Voluntary Data Sharing Agreement

USER GUIDE

Version Effective Date:
February 20, 2008

RECENT CHANGES

In this section, "**Recent Changes**," we list all the significant changes made in this edition of the VDSA User Guide.

The document that follows replaces the previous edition of the VDSA User Guide, dated January 10, 2008, as well as all earlier and interim later versions. We continue to edit all text in the User Guide for accuracy and clarity.

Updates to this Edition of the User Guide

To give partners End Stage Renal Disease (ESRD) information we have added new ESRD data fields to the MSP and Non-MSP Response Files. The new fields are the ESRD Coordination Period start and end date in the MSP Response File, the ESRD Coverage Period start and end dates in the Non-MSP Response File, and the first (oldest) dialysis date, the self-training date, the most recent transplant date and most recent transplant failure date in both. ESRD Coordination Period start and end dates are also noted in appropriate data fields as possible adjustments to the MSP effective date and termination date. The precise data definitions are given in each field. In the MSP Response File the new ESRD data starts at Field 75. In the Non-MSP Response File the new ESRD data starts at Field 55.

For both the MSP and Non-MSP Input and Response Files, in all "Relationship Code" fields we have made clear that an additional code number can be supplied or received. This new code has been more precisely defined as "20 – Domestic Partner."

We have revised the text in "Using BASIS for Queries," starting on Page 82. Queries must be made using an individual's SSN. Use of a corresponding HICN is not an option.

On Pages 12, 31, and 44 we remind Partners that file headers and trailers are not to be included in the total record count when preparing a file for submission.

We wish to draw the attention of new data sharing partners to the topic, "Establishing Electronic Data Exchange," in Section C. It starts on Page 71.

We added a Field 27 (Rx Insurer Name) on Page 30 in the Non-MSP Input File that will permit partners to give CMS the name of the Insurer providing the prescription drug coverage indicated in that particular record. This is not a mandatory field, but like Field 17 (Rx Toll Free Number), filling it will allow CMS to provide pharmacies with more precise information to facilitate point of sale billing.

We have added a table providing a crosswalk between certain RDS Reason Codes and VDSA 'S' Disposition Codes, with accompanying explanatory text. This section starts on Page 78, at *Changes in 'S' Record Data*.

We added information about the "ID" Disposition Code, which can appear in the Rx Disposition Code field in the MSP Response File (Field 69) and in the D/N Disposition Code field in the Non-MSP Response File (Field 48). See Page 80.

Starting on Page 82 you will find instructions and a Contact Protocol on how to get additional help from the COBC if you are having persistent data exchange problems.

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January 10, 2008

INTRODUCTON

This Voluntary Data Sharing Agreement (VDSA) USER GUIDE provides information and instructions VDSA partners will find useful as they manage the VDSA data sharing process with the Centers for Medicare & Medicaid Services (CMS). In particular, a VDSA and the information in this document will allow users to coordinate Medicare Part D drug benefits with CMS under the terms of the Medicare Modernization Act (MMA).

FROM TIME TO TIME THE INFORMATION PROVIDED IN THIS USER GUIDE WILL CHANGE. As current data exchange requirements are refined and new processes developed, CMS will add new and revised material to this Guide. Existing and potential VDSA partners will then be notified that a new version is available on the CMS VDSA Web sites, www.cms.hhs.gov/EmployerServices/03_employervdsa.asp#TopOfPage or www.cms.hhs.gov/InsurerServices/02_insurervdsa.asp#TopOfPage. VDSA partners must replace old versions of this Guide whenever CMS makes a new version available.

This VDSA User Guide assumes a fairly comprehensive understanding of the current VDSA process. Please contact us if you find material that is unclear or if you have questions that aren't addressed. All official CMS documentation regarding the VDSA process, including up-to-date record layouts and other information (such as Frequently Asked Questions) may also be obtained from the Coordination of Benefits Contractor (COBC). Its email address is – COBVA@GHImedicare.com ; its main phone number is 646-458-6740.

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

SECTION A: COMPLETING AND SIGNING A VOLUNTARY DSA

To make the VDSA relationship operational, the VDSA partner and CMS have to sign and exchange completed copies of the VDSA. These are the instructions for completing these Data Sharing Agreements for signature. Current versions of the Insurer and Employer VDSAs are available in a pdf file format at the following CMS VDSA Web sites: www.cms.hhs.gov/EmployerServices/03_employervdsa.asp#TopOfPage or www.cms.hhs.gov/InsurerServices/02_insurervdsa.asp#TopOfPage.
For ease of completing your VDSA, convert the VDSA file to a Microsoft Word document so that you can insert the required VDSA partner specific information, as follows below, into an electronic version of the document.

1. In the first paragraph of the VDSA, insert all of your specific identifying information where indicated. The date the signature process is completed by both the partner and CMS will be entered here, and will be the "Effective Date." If you wish, the date you enter may be prospective or retroactive. For example, some VDSA partners prefer to enter the first day of the month in which they expect the VDSA to be signed. But bear in mind that if you enter a prospective date, CMS cannot begin full implementation of the VDSA until we reach it.

2. Enter the date that is requested on Page 5 of the VDSA, in Section C, 1. This is the starting date for health plan enrollment information that is entered on the first regular production MSP Input File you provide to CMS.

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

NOTE TO EMPLOYERS: Providing historical enrollment data covering a period starting no later than January 1 of the first complete year prior to the execution of the Agreement will allow CMS to immediately suppress mailings of all future IRS/SSA/CMS Data Match questionnaires. Because the IRS/SSA/CMS Data Match for any given year is based on information that is almost two years old when we receive it, without the historical data we suggest you provide us, employers will continue to be required to complete questionnaires until the IRS/SSA/CMS Data Match catches up to the end of the current tax year, which will take about two years.

3. On Page 14, in Section N, enter the partner's Administrative and Technical contact information.

4. Page 15, Section O: Upon receipt of a VDSA signed by the partner, CMS will provide the required Technical contact information. This does not need to be completed to execute the Agreement.

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

The VDSA signature package consists of two documents: The VDSA itself, and the VDSA Implementation Questionnaire. The VDSA Implementation Questionnaire is used to assure both the VDSA partner and CMS that agreement on essential operational questions has been reached. VDSA partners must complete and return a copy of the VDSA Implementation Questionnaire to CMS with their signed VDSA. An Employer or Insurer version of the Questionnaire is included as part of the original package of material accompanying a VDSA to be signed and returned to CMS. The Questionnaire is available at the Web addresses listed at the beginning of this Section.

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

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

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

SECTION B: THE VDSA DATA FILES – Standard Reporting Information

Standard Data Files: The data exchanged through the VDSA process is arranged in six different file schematics (also referred to as record layouts). A VDSA partner electronically transmits a data file to CMS. CMS processes the data in this *input file*, and at a prescribed time electronically transmits a *response file* to the partner. In a very few instances (as part of the retiree drug subsidy [RDS] file exchange process, for example) CMS will transmit a record layout to a partner without having first received a specific

input file, but these are rare exceptions. In ordinary circumstances it will be an input file that will generate a response file.

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

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

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

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

I. The Input and Response File Data Layouts

A – *The MSP* (Medicare Secondary Payer) *Input File*. This is the data set transmitted from a VDSA partner to CMS that is used to report information regarding Active Covered Individuals – people who are currently working (not carried as retired), and a spouse and (or) other dependents, and who are enrolled in and covered by an employer group health plan (GHP). At a minimum, we require the partner to include information about all Active Covered Individuals who are at least 55 years of age, and older. We have found that about ninety-seven percent of all Medicare beneficiaries are 55 and above.

VDSA Attachment A

Employer/Insurer Voluntary MSP Input File Layout – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
1.	HIC Number	12	1-12	Alpha-Numeric	Beneficiary's Health Insurance Claim Number. Required if SSN not provided. Populate with spaces if unavailable.
2.	Beneficiary Surname	6	13-18	Text	Beneficiary's Last Name – Required.
3.	Beneficiary First Initial	1	19-19	Alpha	Beneficiary's First Initial – Required.
4.	Beneficiary Date of Birth	8	20-27	Date	Beneficiary's DOB (CCYYMMDD) – Required.
5.	Beneficiary Sex Code	1	28-28	Numeric	Beneficiary's Sex – Required. Valid Values: 0 = Unknown 1 = Male 2 = Female
6.	DCN	15	29-43	Text	Document Control Number; assigned by the VDSA partner. Mandatory. Each record shall have a unique DCN.
7.	Transaction Type	1	44-44	Numeric	Type of Maintenance – Required. Valid Values: '0' = Add Record '1' = Delete record '2' = Update record
8.	Coverage Type	1	45-45	Alpha-Numeric	Type of Insurance – Required. Valid Values: 'J' = Hospital Only 'K' = Medical Only 'A' = Hospital and Medical 'U' = Drug Only (network Rx) 'V' = Drug with Major Medical

Employer/Insurer Voluntary MSP Input File Layout – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
					(non-network Rx) 'W' = Comprehensive Coverage –Hosp/Med/Drug (network Rx) 'X' = Hospital and Drug (network Rx) 'Y' = Medical and Drug (network Rx) 'Z' = Health Reimbursement Account (non-network Rx) '4' = Comprehensive Coverage –Hosp/Med/Drug (non-network Rx) '5' = Hospital and Drug (non-network Rx) '6' = Medical and Drug (non-network Rx)
9.	Beneficiary Social Security Number	9	46-54	Numeric	Beneficiary's SSN – Required if HICN not provided. Populate with 9 spaces if unavailable.
10.	Effective Date	8	55-62	Date	Start Date of Covered Individual's Primary Coverage by Insurer. (CCYYMMDD) – Required.
11.	Termination Date	8	63-70	Date	End Date of Covered Individual's Primary Coverage. CCYYMMDD, Required. *Use all zeros if open-ended.
12.	Relationship Code	2	71-72	Numeric	Covered Individual's Relation to Policy Holder – Required. Valid values: '01' = Covered Individual is Policy Holder '02' = Spouse '03' = Child '04' = Other '20' = Domestic partner
13.	Policy Holder's First Name	9	73-81	Text	Policy Holder's First name – Required.

