards apply unless otherwise noted in the layouts.		

II. Process Overview

A Pharmacy Benefit Manager (PBM) is a third party administrator (TPA) that processes drug benefits for insurers and/or employers.

Current COB processing is enhanced to include the acceptance of drug coverage information from Pharmacy Benefit Managers (PBM). Data from PBMs may come from multiple sources and may contain information regarding a beneficiary's comprehensive health insurance coverage plan.

A PBM can use the PBM Data Sharing Agreement (DSA) process to provide data on behalf of an insurer, employer, State Pharmaceutical Assistance Program (SPAP), employer subsidy, COBA partner, or itself. A consolidated record layout has been created that will allow the PBM to send a single transmission with data from any and all of the entity types for which they provide administration.

Hospital and medical records may also be accepted from PBMs, although we do not expect to receive many, since these records fall outside of the ordinary scope of the current PBM data exchange parameters.

Each PBM will be assigned a unique *plan number* that will have a 'P' identifier as the first character. This plan number will be assigned by GHI (the COBC), and will be applied by the COBC for use in file processing. The PBM *contractor number* will be '11118' for all reporting PBMs.

PBMs will provide an Insurer/Employer TIN reference file as a separate file feed. The two record feeds (Input File and TIN File) will share the same header and trailer layouts, differentiated by the File Type field.

The File Type/File Action Type combination fields on the header records within the PBM input file will be used as the initial drivers for determining file processing requirements.

Upon receipt of a PBM input file, the COBC will analyze and separate the various plan types reported and convert all records to the correct input format needed for each plan type, determined by the File Type/Action Type field combination. The COBC will merge all records received from PBMs onto a single converted input file for each plan. PBMs reporting multiple file types (e.g. VDSA MSP, VDSA non-MSP change file, SPAP, etc.) will receive a separate response file for each file type. SPAP and COBA plans will be returned using the non-MSP file type.

The COBC will check for duplicate data, and post new or updated records at CWF.

A single overall layout will be used for the response file. Records will be delineated by header/trailer sections. Data fields will be populated according to the response file type returned by the COBC.

III. System Requirements

1. The System shall provide the ability to receive an external file from a PBM.

2. The System shall be able to confirm the external PBM file layout.

3. The System shall validate the records on the PBM file for the existence of mandatory fields.

4. The System shall provide the ability to accept Insurer/Employer TIN Reference files as accompaniment to the PBM external files.

5. The System shall be able to confirm the external Reference File layout.

6. The System shall validate the records on the Reference File for the existence mandatory fields.

7. The System shall provide the ability to store and process all data submitted on PBM input files.

8. The System shall allow for the reporting of hospital and medical coverage by the PBM if the beneficiary’s prescription coverage is part of a comprehensive plan.

9. The System shall maintain the ability to post new and updated records at CWF.

10. The System shall provide the ability to transmit SPAP records received on the PBM file to MBD.

11. The System shall provide the ability to transmit MSP drug records received on the PBM file through the VDSA MSP process to MBD and the Eligibility Database.

12. The System shall provide the ability to transmit supplemental drug records received on the PBM file for VDSA non-MSP processing.

13. The System shall provide the ability to transmit RDS employer subsidy records received on the PBM file through the VDSA process to the RDS Contractor.

14. The System shall provide the ability to transmit COBA records received on the PBM file for VDSA non-MSP processing.

15. The system shall maintain the ability to display processing outputs of all submitted file types submitted on the PBM file through CHAPS.

16. The System shall provide the ability to accept a response file from MBD for submitted MSP records.

17. The System shall provide the ability to accept a response file from MBD for submitted SPAP records.

18. The System shall provide the ability to accept a response file from the RDS Contractor for submitted employer subsidy records.

19. The System shall provide the ability to accept a response file from MBD for submitted supplemental drug records.

20. The System shall maintain disposition and error codes for the responses back to the PBM.

21. The System shall maintain the ability to compile and merge, by PBM, all processed response files.

22. The System shall maintain the ability to return response files to the PBM as processed or generated. The System will be able to transmit multiple response files for each input file sent.

23. The System shall provide the ability to transmit LIS data for qualified SPAP submissions on the PBM return file.

24. The System shall place a submitted input file into a severe error status when it is identified as a full-file replacement and the variance in the number of records received exceeds thirty percent (30%).

25. The System shall place a submitted input file into an error status when it is identified as a change file and the number of records with a transaction type of delete exceeds thirty percent (30%) of the total number of submitted records.

IV. Business Rules

1. Existing MSP (Medicare Secondary Payer) rules will be used for processing all MSP records submitted.

2. Existing VDSA non-MSP rules will be used for processing all COBA records submitted.

3. Existing SPAP rules will be used for processing all SPAP records submitted.

4. Existing VDSA non-MSP rules will be used for processing all supplemental drug coverage records submitted.

5. The Coverage Type field will be used for MSP records, and the Insurance Type field will be used for Supplemental and SPAP records.