Employer/Insurer Voluntary MSP Input File Layout – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
14.	Policy Holder's Last Name	16	82-97	Text	Policy Holder's Last Name – Required.
15.	Policy Holder's SSN	9	98-106	Numeric	Policy Holder's SSN – Required.
16.	Employer Size	1	107	Numeric	Valid Values: '0' = 1 to 19 employees* '1' = 20 to 99 employees* '2' = 100 or more employees *Employer Size Rule: 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. Enter '2' if employer has fewer than 100 employees but is part of a multi-employer plan where another employer in that plan has 100 or more employees. Required.
17.	Group Policy Number	20	108-127	Text	Policy Number Assigned by primary Payer – For use when coverage type is V, Z, 4, 5, and 6.
18.	Individual Policy Number	17	128-144	Text	Individual Policy Number. Required for Coverage types V, Z, 4, 5, and 6.
19.	Employee Coverage Election	1	145	Numeric	Who the Policy Covers – Required. '1' = Policyholder Only. '2' = Policyholder & Family. '3' = Policyholder & Dependents, but not Spouse.

Employer/Insurer Voluntary MSP Input File Layout – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
20.	Employee Status	1	146	Numeric	'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 (End-Stage Renal Disease). Required.
21.	Employer TIN	9	147-155	Numeric	Employer Tax Identification Number – Required.
22.	Insurer TIN	9	156-164	Numeric	Insurer Tax Identification Number – Required.
23.	National Health Plan	10	165-174	Filler	National Health Plan Identifier – (Future Use).
24.	Rx Insured ID number	20	175-194	Text	Insured's Identification Number. Required for coverage types U, W, X, & Y
25.	Rx Group Number	15	195-209	Text	Group Number For use when coverage type is V, Z, 4, 5, and 6.
26.	Rx PCN	10	210-219	Text	Processor Control Number
27.	Rx BIN Number	6	220-225	Text	International Identification Number. Required for coverage types U, W, X, & Y
28.	Rx Toll Free Number	18	226- 243	Text plus "(" and ")"	Toll Free Number.
29.	Person Code	3	244-246	Text	Person code the plan uses to identify specific individuals on a policy. Values are policy specific.
30.	Reserved	10	247-256	Alpha-Numeric	Reserved for COBC use. Fill with spaces only.

Employer/Insurer Voluntary MSP Input File Layout – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
31.	Reserved	5	257-261	Alpha-Numeric	Reserved for COBC use. Fill with spaces only.
32.	Filler	164	262-425	Alpha-Numeric	Unused Field. Fill with spaces only.

A: Header Record					
1.	Header Indicator	2	1-2	Alpha	Should be: 'H0'
2.	VDSA ID	4	3-6	Numeric	'0001', '0002', etc. ID number assigned by COBC. (Previously labeled as "Plan Number.")
3.	Contractor Number	5	7-11	Numeric	'11105' – Employer. '11106' – Insurer. '11112' – BCBS.
4.	File Type	4	12-15	Alpha	Valid values: 'REFR' – TIN reference file. 'MSPI' – MSP input file.
5.	File Date	8	16-23	Numeric Date	CCYYMMDD
6.	Filler	402	24-425	Alpha Numeric	Unused Field – fill with spaces.

A: Trailer Record					
1.	Trailer Indicator	2	1-2	Alpha	Should be: 'T0'
2.	VDSA ID	4	3-6	Numeric	'0001', '0002', etc. ID number assigned by COBC. (Previously labeled as "Plan Number.")

3.	Contractor Number	5	7-11	Numeric	'11105' – Employer. '11106' – Insurer. '11112' – BCBS.
4.	File Type	4	12-15	Alpha	'REFR' – TIN reference file. 'MSPI' – MSP input file.
5.	File Date	8	16-23	Numeric Date	CCYYMMDD
6.	Record Count	9	24-32	Numeric	Number of beneficiary records in this file. Do not include the Header and Trailer Records in the Record Count.
7.	Filler	393	33-425	Alpha-Numeric	Unused Field – fill with spaces.

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

B – *The TIN Reference File.*

The TIN Reference File consists of a business entity's federal TIN and the firm's business mailing address that is linked to the particular TIN as reported in Field 21 (Employer TIN) and Field 22 (Insurer TIN) of an MSP Input File Record. Any TIN submitted on any MSP Input Record must be included in the TIN Reference File for the record to process.

The same firm can have more than one TIN. For example, a company can operate both a Health Maintenance Organization (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 VDSA partner.

The VDSA partner's TIN Reference File should be comprised of all the TINs relevant to the partner's business as it relates to CMS. For example, an employer's TIN Reference File may consist of just the one employer and insurer TIN and associated business address of the employer and insurer that administers all aspects of the employer's health

benefit coverage. But an insurer must provide complete TIN information about all its employer clients.

NOTE: To update a TIN Reference File the entire file must be submitted; any TIN field updated requires a full TIN Reference File submission.

VDSA Attachment B

TIN Reference File Layout – 425 bytes					
Field	**Name**	**Size**	**Displacement**	**Data Type**	**Description**
1.	TIN	9	1-9	Numeric	Tax identification number of the entity, or cross-reference number to TIN field in the detail records. The TIN indicator field identifies which has been used.
2.	Name	32	10-41	Text	Name of the entity.
3.	Address Line 1	32	42-73	Text	Address Line 1.
4.	Address Line 2	32	74-105	Text	Address Line 2.
5.	City	15	106-120	Text	City.
6.	State	2	121-122	Alpha	State – Must be a valid USPS state abbreviation.
7.	Zip Code	9	123-131	Alpha-Numeric	Zip Code.
8.	TIN indicator	1	132	Alpha	Used to indicate whether the TIN is for an insurer or employer, or if a pseudo TIN number is contained in the TIN field. Values: E = The TIN field contains a valid TIN for an Employer. I = The TIN field contains a valid TIN for an Insurer. Y = Value contained in the TIN field is only to be used as a cross-reference to the address fields. The field does not contain an actual TIN.
9.	Filler	293	133-425	Text	Future use – Fill with spaces.

C – *The MSP Response File*. This is the data set transmitted from CMS to the VDSA partner after the information supplied in the partner's MSP Input File has been processed.

It consists of the same data elements in the Input File, with corrections applied by CMS, disposition and edit codes which let you know what we did with the record, as well as new information for the partner regarding the covered individuals themselves, such as Medicare program coverage details.

VDSA Attachment C

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
1.	Filler	4	1-4	For COBC internal use.
2.	HIC Number	12	5-16	Beneficiary Health Insurance Claim Number. Field will contain either the HICN matched or a corrected HICN based on an SSN match.
3.	Beneficiary Surname	6	17-22	Beneficiary's Last Name. Field will contain either the name supplied or corrected name from COBC database.
4.	Beneficiary First Initial	1	23	Beneficiary's First Initial. Field will contain either the value supplied or corrected value from COBC database.
5.	Beneficiary Date of Birth	8	24-31	Beneficiary's DOB. (CCYYMMDD) Field will contain either the value supplied or corrected value from COBC database.
6.	Beneficiary Sex Code	1	32	Beneficiary's Sex: 0 = Unknown 1 = Male 2 = Female Field will contain either the value supplied or corrected value from COBC database.
7.	COBC DCN	15	33-47	Document Control Number assigned by COBC.
8.	Disposition Code	2	48-49	Response Disposition Code; from CWF.

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
9.	Transaction Type	1	50	Type of Maintenance: '0' = Add Record '1' = Delete record '2' = Update record Type of transaction applied by COBC.
10.	Reason for Medicare Entitlement	1	51	Reason for Medicare Entitlement: 'A' = Working Aged 'B' = ESRD 'G' = Disabled Value returned if individual is entitled. COBC Supplied.
11.	Coverage Type (insurer type/policy type)	1	52	Type of Insurance: 'J' = Hospital Only 'K' = Medical Only 'A' = Hospital and Medical 'U' = Drug Only (network Rx) 'V' = Drug with Major Medical (non-network Rx) 'W' = Comprehensive Coverage - Hosp/Med/Drug (network Rx) 'X' = Hospital and Drug (network Rx) 'Y' = Medical and Drug (network Rx) 'Z' = Health Reimbursement Account (non-network Rx) '4' = Comprehensive Coverage - Hosp/Med/Drug (non-network Rx) '5' = Hospital and Drug (non-network Rx) '6' = Medical and Drug (non-network Rx) Field will contain value supplied on input.
12.	Insurer Name	32	53-84	Insurer name. Field will contain the value supplied on input.

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
13.	Insurer Address 1	32	85-116	Insurer's Address Line 1. Field will contain the value supplied on input.
14.	Insurer Address 2	32	117-148	Insurer's Address Line 2. Field will contain the value supplied on input.
15.	Insurer City	15	149-163	Insurer's City. Field will contain the value supplied on input.
16.	Insurer State	2	164-165	Insurer's State. Field will contain the value supplied on input.
17.	Insurer Zip Code	9	166-174	Insurer's Zip Code. Field will contain the value supplied on input.
18.	Beneficiary SSN	9	175-183	Beneficiary's SSN. Field will contain either the SSN that matched or a corrected SSN based on a HICN match.
19.	MSP Effective Date	8	184-191	Start Date of Beneficiary's Primary Coverage by Insurer (CCYYMMDD). NOTE: For beneficiaries with End Stage Renal Disease (ESRD) entitlement, the MSP effective date could be adjusted to coincide with the start date for the 30-month coordination period in which GHP coverage is considered primary to Medicare.

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
20.	MSP Termination Date	8	192-199	End Date of Beneficiary's Primary Coverage by Insurer (CCYYMMDD). *All zeros if open-ended. NOTE: For beneficiaries with ESRD entitlement, the MSP Termination Date could be adjusted to coincide with the end date of the ESRD 30-month coordination period in which GHP coverage is considered primary to Medicare. A corresponding GHP coverage will no longer be considered an MSP record after the 30-month coordination period has expired.
21.	Relationship Code	2	200-201	Covered Individual's Relationship to Active Employee: '01' = Covered Individual is Active Employee '02' = Spouse '03' = Child '04' = Other '20' = Domestic Partner Default is '01'
22.	Policy Holder's First Name	9	202-210	Active Employee's First Name.
23.	Policy Holder's Last Name	16	211-226	Active Employee's Last Name.
24.	Policy Holder's SSN	12	227-238	Active Employee's SSN. (9 digits, left justified.)
25.	Employer's Name	32	239-270	Employer Providing Coverage. Field will contain the value supplied on TIN input.
26.	Employer's Address Line 1	32	271-302	Employer's Street Address line 1. Field will contain the value supplied on TIN input.

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
27.	Employer's Address Line 2	32	303-334	Employer's Street Address line 2. Field will contain a TIN input value.
28.	Employer's City	15	335-349	Employer's City. Field will contain the value supplied on TIN input.
29.	Employer's State	2	350-351	Employer's State Code. Field will contain the value supplied on TIN input.
30.	Employer's Zip Code	9	352-360	Employer's Zip Code. Field will contain the value supplied on TIN input.
31.	Group Policy Number	20	361-380	Group Policy Number. Field will contain the value supplied on input.
32.	Individual Policy Number	17	381-397	Individual's Policy Number. Field will contain the value supplied on input.
33.	Last Query Date	8	398-405	Last Date Sent to CWF (Common Working File). (CCYYMMDD) COBC supplied.
34.	Current Disposition Code	2	406-407	Result from Most Current CWF Transmission (same as in Field #8). COBC supplied.
35.	Current Disposition Date	8	408-415	Date of Most Current CWF Transmission. (CCYYMMDD) COBC supplied.
36.	Previous Disposition Code	2	416-417	Result from Previous CWF Transmission. COBC supplied.
37.	Previous Disposition Date	8	418-425	Date of Previous CWF Transmission. (CCYYMMDD) COBC supplied.

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
38.	First Disposition Code	2	426-427	Result from First CWF Transmission. COBC supplied.
39.	First Disposition Date	8	428-435	Date of First CWF Transmission. (CCYYMMDD) COBC supplied.
40.	Error Code 1	4	436-439	SP Error Code 1 COBC or CWF supplied.
41.	Error Code 2	4	440-443	SP Error Code 2 COBC or CWF supplied.
42.	Error Code 3	4	444-447	SP Error Code 3 COBC or CWF supplied.
43.	Error Code 4	4	448-451	SP Error Code 4 COBC or CWF supplied.
44.	Split Entitlement Indicator	1	452	Entitlement Split Indicator: 'Y' = yes 'N' or blank = no COBC supplied.
45.	Original Reason for Medicare Entitlement	1	453	Original Reason for Medicare Entitlement: 'A' = Working Aged 'B' = ESRD 'G' = Disabled COBC supplied.
46.	Original Coverage Effective Date	8	454-461	The original coverage effective date sent. This gets populated if a SP31 error occurs. (CCYYMMDD) Field will be the value supplied on input.
47.	Original Coverage Termination Date*	8	462-469	The original coverage termination date sent. This gets populated if a SP32 error occurs. (CCYYMMDD) Field will be the value supplied on input. *All zeros if open-ended.

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
48.	Partner Assigned DCN	15	470-484	The Document Control Number assigned by the VDSA partner. It is located here so we can provide our own unique COBC DCN in Field 7. Field will be the value supplied on input.
49.	Current Medicare Part A Effective Date	8	485-492	Effective Date of Medicare Coverage. (CCYYMMDD) COBC supplied.
50.	Current Medicare Part A Termination Date*	8	493-500	Termination Date of Medicare Coverage. (CCYYMMDD) COBC supplied. * All zeros if open-ended.
51.	Current Medicare Part B Effective Date	8	501-508	Effective Date of Medicare Coverage. (CCYYMMDD) COBC supplied.
52.	Current Medicare Part B Termination Date*	8	509-516	Termination Date of Medicare Coverage. (CCYYMMDD) COBC supplied. * All zeros if open-ended.
53.	Medicare Beneficiary Date of Death	8	517-524	Medicare Beneficiary Date of Death. (CCYYMMDD) COBC supplied.
54.	Current Medicare Part C Plan Contractor Number	5	525-529	Contractor Number of the current Medicare Part C Plan in which the beneficiary is enrolled. COBC supplied.

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
55.	Current Medicare Part C Plan Enrollment Date	8	530-537	Effective Date of coverage provided by current Medicare Part C Plan. (CCYYMMDD) COBC supplied.
56.	Current Medicare Part C Plan Termination Date*	8	538-545	Termination Date of coverage provided by current Medicare Part C Plan. (CCYYMMDD) COBC supplied. * All zeros if open-ended (i.e., if coverage is not terminated).
57.	Current Medicare Part D Plan Contractor Number	5	546-550	Contractor Number of the current Medicare Part D Plan in which the beneficiary is enrolled. COBC supplied.
58.	Current Part D Plan Enrollment Date	8	551-558	Effective Date of coverage provided by current Medicare Part D Plan. (CCYYMMDD) COBC supplied.
59.	Current Medicare Part D Plan Termination Date*	8	559-566	Termination Date of coverage provided by current Medicare Part D Plan. (CCYYMMDD) COBC supplied. * All zeros if open-ended (i.e., if coverage is not terminated).
60.	Part D Eligibility Start Date	8	567-574	Earliest date that Beneficiary is eligible to receive Part D Benefits – Refer to Field 58 for Part D Plan Enrollment Date. (CCYYMMDD) COBC supplied.

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
61.	Part D Eligibility Stop Date*	8	575-582	Date the Beneficiary is no longer eligible to receive Part D Benefits – Refer to Field 59 for Part D Plan Termination Date. (CCYYMMDD) COBC supplied. * All zeros if open-ended.
62.	National Health Plan ID	10	583-592	National Health Plan Identifier. (A future requirement.) Field will contain value supplied on input.
63.	Rx Insured ID number	20	593-612	Insured's Identification Number. Field will contain value supplied on input.
64.	Rx Group Number	15	613-627	Group Number. Field will contain value supplied on input.
65.	Rx PCN	10	628-637	Processor Control Number. Field will contain value supplied on input.
66.	Rx BIN Number	6	638-643	Benefit International Number. Field will contain value supplied on input.
67.	Rx 800 Number	18	644-661	Toll Free Number. Field will contain value supplied on input.
68.	Person Code	3	662-664	Person Code. Field will contain value supplied on input.
69.	Rx Disposition Code	2	665-666	Rx result from the MBD. Code supplied by the COBC.
70.	Rx Disposition Date	8	667-674	Date - Rx result from the MBD. (CCYYMMDD) Code supplied by the COBC.
71.	Rx Error Code 1	4	675-678	Rx Error Code 1. COBC supplied.
72.	Rx Error Code 2	4	679-682	Rx Error Code 2. COBC supplied.
73.	Rx Error Code 3	4	683-686	Rx Error Code 3. COBC supplied.

Employer/Insurer Voluntary MSP Response File Layout - 800 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
74.	Rx Error Code 4	4	687-690	Rx Error Code 4. COBC supplied.
75.	ESRD Coordination Period Start Date	8	691-698	The start date for the 30-month coordination period in which GHP coverage is considered primary to Medicare because the beneficiary has a diagnosis of End Stage Renal Disease. (CCYYMMDD)
76.	ESRD Coordination Period End Date	8	699-706	The ending date for the 30-month coordination period in which GHP coverage is considered primary to Medicare because the beneficiary has a diagnosis of ESRD. A corresponding GHP coverage will no longer be considered an MSP record after the 30-month coordination period is terminated. (CCYYMMDD)
77.	First Dialysis Date - Oldest	8	707-714	A date that indicates when the ESRD Dialysis first started. (CCYYMMDD) Value will be spaces if not applicable.
78.	ESRD Self-Training Date	8	715-722	A date that indicates when the beneficiary participated in ESRD Self Care Training.(CCYYMMDD) Value will be spaces if not applicable.
79.	Transplant Date – Most Recent	8	723-730	A date that indicates when a Kidney Transplant Operation Occurred. (CCYYMMDD) Value will be spaces if not applicable.
80.	Transplant Failure Date – Most Recent	8	731-738	A date that indicates when a Kidney Transplant failed. Last occurrence will be reported. (CCYYMMDD)
81.	Filler	62	739-800	Unused Field. Space filled.

C: Header Record				
1.	Header Indicator	2	1-2	Should be: 'H0'
2.	VDSA ID	4	3-6	'0001', '0002', etc. ID number assigned by COBC. (Previously labeled as "Plan Number.") Field will contain value supplied on input.
3.	Contractor Number	5	7-11	'11105' – employer '11106' - insurer '11112' – BCBS Field will contain value supplied on input.
4.	File Type	4	12-15	'MSPR' – MSP input file.
5.	File Date	8	16-23	CCYYMMDD COBC supplied.
6.	Filler	777	24-800	Unused Field. Space filled.

C: Trailer Record				
1.	Trailer Indicator	2	1-2	Should be: 'T0'
2.	VDSA ID	4	3-6	'0001', '0002', etc. ID number assigned by COBC. (previously labeled as "Plan Number") Field will contain value supplied on input.
3.	Contractor Number	5	7-11	'11105' – employer '11106' - insurer '11112' – BCBS Field will contain value supplied on input.
4.	File Type	4	12-15	'MSPR' – MSP response file.
5.	File Date	8	16-23	CCYYMMDD COBC supplied.
6.	Record Count	9	24-32	Number of beneficiary records in this file. COBC supplied.
7.	Filler	768	33-800	Unused Field – Space filled.