6. An SPAP identifier will be used for SPAP records on the PBM file. Each SPAP will be assigned a unique identifier of the format "Sxxx." COBA records will use their assigned unique COBA ID number. VDSA records will use their unique Plan ID.

7. Full File replacements will be accepted for files containing Supplemental records.

8. Add, update, and deletes will be accepted for files containing Supplemental records

9. Add, update, and deletes will not be accepted for files containing SPAP records

10. Full file replacements will not be accepted for files containing RDS records.

11. Full file replacements will not be accepted for files containing MSP records.

12. Deletes for full file replacements will follow the same rules as the pre-existing rules for COBA.

13. Each record will have a 10-position TIN identification number. This record will be:

    - Populated with the employer's TIN if the data is being sent on behalf of an employer in the Employer TIN field,

    - Populated with the insurer's TIN if the data is being sent on behalf of an insurer in the Insurer TIN field,

- Populated with the PBM's TIN if the data is being sent on behalf of an insurer or employer for which no TIN is available. In such instances the PBM's TIN will be populated in the Insurer or Employer TIN fields, as applicable.

14. Response records will be formatted dependent upon the Action Type / File Type combination for which the PBM is reporting.

15. A PBM can potentially receive four or more response files for each input file sent, depending upon the number of file types the PBM is reporting on behalf of. Responses will be transmitted to the PBM as they are processed and returned back to COB.

16. Records received on full-file replacements that are identified as non-updated (unchanged since the previous transmission) will not be included on the return file to the PBM.

17. Processing of input files from PBMs will not reject a record if data that has been identified as required is not provided. The record will be permitted to go through as long as all fields to build a valid MSP record are provided.

18. SPAPs will be assigned an SPAP source code and plan number. All others will be assigned a five-byte contractor number.

19. Each record type will have its own header/trailer combination (e.g., MSP, non-MSP, SPAP, RDS) based upon the Action Type/File Type indicator fields. COBA plans will be reported using the Supplemental record type.

20. Input files for reporting SPAPs will always be treated as full replacement files.

21. The TIN Reference input file will be processed as a change file using these rules:

    - If a match is found on the record, the record is replaced;
    - If no match is found, the record is added as a new record.
    - There will be no deletions from the input file.

22. Non-used fields will be populated with spaces unless otherwise instructed.

23. When a received input file is marked as a full-file replacement, the number of records on the file will be divided by the number of records received from the previous transmission. If the variance exceeds 30%, the file will be placed in an error status, requiring manual intervention by an EDI representative. Files with variances of 30% or less will be processed.

24. All input files will be pre-processed to ensure that the number of records identified as ‘deletes’ does not exceed 30% of the current file (based upon number of records transmitted, excluding header and trailers). Files with greater than 30% deletes will be placed in an error status, requiring manual intervention by an EDI representative. Files with delete records comprising 30% or less of the total will be processed.

25. There is no manual updating.

V. Testing The Data Exchange Process

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

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

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

In order to test the process for creating an Update File, a test "Update" shall be prepared by the partner. It will use data about individuals included in the first Test File. The partner shall submit the test Update, and an updated TIN test Reference File, within ninety (90) days after receipt of the original test Response File. The test Update File shall also include:

- An agreed upon number of newly reported Covered Individuals ("adds") that were previously sent to the partner;
- Previously Covered Individuals who have become Medicare eligible as reported by CMS in its Response File to the Test File ("adds");
- Changes in status as an Active Employee and GHP coverage for Covered Individuals identified in the Test File ("updates"), and;

- Deletions for individuals who were erroneously included on the Test File ("deletes").

Upon completion of its review of the test update, CMS shall provide to the partner a Response for every record found on the Test Update File. CMS shall provide this test Update Response File to the partner, usually within with a week, but no longer than forty-five (45) days after receipt of the partner's Test Update File.

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

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

From time to time a PBM partner will need to update data it has previously supplied to CMS. All information to be changed will be entered on the PBM Input File and transmitted to CMS.

PBMs will use either full-file replacement to make changes in previously supplied information, or will submit an "Add," "Update" or "Delete" file to make changes. The submission method used will depend on what type of client organization the PBM is reporting for.

The monthly file submitted by SPAPs is a full-file replacement file. Each month's input file will include any corrections from the previous month's response file and will fully replace an SPAP's previous input file.

As a consequence, when reporting data changes for an SPAP, the PBM will *always* use full-file replacement. When reporting data changes for any other type of organization the PBM will use an "Add," "Update" or "Delete" file submission process.