D – *The Non-MSP Input File.* This is the data set transmitted from a VDSA partner to CMS that is used to report information regarding the health insurance coverage information of a VDSA partner's Inactive Covered Individuals – people who are currently not working (most are carried as retired), and a spouse and (or) other dependents, and who are enrolled in a health plan or policy, including but not limited to a GHP or policy, for which the partner or a subsidiary acts as an employer, insurer, third party administrator, health plan sponsor or any combination thereof – and who cannot be classified as Active Covered Individuals. The Non-MSP Input File is used to report drug coverage information that is secondary to Medicare Part D. The Non-MSP Input File can also be used to query CMS about potential beneficiary Part D coverage and can be used as a way to submit enrollment files to the Retiree Drug Subsidy (RDS) Center for those employers claiming the Employer Drug Subsidy.

VDSA Attachment D

Voluntary Non-MSP Input File Layout – 300 bytes					
Field	**Name**	**Size**	**Displacement**	**Data type**	**Description**
1.	Beneficiary Social Security Number	9	1-9	Numeric	Covered Individual's Social Security Number. Required if HICN not populated. Use any 9 digits, 0-9. Fill with spaces if SSN is not available.
2.	HIC Number	12	10-21	Alpha-Numeric	Covered Individual's Health Insurance Claim Number. Required if SSN not populated. Populate with spaces if not available.
3.	Covered Individual's Surname	6	22-27	Text	Covered Individual's Last Name – Required.
4.	Covered Individual's First Initial	1	28-28	Alpha	Covered Individual's First Initial – Required.
5.	Covered Individual's Middle Initial	1	29-29	Alpha	Covered Individual's Middle Initial – Optional.
6.	Covered Individual's	8	30-37	Numeric Date	Covered Individual's DOB. (CCYYMMDD).

Voluntary Non-MSP Input File Layout – 300 bytes					
Field	**Name**	**Size**	**Displacement**	**Data type**	**Description**
	Date of Birth				Required.
7.	Covered Individual's Sex Code	1	38-38	Numeric	Covered Individual's Sex – Valid values: 0 = Unknown 1 = Male 2 = Female Required.
8.	Group Health Plan (GHP) Number	20	39-58	Text	GHP Number assigned by Payer for action type D, or, Unique Benefit Option Identifier assigned by Payer for action type S. For use with Action Types D and S. Required for Action Type S when Coverage Type is V, Z, 4, 5 or 6.
9.	Individual Policy Number	17	59-75	Text	Unique Identifier assigned by the payer to identify the covered individual. For use with Action Types D and S. Required for Action Type D when coverage type is V, Z, 4, 5, and 6.
10.	Effective Date	8	76-83	Numeric Date	Start Date of Covered Individual's Primary Coverage by Insurer. (CCYYMMDD) Required for Action Types D and S.
11.	Termination Date**	8	84-91	Numeric Date	End Date of Covered Individual's Primary Coverage by Insurer. (CCYYMMDD). For use with Action Types D and S. Required for Action Type S. **All zeros if open-ended.

Voluntary Non-MSP Input File Layout – 300 bytes					
Field	**Name**	**Size**	**Displacement**	**Data type**	**Description**
12.	National Health Plan	10	92-101	Filler	National Health Plan Identifier. *(Future Use.)*
13.	Rx Insured ID number	20	102-121	Text	Insured's Rx Identification Number. For use with Action Types D and S. Required for Action Type D when coverage type = U, W, X, or Y.
14.	Rx Group Number	15	122-136	Text	Rx Group Health Plan Number assigned by Payer for action type D, or, Unique Benefit Option Identifier, as defined by the RDS Center, and assigned by Payer for action type S. Required with Action Type S when Coverage Type = U, W, X, or Y.
15.	Rx PCN	10	137-146	Text	Processor Control Number for Medicare Beneficiaries. For use with Action Type D and S when Coverage Type = U, W, X, or Y.
16.	Rx BIN Number	6	147-152	Text	International Identification Number for Medicare Beneficiaries. For use with Action Types D and S. Required for Action Type D when Coverage Type = U, W, X, or Y.
17.	Rx Toll Free Number	18	153-170	Text plus "(" and ")"	Toll Free Number Pharmacist can use to contact Rx Insurer. For use with Action Types

Voluntary Non-MSP Input File Layout – 300 bytes					
Field	**Name**	**Size**	**Displacement**	**Data type**	**Description**
					D and S.
18.	Relationship Code	2	171-172	Numeric	Covered Individual's Relation to Policy Holder: Valid values: '01' = Covered Individual is Policy Holder '02' = Spouse '03' = Child '04' = Other '20' = Domestic Partner Or spaces. Required for Action Types D and S.
19.	Partner Assigned DCN	15	173-187	Text	Document Control Number; assigned by the VDSA partner. Mandatory. Each record shall have a unique DCN.
20.	Action Type	1	188	Alpha	Type of Maintenance: Valid values: 'D' = Drug Reporting record 'S' = Subsidy Reporting record 'N' = Non-Reporting record Required.
21	Transaction Type	1	189	Numeric	Type of Maintenance: Valid values: '0' = Add Record '1' = Delete record '2' = Update record Or space. Required for action type D or S.

Voluntary Non-MSP Input File Layout – 300 bytes					
Field	**Name**	**Size**	**Displacement**	**Data type**	**Description**
22.	Coverage Type	1	190	Alpha-Numeric	Type of Coverage: 'U' - Drug Only (network Rx) 'V' - Drug with Major Medical (non-network Rx) 'W' - Comprehensive Coverage - Hosp/Med/Drug (network Rx) 'X' - Hospital and Drug (network Rx) 'Y' - Medical and Drug (network Rx) 'Z' - Health Reimbursement Account (non-network Rx) '4' = Comprehensive Coverage - Hosp/Med/Drug (non-network Rx) '5' = Hospital and Drug (non-network Rx) '6' = Medical and Drug (non-network Rx). Required for action type D or S.
23.	Person Code	3	191-193	Text	Person code the plan uses to identify specific individuals on a policy. For use with Action Types D and S.
24.	Reserved	10	194-203	Internal use	Reserved for COB internal use; Fill with spaces only.
25.	Reserved	5	204-208	Internal use	Reserved for COBC internal use; Fill with spaces only.

Voluntary Non-MSP Input File Layout – 300 bytes					
Field	**Name**	**Size**	**Displacement**	**Data type**	**Description**
26.	Reserved	1	209	Internal use	Reserved for COBC internal use; Fill with spaces only.
27.	Insurer Name	32	210-241	Text	Name of Insurance company providing Prescription Drug coverage. For use with Action Types D and S.
28.	Filler	59	242-300	Filler	Unused field.

D: Header Record					
1.	Header Indicator	2	1-2	Alpha	Should be: 'H0'
2.	VDSA ID	4	3-6	Numeric	'0001', '0002', etc. ID number assigned by COBC. (Previously labeled as "Plan Number.")
3.	Contractor Number	5	7-11	Numeric	'11105' employer '11106' – insurer '11112' – BCBS
4.	File Type	4	12-15	Alpha	'NMSI' – non-MSP input file.
5.	File Date	8	16-23	Numeric	CCYYMMDD
6.	RDS Application Number	10	24-33	Alpha-Numeric	Retiree Drug Subsidy ID number assigned by the RDS Contractor that is associated with a particular RDS application. When populated this field should contain 10 digits (0-9), right justified with leading positions zero filled. This application number will change each year when a new application is submitted. Required for files containing Action Type S. Fill with spaces for Action Types D and N.
7.	Filler	267	34-300	Filler	Unused Field.

D: Trailer Record					
1.	Trailer Indicator	2	1-2	Alpha	Should be: 'T0'
2.	VDSA ID	4	3-6	Numeric	'0001', '0002', etc. ID number assigned by COBC (previously labeled as "Plan Number").
3.	Contractor Number	5	7-11	Numeric	'11105'- employer '11106' – insurer '11112' – BCBS
4.	File Type	4	12-15	Alpha	'NMSI' – non-MSP input file.
5.	File Date	8	16-23	Numeric	CCYYMMDD
6.	S Record Count	9	24-32	Numeric	Number of Action Type 'S' records on file.
7.	D Record Count	9	33-41	Numeric	Number of Action Type 'D' records on file.
8.	N Record Count	9	42-50	Numeric	Number of Action Type 'N' records on file.
9.	Total Record Count	9	51-59	Numeric	Number of beneficiary records in this file. Do not include the Header and Trailer Records in the Record Count.
10.	Filler	241	60-300	Filler	Unused Field.

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

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

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

VDSA Attachment E

VDSA Non-MSP Response File Layout - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
1.	Filler	4	1-4	COBC use
2.	SSN	9	5-13	Beneficiary's SSN. Included for action types D, S, and N. Field will contain either the SSN that matched, or a corrected SSN based on a HICN match.
3.	HIC Number	12	14-25	Beneficiary's Health Insurance Claim Number. Included for action types D, S, and N. Field will contain either the HICN that matched, or a corrected HICN based on an SSN match.
4.	Covered Individual's Surname	6	26-31	Beneficiary's Last Name. Included for action types D, S, and N. Field will contain either the name supplied or corrected name from COBC database.
5.	Beneficiary First Initial	1	32	Beneficiary's First Initial. Included for action types D, S, and N. Field will contain either the value supplied or corrected value from COBC database.
6.	Beneficiary Middle Initial	1	33	Beneficiary's Middle Initial. Included for action types D, S, and N. Field will contain the value supplied.
7.	Beneficiary Date of Birth	8	34-41	Beneficiary's DOB (CCYYMMDD). Included for action types D, S, and N. Field will contain either the value supplied or a corrected value from COBC database.
8.	Beneficiary Sex Code	1	42	Beneficiary's Sex: 0 = Unknown 1 = Male 2 = Female Included for action types D, S, and N Field will contain either the value supplied or a corrected value from COB database.

VDSA Non-MSP Response File Layout - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
9.	Group Health Plan Number	20	43-62	GHP Number assigned by Payer for action type 'D,' or, Unique Benefit Option Identifier, as defined by the RDS Center, and assigned by Payer for action type 'S.' Included for action types D and S. Field will contain the value supplied on input.
10.	Individual Policy number	17	63-79	Policy Number. Included for action types D and S. Field will contain the value supplied on input.
11.	Effective Date	8	80-87	Start Date of Beneficiary's Insurance Coverage. (CCYYMMDD). Included for action types D and S. Field will contain the effective date applied to the CWF and/or Drug record.
12.	Termination Date	8	88-95	End Date of Beneficiary's Insurance Coverage. (CCYYMMDD) All zeros if open-ended or non-applicable. Included for action types D and S. Field will contain the term date applied to the CWF and/or Drug record.
13.	National Health Plan ID	10	96-105	National Health Plan Identifier. For action types D and S. (*For Future Use*).
14.	Rx Insured ID number	20	106-125	Insured's Identification Number. Included for action types D and S. Field will contain the value supplied on input.
15.	Rx Group Number	15	126-140	Rx Group Health Plan Number assigned by payer for action type 'D,' or Unique Benefit Option Identifier assigned by payer for action type 'S.' Included for action types D and S. Field will contain a value supplied on input.
16.	Rx PCN	10	141-150	Processor Control Number. Included for action types D and S. Field will contain the value supplied on input.

VDSA Non-MSP Response File Layout - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
17.	Rx BIN Number	6	151-156	Benefit International Number. Included for action types D and S. Field will contain the value supplied on input.
18.	Rx Toll Free Number	18	157-174	Toll Free Number, with extension. Included for action types D and S. Field will contain the value supplied on input.
19.	Person Code	3	175-177	Person Code the Plan uses to identify specific individuals on a policy. Included for action types D and S. Defaults to '001' for D records if not provided.
20.	Relationship Code	2	178-179	Beneficiary's Relation to active employee: '01' = Beneficiary is Policy Holder '02' = Spouse '03' = Child '04' = Other '20' = Domestic Partner Included for action types D and S. Field will contain a value supplied on input.
21.	Partner Assigned DCN	15	180-194	The Document Control Number assigned by the VDSA partner. Included for action types D, S, and N. Field will contain the value supplied on input.
22.	COBC DCN	15	195-209	COBC Document Control Number. Included for action types D, S, and N. Field will contain DCN created for this record by the COBC.
23.	Original Action Type	1	210	Type of Maintenance: 'D' = Drug Reporting record 'S' = Subsidy Reporting record 'N' = Non-Reporting record Included for action types D, S, and N. Field will contain the value supplied on input.

VDSA Non-MSP Response File Layout - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
24.	Action Type	1	211	Type of Maintenance; applied by COBC. (COBC may change an S Action Type to a D if RDS rejects the record due to Part D enrollment): 'D' = Drug Reporting record 'S' = Subsidy Reporting record 'N' = Non-Reporting record Included for action types D, S and N. COBC supplied value.
25.	Transaction Type	1	212	Type of Maintenance: '0' = Add Record '1' = Delete record '2' = Update record Included for action types D and S. Field will indicate type of maintenance applied.
26.	Coverage Type	1	213	Type of Coverage: 'U' = Drug Only (network Rx) 'V' = Drug with Major Medical (non-network Rx) 'W' = Comprehensive Coverage - Hosp/Med/Drug (network Rx) 'X' = Hospital and Drug (network Rx) 'Y' = Medical and Drug (network Rx) 'Z' = Health Reimbursement Account. (non-network Rx) '4' = Comprehensive Coverage - Hosp/Med/Drug (non-network Rx) '5' = Hospital and Drug (non-network Rx) '6' = Medical and Drug (non-network Rx) Included for action types D and S. Field will contain value supplied on input.
27.	Filler	1	214	Unused Field.

VDSA Non-MSP Response File Layout - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
28.	Reason for Medicare Entitlement	1	215	Reason for Medicare Entitlement: 'A' = Aged 'B' = ESRD 'G' = Disabled Included for action types D and N. COBC supplied value.
29.	S Disposition Code	2	216-217	Result from RDS processing. Included for records submitted with 'S' action types. RDS supplied value converted to VDSA specific S Disposition Code. Refer to Field 54 (RDS Reason Code) for actual RDS Reason Code as supplied by the RDS Center.
30.	S Disposition Date	8	218-225	Date of BENEMSTR/MBD or RDS Result for S disposition code. (CCYYMMDD). Included for records with an original S action types. RDS supplied value.
31.	Current Medicare Part A Effective Date	8	226-233	Effective Date of Part A Medicare Coverage. (CCYYMMDD) Included for all action types. COBC supplied value.
32.	Current Medicare Part A Termination Date*	8	234-241	Termination Date of Part A Medicare Coverage. (CCYYMMDD). Included for all action types. COBC supplied value. * All zeros if open-ended or not applicable.
33.	Current Medicare Part B Effective Date	8	242-249	Effective Date of Part B Medicare Coverage. (CCYYMMDD). Included for all action types. COBC supplied value.

VDSA Non-MSP Response File Layout - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
34.	Current Medicare Part B Termination Date*	8	250-257	Termination Date of Part B Medicare Coverage. (CCYYMMDD). Included for all action types. COBC supplied value. * All zeros if open-ended or not applicable.
35.	Part D Eligibility Start Date	8	258-265	Earliest date that beneficiary is eligible to enroll in Part D – Refer to Field 42 for the Part D Plan Enrollment Date. (CCYYMMDD). Included for all action types. COBC supplied value.
36.	Part D Eligibility Stop Date*	8	266-273	Date the Beneficiary is no longer eligible to receive Part D Benefits – Refer to Filed 43 for the Part D Plan Termination Date. (CCYYMMDD). Included for all action types. COBC supplied value. * All zeros if open-ended or not applicable.
37.	Medicare Beneficiary Date of Death*	8	274-281	Medicare Beneficiary Date of Death (CCYYMMDD). Included for all action types. COBC supplied value. * All zeros if not applicable.
38.	Current Medicare Part C Plan Contractor Number	5	282-286	Contractor Number of the current Part C Plan in which the beneficiary is enrolled. Included for all action types. COBC supplied value.
39.	Current Medicare Part C Plan Enrollment Date	8	287-294	Effective Date of coverage provided by the Beneficiary's current Medicare Part C Plan. (CCYYMMDD). Included for all action types. COBC supplied value.

VDSA Non-MSP Response File Layout - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
40.	Current Medicare Part C Plan Termination Date*	8	295-302	Termination Date of the coverage provided by the Beneficiary's current Medicare Part C Plan. Included for all action types. COBC supplied value. * All zeros if open-ended or not applicable.
41.	Current Medicare Part D Plan Contractor Number	5	303-307	Contractor Number of the current Medicare Part D Plan in which the Beneficiary is enrolled. Included for all action types.
42.	Current Medicare Part D Plan Enrollment Date	8	308-315	Effective Date of coverage provided by the Current Medicare Part D Plan. (CCYYMMDD). Included for all action types. COBC supplied value.
43.	Current Medicare Part D Plan Termination Date*	8	316-323	Termination Date of coverage provided by the current Medicare Part D Plan. (CCYYMMDD) Included for all action types. COBC supplied value. * All zeros if open-ended or not applicable.
44.	Error Code 1	4	324-327	Error Code 1 – Contains SP or RX error codes from COBC or RDS processing if applicable. COBC supplied value for D/N records. RDS supplied value for S records.
45.	Error Code 2	4	328-331	Error Code 2 – Contains SP or RX error codes from COBC or RDS processing if applicable. COBC supplied value for D/N records. RDS supplied value for S records.
46.	Error Code 3	4	332-335	Error Code 3 – May contain SP or RX error codes from COBC or RDS processing if applicable. COBC supplied value for D/N records. RDS supplied value for S records.
47.	Error Code 4	4	336-339	Error Code 4 – May contain SP or RX error codes from COBC or RDS processing if applicable. COBC supplied value for D/N records. RDS supplied value for S records.

VDSA Non-MSP Response File Layout - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
48.	D/N Disposition Code	2	340-341	Result from processing of an action type D or N record. This will also be used to provide a disposition for D records converted from S records – in such case, the S disposition (Field 30) will also be populated. Code supplied by the COBC.
49.	D/N Disposition Date	8	342-349	Processing date associated with the D/N disposition code. (CCYYMMDD) Supplied by the COBC.
50.	RDS Start Date	8	350-357	Start date for subsidy period. RDS supplied value.
51.	RDS End Date	8	358-365	End date for subsidy period. RDS supplied value.
52.	RDS Split Indicator	1	366	Indicates multiple subsidy periods within the plan year. Expect multiple records. Values: 'Y' if applicable. Space if not-applicable. RDS supplied value.

VDSA Non-MSP Response File Layout - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
53.	RDS Reason Code*	2	367-368	Spaces = Accepted 01=Application deadline missed 02=Invalid application number 03=Invalid Last Name 04=Invalid First Name 05=Invalid Date of Birth 06=Invalid Gender 07=Invalid Coverage Effective date 08= Invalid coverage termination date 09= Invalid benefit option identifier 10= Enrolled in Part D 11= Not eligible for Medicare 12= Beneficiary is deceased 13= Invalid HICN or SSN 14=Termination date less than Effective date 15= Missing Trailer record 16= Not a valid Medicare Beneficiary 17= No coverage period exists for delete transaction 18= Invalid action type 19= Invalid relationship code 20= Beneficiary attempted to enroll in Part D and received an initial rejection. 21= New Medicare information has been received – resend record. *RDS Center supplied codes.
54.	RDS Determination Indicator	1	369	Y = Yes, the retiree qualifies for the RDS subsidy. N = No, the retiree does not qualify for the RDS subsidy. *Partner may not always receive this indicator.* RDS supplied value.
55.	ESRD Coverage Period Start Date – Start	8	370-377	The date on which the beneficiary is entitled to Medicare in any part because of a diagnosis of End Stage Renal Disease. (CCYYMMDD) Last coverage period will be reported if multiple coverage periods exist.