Remember that files submitted subsequent to the first production files (the initial Input Files) are generically referred to as update files. These newly submitted update files are not the same as record "Updates," which are discussed below.

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

Example: Mr. John X. Smith has not yet been included on an Input File. Although he had health insurance as a covered benefit through his employer, Mr. Smith was not yet 55 years of age (the minimum age of Active Covered Individuals that CMS requires to be reported on the MSP Input File). Mr. Smith reaches age 55. Consequently, in a succeeding Update File a record for Mr. Smith is added to the existing database, using an "Add" Transaction Type.

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

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

Example: In January, a partner sent an "add" record for an Active Covered Individual identified as a Medicare beneficiary, and an MSP record was created and posted for the individual. On July 15th, the individual stopped working and retired. The partner sends this "update" to CMS in the next Update File, which will result in an indication that Medicare is now the primary payer – it changes a formerly open-ended termination date to a July 15 termination date.

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

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

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

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

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

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

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

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

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

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

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

Situation: A partner has had a record previously accepted by CMS (the partner received an "01" Disposition Code on the response record from CMS). The partner wishes to update the record previously accepted by CMS by sending an Update record. In addition to the standard Matching Criteria (SSN or HICN, first initial of the first name, first 6 characters of the last name, DOB and sex), for Update records we also match against the effective date of the coverage, the insurance coverage type, and the patient relationship code. If there is not a match on all of them, we treat the record as an "add" and build a new record, while leaving the original record unmodified on CMS's database. If a partner attempts to "delete" a previously accepted record and the fields listed above don't match, the record will error out.

NOTE: In some cases, CMS will convert the originally submitted coverage effective date to the MSP Effective Date. This occurs where the Medicare Part A Entitlement Date is later than the coverage effective date submitted by the partner. When attempting to update or delete a record in which CMS changed the coverage effective date to the MSP effective date, the partner should submit the MSP effective date provided by CMS.

VII. 'D,' 'S' and 'N' Data Exchanges

'D' – Drug Coverage Reporting

The 'D' Action Type on an Input File signals that the record contains information about drug coverage that is supplemental to (paying after) Medicare Part D. The 'D' Action Type Response File will contain whatever information was provided in the incoming file (SSN or HICN, DOB, Rx Insured ID Number, etc.).

'S' – Employer Subsidy Enrollment File Sharing Record, and Response

The 'S' Action Type is used to report retiree drug coverage, and for which the PBM's client is claiming the Retiree Drug Subsidy. After it enrolls with the RDS Contractor, an employer can arrange to have a PBM submit the employer's subsidy records to GHI (the COBC) for coordination with the RDS Center. 'S' records require the RDS Application ID in the header, a data element the RDS Contractor will assign to an employer at the start of the application process.

The RDS Contractor will determine whether the individuals in the file are eligible for the Subsidy (Part D eligible but not enrolled). On a response to the COBC, the RDS Contractor will indicate whether a covered individual was accepted (eligible to be included as part of the employer's subsidy population) or rejected. The COBC will then return a completed 'S' Action Type response file to the PBM partner.

Prior to transmitting the 'S' File back to the PBM partner, the COBC will screen the data it received from the RDS Center to identify individuals who are enrolled in Part D. COBC will change the Action Type of these records from S' to D' and apply them to the MBD in the same way a record originally submitted as a 'D' record is. Partners will then receive back a new 'D' response for that individual's record, including all Medicare entitlement history included in Type 'D' and 'N' responses. Partners will be required to submit adds, updates or deletes for records changed to 'D' as if they had originally submitted them as a 'D' Action Type.

'N' – Non-Reporting Query Record and Response

Input Files with an 'N' Action Type (that is, a "query only" filing) will require the following *minimum* data set: HIC Number (HICN) or SSN, last name, first initial, date of birth, and sex. All are included as part of the current Input File. In response, CMS will provide the standard Medicare Part A and B entitlement information as well as the new Medicare Part D entitlement information.

Obtaining a TrOOP Facilitation RxBIN or PCN

PBM partners will need to obtain a TrOOP Facilitation RxBIN or PCN to route claims through the TrOOP Facilitator. The TrOOP Facilitation RxBIN or PCN are routing numbers used to flag claims for coverage supplemental to Medicare Part D that will be paid by DSA partners or their agents. As it is being routed to the pharmacy, the TrOOP Facilitation RxBIN or PCN will enable the TrOOP Facilitation Contractor to identify a Part D supplemental claim, capture it, and transmit the supplemental paid claim amount to the appropriate Part D Plan to support the Plan's TrOOP calculation responsibilities. To route these claims through the TrOOP Facilitation Contractor, partners may use a separate and unique RxBIN by itself, or a unique PCN in addition to their existing RxBIN.

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

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

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