VDSA Non-MSP Response File Layout - 500 bytes				
Field	**Name**	**Size**	**Displacement**	**Description**
56.	ESRD Coverage Period End Date	8	378-385	The date on which the beneficiary is no longer entitled to Medicare under ESRD Provisions (CCYYMMDD) The last coverage period will be reported if multiple coverage periods exist.
57.	First Dialysis Date - Oldest	8	386-393	The date the beneficiary first started ESRD Dialysis (CCYYMMDD)
58.	ESRD Self-Training Date	8	394-401	A date indicating when the beneficiary participated in ESRD Self Care Training. (CCYYMMDD)
59.	Transplant Date – Most Recent	8	402-409	A date indicating when a Kidney Transplant Operation Occurred. (CCYYMMDD) The latest occurrence will be reported.
60.	Transplant Failure Date – Most Recent	8	410-417	A date that indicates when a Kidney Transplant failed. (CCYYMMDD) The latest occurrence will be reported.
61.	Filler	83	418-500	Unused Field. Filled with spaces.

E: Header Record				
1.	Header Indicator	2	1-2	Should be: ‘H0’
2.	VDSA ID	4	3-6	‘0001’, ‘0002’, etc. ID number assigned by COBC. (Previously labeled as “Plan Number.”) Field will contain value supplied on input.
3.	Contractor Number	5	7-11	‘11105’ employer ‘11106’ – insurer ‘11112’ – BCBS Field will contain value supplied on input.
4.	File Type	4	12-15	‘NMSR’ – Non-MSP Response file. ‘RDSU’ – Unsolicited RDS Response file.
5.	File Date	8	16-23	CCYYMMDD COB supplied.

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

E: Trailer Record				
1.	Trailer Indicator	2	1-2	Should be: 'T0'
2.	VDSA ID	4	3-6	'0001', '0002', etc. ID number assigned by COBC. (Previously labeled as "Plan Number.") Field will contain value supplied on input.
3.	Contractor Number	5	7-11	'11105' – employer '11106'- insurer '11112' – BCBS Field will contain value supplied on input.
4.	File Type	4	12-15	'NMSR' – non-MSP response file. Field will contain value supplied on input.
5.	File Date	8	16-23	CCYYMMDD COB supplied.
6.	Record Count	9	24-32	Number of beneficiary records in this file. COBC Supplied.
7.	Filler	468	33-500	Unused Field. Space filled.

II. The Query Only HEW Input and Response File Layouts

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

HEW Input File. Using this HEW software, the VDSA partner will translate ("wrap") the Non-MSP File into a HIPAA-compliant 270 eligibility query file format.

VDSA Attachment F

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

F: Header Record				
1.	Header Indicator	2	1-2	Should be: 'HO'
2.	VDSA ID	4	3-6	'0001', '0002', etc. ID number assigned by COBC (previously known as "Plan Number").
3.	Contractor Number	5	7-11	'11106' - Insurer '11105' – Employer '11112' – BCBS
4.	File Type	4	12-15	'IACT' – Inactive.
5.	Cycle Date	8	16-23	File date 'CCYYMMDD'
6.	Filler	15	24-38	Unused Field.

F: Trailer Record				
1.	Trailer Indicator	2	1-2	Should be: 'TO'
2.	VDSA ID	4	3-6	'0001', '0002', etc. ID number assigned by COBC (previously known as "Plan Number").
3.	Contractor Number	5	7-11	'11106' – Insurer '11105' – Employer '11112' – BCBS
4.	File Type	4	12-15	'IACT' – Inactive.
5.	Cycle Date	8	16-23	File date 'CCYYMMDD'
6.	Record Count	9	24-32	Number of individual query records in this file. Do not include the Header and Trailer Records in the Record Count.
7.	Filler	6	33-38	Unused Field.

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

G – *The Query Only HIPAA Eligibility Wrapper (HEW) Response File.* After CMS has processed the Query Only Input File it will return it to the VDSA partner as a Query Only Response File. The same CMS-supplied software that "wrapped" the Input File will now "unwrap" the Response file, so that it is converted from a HIPAA -compliant 271 eligibility response file format into the Query Only HEW Response File for the partner's use. **NOTE**: This response file does not have a header or trailer.

VDSA Attachment G

G: VDSA Query Only Response File Layout				
Field	***Name***	***Size***	***Displacement***	***Description***
1.	HIC Number	12	1-12	Medicare Health Insurance Claim Number.
2.	Surname	6	13-18	Surname of Covered Individual.
3.	First Initial	1	19-19	First Initial of Covered Individual.
4.	DOB	8	20-27	Covered Individual's Date of Birth. (CCYYMMDD)
5.	Sex Code	1	28-28	Covered Individual's Sex: 0 = Unknown 1 = Male 2 = Female

G: VDSA Query Only Response File Layout				
Field	***Name***	***Size***	***Displacement***	***Description***
6.	SSN	9	29-37	Social Security Number of the Covered Individual.
7.	Entitlement Reason (Medicare reason)	1	38	Reason for Medicare Entitlement: A = Working Age B = ESRD G = Disabled
8.	Current Medicare Part A Effective Date	8	39-46	Effective Date of Medicare Part A Coverage. (CCYYMMDD)
9.	Current Medicare Part A Termination Date*	8	47-54	Termination Date of Medicare Part A Coverage. (CCYYMMDD) * Blank if ongoing.
10.	Current Medicare Part B Effective Date	8	55-62	Effective Date of Medicare Part B Coverage. (CCYYMMDD)
11.	Current Medicare Part B Termination Date*	8	63-70	Termination Date of Medicare Part B Coverage. (CCYYMMDD) *Blank if ongoing.
12.	Medicare Beneficiary Date of Death	8	71-78	Beneficiary Date of Death. (CCYYMMDD)
13.	Current Medicare Part C Plan Contractor Number	5	79-83	Contractor Number of the current Part C Plan in which the beneficiary is enrolled. COBC supplied value.
14.	Current Medicare Part C Plan Enrollment Date	8	84-91	Effective Date of coverage provided by the beneficiary's current Medicare Part C Plan. (CCYYMMDD)
15.	Current Medicare Part C Plan Termination Date*	8	92-99	Termination Date of the coverage provided by the beneficiary's current Medicare Part C Plan. (CCYYMMDD) *Blank if ongoing.
16.	Disposition Code	2	100-101	01 = Record Accepted. Beneficiary is on File on CMS System. 51 = Beneficiary is not in File on file in CMS System.
17.	CMS Document Control Number	15	102-116	VDSA ID (102-105), Julian Date (106-110), Sequence Counter (111-116).

III. The VDSA Business Rules

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

Conventions for Describing Data Values

The table below defines the data types used by COBC 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 layouts.

VDSA Processing: CMS System Requirements

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

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

New MSP Processing Requirements:

- The System shall accept an MSP record from a VDSA for reporting of MSP and/or drug coverage.
- The System shall edit drug records received on the VDSA MSP file for the presence of mandatory fields.
- The System shall match drug records received on the VDSA MSP file against the COB drug coverage database.
- The System shall apply RX error codes generated by COB to invalid MSP drug records to return them on the MSP response file.
- The System shall forward validated VDSA MSP drug records to MBD (Medicare Beneficiary Database).
- The System shall establish a drug coverage record in the COB system for drug records sent to MBD.
- The System shall accept a response file from MBD for submitted drug records.

- The System shall update the MBD disposition for the drug record on the drug coverage table.

- The System shall notify VDSA submitters on the MSP Response File of the disposition of MSP and drug records provided.

- The System shall accept lower case characters on a MSP Input File in text fields.

- The System shall reject MSP records submitted by VDSA partners when the employer size does not meet the minimum requirements to be responsible for MSP coverage. This includes situations where the employer has less than 100 employees and the beneficiary's entitlement reason is G (Disabled).

New Non-MSP Processing Requirements:

1. The System shall accept a non-MSP record from a VDSA for reporting of employer subsidy.

2. The System shall forward employer subsidy records submitted on a VDSA non-MSP file to the RDS Contractor.

3. The System shall convert employer subsidy records rejected by the RDS Contractor for beneficiaries that are already enrolled in Part D to drug records when the record pertains to a Part D beneficiary and contains all the required data.

4. The System shall notify VDSA submitters on the Non-MSP Response File when a subsidy record is converted by the COBC to a drug record.

5. The System shall notify VDSA submitters on the Non-MSP Response File when a subsidy record was rejected by RDS as not eligible for the subsidy.

6. The System shall accept a non-MSP record from a VDSA for reporting of other drug coverage.

7. The System shall edit drug records received on the VDSA non-MSP file for the presence of mandatory fields.

8. The System shall match drug records received on the VDSA non-MSP file against the drug coverage database.

9. The System shall apply RX error codes generated by the COBC to invalid non-MSP drug records to return them on the Non-MSP Response file.

10. The System shall forward validated VDSA non-MSP drug records to MBD.

11. The System shall establish a drug coverage record in the COB system for supplemental drug records sent to MBD.

12. The System shall accept a response file from MBD for submitted supplemental drug records.

13. The System shall update the MBD disposition for the supplemental drug record on the Drug Coverage Table.

14. The System shall notify VDSA submitters on the Non-MSP Response File of the disposition of supplemental drug records provided.

15. The System shall accept lower case characters on a Non-MSP Input File in text fields.

16. The System shall forward unsolicited subsidy record updates from RDS to VDSA partners.

Methodological Description

Introduction

The scope of the VDSA process - determining primary versus secondary payer responsibility – has been expanded to include the reporting of prescription drug coverage information to CMS. Under the existing Part A/B MSP rules based on employer size, prescription drug coverage that is part of an active employee's Medicare GHP coverage is primary to Medicare.

In addition to the drug information that is part of standard MSP situations, VDSA partners are now able to report drug coverage that is supplemental to Medicare, and coverage data to support employer Retiree Drug Subsidy operations.

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

The new **active file** is known as the **MSP File**. The new **inactive file** format is known as the **Non-MSP File**. VDSA participants are able to report prescription drug coverage information, Retiree Drug Subsidy enrollment data and inquire on beneficiary entitlement status on the new Non-MSP File. Legacy VDSA partners have been encouraged to switch over to the new MSP and non-MSP formats so that all prescription drug data can be reported. All VDSA partners using pre-MMA VDSA documents (Legacy Partners) were expected to migrate to all of the new VDSA record layouts by the end of March, 2006.

Only partners submitting D or S records may use the Non-MSP File for "N" queries. Those not submitting D or S records (that is, those wishing to submit nothing but a Non-

MSP "N" record) must continue to use the Query Only HEW Input File and accompanying HEW software.

All VDSA partners will need to submit a TIN Reference File to go with the new MSP files. The TIN Reference File may now include a new "pseudo" TIN indicator. BCBS plans will also need to submit a TIN Reference File to use the new BCBS VDSA (VDEA) format. If the VDSA partner is unable to obtain the TINs associated with their file, the TIN field on the input file may be populated with an identifying number that matches a pseudo TIN on their TIN Reference File. The pseudo TIN indicator field has been added to the TIN record layout that, if populated with a 'Y,' allows the submitter to indicate a pseudo TIN is being used. The TIN Reference File should contain a record for each TIN included in the file, including the TIN associated with the entity submitting the file; at least one of the TIN records should contain a valid TIN. If a pseudo TIN is used, the TIN will not be used for anything except to populate the address in the MSP (CWF Maintenance Transaction) record. *If an employer reports a pseudo TIN for itself, the employer will not be systematically excluded from its reporting requirements under the IRS/SSA/CMS Data Match*.

Error Codes

Following is an introduction to the subject of Error Code Reporting in both the MSP and Non-MSP Response Files. A comprehensive listing of all error codes that a partner may encounter can be found in Section IV, The Complete Disposition and Edit Code List.

Most error reporting can be avoided by completing required fields on the Input File. Required fields include the Surname of Covered Individual, First Initial, Date of Birth, Sex, a DCN assigned by the VDSA partner, Transaction Type, Coverage Type, individual's SSN, Effective Date, Termination Date, Patient Relationship, Subscribers' First and Last name, Subscriber's SSN, Employer Size, Group Health Plan Number, Policy Number, Employee Coverage Election, Employee Status, Employer TIN, and Insurer TIN.

MSP processing will generate SP errors (MSP Maintenance Transaction errors) and disposition codes for records with duel MSP/Drug coverage. All of the existing CWF SP errors apply. For Coverage Type A, J, and K, the required input fields do not change. The combination Coverage Types that include Part A/B coverage also need to incorporate the fields required by CWF. These combination Coverage Types include V, W, X, Y, 4, 5, and 6.

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

Error Code	Description
SP 12	Invalid HIC Number or SSN. At least one of the fields must contain alpha or numeric characters. Both fields cannot be blank or contain spaces.
SP 13	Invalid Beneficiary Surname. Field must contain alpha characters. Field cannot be blank, contain spaces or numeric characters.
SP 14	Invalid Beneficiary First Name Initial. Field must contain alpha characters. Field cannot be blank, contain spaces, numeric characters or punctuation marks.
SP 15	Invalid Beneficiary Date of Birth. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Day of the month must be correct. For example, if month = 02 and date = 30, the record will reject.
SP 16	Invalid Beneficiary Sex Code. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Acceptable numeric characters include the following: 1 = Male 2 = Female
SP 19	Invalid Transaction Type. Field must contain numeric characters. Field cannot be blank, contain alpha characters or spaces. Acceptable numeric characters include the following: 0 = Add Record 1 = Delete Record 2 = Update Record
SP 24	Invalid Coverage Type. Field may contain alpha or numeric characters. Field cannot be blank. Valid values are: A, J, K, U, V, W, X, Y, Z, 4, 5, 6 for MSP layout U, V, W, X, Y and Z for Non-MSP layout
SP 31	Invalid Effective Date. Field must contain numeric characters. Field cannot be blank, contain spaces, alpha characters or all zeros. Number of days must correspond with the particular month.
SP 32	Invalid MSP Termination Date. Field must contain numeric characters. Date must correspond with the particular month – CCYYMMDD. For example, 02/27/1997 is acceptable, but not 02/30/1997. Cannot be earlier than the MSP effective date. If there is no termination date (coverage is still active), must use zeros (not spaces) in this field.
SP 34	Invalid Subscriber First Name. Field may contain alpha characters. If field is not used, field must contain spaces. Field cannot be blank or contain numeric characters. Only alpha characters used when subscriber is identified.
SP 35	Invalid Subscriber Last Name. Field may contain alpha characters. If field is not used, field must contain spaces. Field cannot be blank or contain numeric characters. May use spaces instead of apostrophe. Only alpha characters may be used when subscriber is identified.
SP 49	No valid record exists for delete request. Attempt to delete a nonexistent MSP will cause a reject.
SP 52	Invalid patient relationship code

Error Code	Description
SP 62	Incoming termination date is less than effective date. MSP termination date must be greater than the effective date.

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

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

MSP Processing

MSP records should be submitted for active beneficiaries with hospital and/or medical coverage, and/or prescription drug coverage.

New fields included to the MSP format for drug coverage reporting include an RxID, Rx Group, RxBin, PCN, Person Code and Toll-free Phone Number.

The Coverage Type field will have several additional values besides the existing values (i.e. J, K, and A) that are passed to CWF and MBD since the coverage can now include drug. These new values are:

U – Drug coverage only
V – Drug coverage with Major Medical
W – Comprehensive coverage (includes Hospital, Medical and Drug)
X – Hospital and drug coverage
Y – Medical and drug coverage
Z – Health reimbursement account (non-network Rx)
4 – Comprehensive coverage -Hosp/Med/Drug (non-network Rx)
5 – Hospital and Drug (non-network Rx)
6 – Medical and Drug (non-network Rx)

Records containing MSP information will be processed in the same way as were those in the previous active process. An MSP record will be created and sent to CWF. The existing edits will continue to be applied and a file will still be created containing the responses received, with any applicable SP errors included.

Records containing a coverage type indicating drug coverage will go through a similar edit process. Separate drug coverage records will be created from the input record.

The drug record will be compared to the COBC's existing drug coverage table for matches for HICN, effective date, patient relationship, VDSA ID/Contractor number, and coverage type. If these fields all match, the record will be considered an update. Updates to records that are not found will be rejected. Otherwise the record will be added to the table and forwarded to MBD.

When a record is received indicating that the coverage type is for combination coverage that includes both MSP and drug, the MSP information will be split off to create a transaction that will be sent to CWF. The drug information will be split into separate transactions that will be sent to MBD. The coverage type on the MSP record will be converted to the CWF corresponding value. An 'X' will be translated to a 'J', a 'Y' translates to 'K', a 'W' to 'A', a '4' to 'A', a '5' to 'J', and a '6' to 'K'.

The entitlement reason code that was included on the active record layout will not be included on the new MSP layout. The entitlement reason will be provided on the response file, but will no longer be required on the input since it can change, and submitters won't always know the correct value.

Non-MSP Processing

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

1. Subsidy Reporting (S) – To utilize the VDSA process to satisfy the reporting requirement of employer subsidy to the Retiree Drug Subsidy (RDS) Contractor.

2. Drug Coverage Reporting (D) – To allow reporting of other drug coverage to MBD for TrOOP to utilize.

3. Non-Reporting (N) – To determine entitlement to Medicare.

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

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

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

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

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

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

When a record is received with an Action Type of 'S,' for subsidy reporting, it will not be edited to verify that all the fields were provided for the type of coverage indicated. The information will be sent to RDS to validate the employer subsidy eligibility of the prescription drug coverage for the beneficiary. The COBC will forward all RDS responses to the submitting data sharing agreement (DSA) partner.

If the record comes back from RDS with a disposition code indicating that the beneficiary is ineligible for the subsidy because he or she is already enrolled in part D, the COBC will change the action type to 'D' on the response record. The 'S' Disposition Code will get populated with the rejected reason. The RDS application number will be passed back to the VDSA partner on the response. The drug record will be validated for completeness of mandatory fields. After it is verified as complete, the record will be forwarded to MDB and a drug record created in the drug coverage database.

But if the subsidy record does not contain enough information to create the drug record it will be rejected, with the applicable SP errors included in the response. If the dates applied for the subsidy are different than those submitted, the revised dates will be provided in separate fields on the response.

Possible ‘S’ Record Disposition Codes are:

Edit	Description
01	Subsidy record accepted.
02	Application pending or in process at RDS (COBC internal use).
03	Rejected - Beneficiary record not found.
04	Rejected - Beneficiary already enrolled in Part D.
05	Rejected – Beneficiary not Medicare entitled.
06	Rejected - Subsidy record rejected for errors.
07	Rejected - Associated RDS application was rejected.
08	Rejected - Beneficiary deceased.
09	Rejected – Missing header/trailer record (for RDS interface only).
10	Beneficiary has attempted to enroll in Part D. Communicate with the beneficiary about his/her intentions regarding the subsidy coverage.
11	Resubmit previously rejected record (re: unsolicited response input).

Because periods of eligibility can be interrupted, or a retiree is not eligible for the subsidy for the entire year, it is possible to receive multiple response records for one ‘S’ record submitted. The RDS Split indicator will be populated with a ‘Y’ in each such record. The records will all contain the original DCN. For example one record may include dates for 01/01/2007 through 03/31/2007 with a‘05’ reason if the person is not yet eligible for Medicare. The second record may have dates 04/01/2007 through 12/31/2007 covering the remainder of the plan year with a ‘01’ subsidy record accepted status.

Business Rules

MSP Processing

1. MSP records that contain both MSP and drug data will receive one response record. The disposition of the MSP and drug record will be provided in separate fields.

2. If the MSP response from CWF is not available, the COBC will hold off on sending the drug response until both parts of the record can be reported on.

3. MSP records for CWF will continue to go through the existing edit process.

4. COBC will attempt to create a drug coverage record for coverage types U, V, W, X, Y, Z, 4, 5, and 6.

5. Since the only rejects MBD plans on sending the COBC will be for ineligible beneficiaries, all drug coverage validation will be based on COB applied edits.

6. Drug records will be considered accepted when they have passed the COB edits and have been forwarded to MBD.

7. Action type is required for all MSP records.

8. Required fields for drug records are HICN or SSN, surname, first initial, date of birth, sex, effective date, relationship code, and coverage type plus group health plan number and policy number for coverage type 'V'. Rx ID and RxBIN are required for coverage type 'U','W', 'X', 'Y', and 'Z'. DCN, middle initial, termination date, Rx PCN, Rx Group Number, and person code should be provided if available.

9. COBC will not send incomplete drug records to MBD.

10. The matching criteria for drug coverage will be HICN, effective date, patient relationship, plan number, and coverage type.

11. Although lower case characters will be accepted in the MSP file, the text in the response file will be returned in upper case since the COBC will need to convert the text to upper case in order to process the file.

12. MSP records will be rejected if the employer does not meet the size requirement for MSP. If the EMP-SIZE = '1' (20 - 99 employees) and the entitlement reason = 'G,' the record will be returned with an 'SPES' (SP – Employer Size).

13. Drug records passed to the Drug Engine from the VDSA MSP files will include an indicator that the coverage is primary coverage.

14. For a drug record sent in on an MSP file to be sent to MBD the coverage period must fall within the current Part D coverage period.

15. The effective date on a Part D coverage received on the MSP file will be defaulted to the start date of the current Part D coverage period.

16. The termination date for a Part D coverage received on the MSP file will be defaulted to the end date of the current Part D coverage period.

Non-MSP Processing

1. Action type will be required on all non-MSP records.

2. Required fields for non-Reporting records are HICN or SSN, surname, first initial, date of birth, and sex. DCN and middle initial can be populated if available.

3. COBC will edit Subsidy records for header/trailer information, record length and action type. Only records with the 'S' indicator will be forwarded to RDS. RDS will pass their disposition and/or error codes back to COBC who will reformat the response into the non-MSP format and return to the VDSA partner. Additional editing of 'S' records will only occur if the subsidy is rejected because the beneficiary is already enrolled in Part D. Then COB will confirm that the required fields are present to convert the record to a 'D' drug record. These fields are HICN or SSN, surname, first initial, date of birth, sex, effective date, relationship code, transaction type, coverage type, group health plan number and policy number for coverage type 'V, 4, 5, or 6'. Rx ID and RxBIN are required for coverage type 'U', 'X', and 'Y'. Type 'Z' records need to include either the group health plan number and policy number, or the Rx ID and Rx BIN fields. DCN, middle initial, termination date, Rx PCN, Rx Group ID and person code should be provided if available. Subsidy records rejected because the beneficiary was not entitled or because insufficient information was submitted to RDS will be returned in the non-MSP response format with the error codes supplied by RDS.

4. Accepted subsidy records will also be returned without editing by COBC.

5. Required fields for other drug records are HICN or SSN, surname, first initial, date of birth, sex, effective date, relationship code, transaction type, and coverage type plus Policy number for coverage type 'V, Z, 4, 5, or 6'. Rx ID and RxBIN are required for coverage type 'U, W X, or Y.' DCN, middle initial, termination date, Rx PCN, Rx Group ID and person code should be provided if available.

6. COBC will not edit employer subsidy records prior to sending them to RDS.

7. Only other drug records for current beneficiaries will be sent to MBD.

8. COBC will not create records in the COBC databases for accepted subsidy records.

9. COBC will not send incomplete other drug records to MBD.

10. Although lower case characters will be accepted in the non-MSP file, the text in the response file will be returned in upper case since the COBC will need to convert the text to upper case in order to process the file.

11. In instances where an S record is converted to a D record, the 'S' disposition code in the record will be used for the disposition of the S record. The 'D/N' disposition field would be for the disposition of the converted D record. If the record was submitted as a D or N action type only the D/N disposition fields will be used.

12. COBC will zero fill termination date fields instead of leaving the field blank for open -ended coverage or where the date is not applicable.

13. Drug records passed to the Drug Engine from the VDSA non-MSP files will include an indicator that the coverage is supplemental coverage.

14. COBC will add all the entitlement information that is available (Part A, B and D) into all the response records regardless of whether the submitted record was a D, S or N.

15. COB will pass the split indicator to the VDSA partner on the response.

16. In cases were a split indicator is used, the COBC will include the entitlement information in both records. Each record will contain its individual status and errors if applicable.

17. Drug coverages sent on the non-MSP file will be sent to MBD using the plan dates submitted.

18. Drug coverages sent on the non-MSP file will be sent to MBD for matched beneficiaries that have a Part D enrollment date.

IV. The Complete Disposition and SP Edit Code List

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

Keep in mind that not all these codes will apply to all response files you can receive from the COB Contractor (COBC). Please contact the COBC if you have questions about any of the Disposition or SP Edit codes.

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

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

DISPOSITION AND SP EDIT CODE LIST

DISPOSITION CODES	DESCRIPTION
01	Record accepted by Common Working File (CWF) as an "Add" or a "Change" record.
SP	Transaction edit; record returned with at least one SP or RX edit (specific SP and RX edits are described below).

DISPOSITION CODES	DESCRIPTION
50	Record still being processed by CMS. Internal CMS use only*; no Agreeing Partner action is required.*
51	Beneficiary is not in file on CMS System. Record will not be recycled. Beneficiary most likely not entitled to Medicare. *Agreeing Partner should re-verify beneficiary status based on information in its files.*
52	Record still being processed by CMS. Internal CMS use only; *no Agreeing Partner action is required.*
53	Record in alpha match at CMS. Internal CMS use only; *no Agreeing Partner action is required.*
55	Name/Personal Characteristic Mismatch. Name or personal characteristic of beneficiary does not match the Health Insurance Claim Number (HICN) on Medicare's files. *Agreeing Partner* needs to re-verify name, HICN, date of birth and sex based on information in its files; then resubmit on next exchange file.
61	Cross-Reference Data Base Problem. Internal CMS use only; *no Agreeing Partner action is required.*
AB	CWF problem that can only be resolved by CWF Technician. Internal CMS use only; *no Agreeing Partner action is required.*
CI	Processing Error. Internal CMS use only; *no Agreeing Partner action is required.*
ID	Drug Record Processing Error. Internal CMS use only; *no Agreeing Partner action is required*. Partner should re-submit record on next file.

Following are the edit codes applied by the Common Working File (CWF) to Medicare Secondary Payer (MSP) records; an Agreeing Partner may receive these in their response file.

SP EDIT CODES	DESCRIPTION	No Partner Action Required	Agreeing Partner Action Required
SP 11	Invalid MSP Transaction Record Type. Mandatory field ("Mandatory") internal CMS use only; non-blank, must be valid record type. *No Agreeing Partner action is required.*	X	
*SP 12	Invalid HICN (Mandatory). Field must contain alpha and numeric characters. You received this error because: 1) either an invalid character was provided in this field, 2) we were unable to match the Social Security number (SSN) you supplied with a valid HICN, or 3) you provided an invalid HICN, and we could not find a match with the SSN. Use spaces if HICN is unknown.		X

SP EDIT CODES	DESCRIPTION	No Partner Action Required	Agreeing Partner Action Required
*SP 13	Invalid Beneficiary Surname (Mandatory). Field must contain alpha characters. Field cannot be blank or contain spaces or numeric characters.		X
*SP 14	Invalid Beneficiary First Name Initial (Mandatory). Field must contain alpha characters. Field cannot be blank or contain spaces, numeric characters, or punctuation marks.		X
*SP 15	Invalid Beneficiary Date of Birth (Mandatory). Field must contain numeric characters. Field cannot be blank or contain spaces or alpha characters. Day of the month must be correct. For example, if month = 02 and date = 30, the record will reject.		X
*SP 16	Invalid Beneficiary Sex Code (Mandatory). 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		X
*SP 17	Invalid Contractor Number (Mandatory). Non-blank, numeric. Must be valid, CMS-assigned Contractor Number. Internal CMS use only.	X	
*SP 18	Invalid Document Control Number (DCN). CMS replaces the Agreeing Partner's original DCN with CMS' DCN. CMS automatically provides a DCN, so the Partner should not receive this error. Mandatory for MSP Transactions only. Blank for all others. (Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # /; :)	X	
*SP 19	Invalid Maintenance Transaction Type (Mandatory). This error results from what is provided in the type of record transaction field. Field must contain numeric characters. Field cannot be blank, contain alpha characters or spaces. Acceptable numeric characters include the following: 0 = Add Record 1 = Delete Record 2 = Update Record		X

SP EDIT CODES	DESCRIPTION	No Partner Action Required	Agreeing Partner Action Required
*SP 20	Invalid Validity Indicator (Mandatory). CMS will generate a 'Y' in this field on the response file. (Y = Beneficiary has MSP coverage.) However, other errors on this listing may be related to the validity indicator provided by CMS. Field cannot be blank or contain a space.	X	
*SP 21	Invalid MSP Code (Mandatory). COB will apply an MSP code based on the entitlement reason for the beneficiary. Field cannot be blank or contain alpha characters. Acceptable numeric characters include the following: A = Working Aged G = Disabled B = ESRD	X	
SP 22	Invalid Diagnosis Code (1-5 spaces allowed). Field is not used; field must be blank. If data is entered, CMS will fill this field with blanks. Valid Values: Alphabetic, Numeric, Space.	X	
SP 23	Invalid Remarks Code (1-3 spaces allowed). Field is not used; field must be blank. If data is entered, CMS will fill this field with blanks.	X	
*SP 24	Invalid Insurer Type. Field must contain alpha characters. Field cannot be blank or contain numeric characters. Type - 'A-M', and spaces are valid. Acceptable alpha characters include the following: J = Hospital only coverage plan – A plan which covers only inpatient hospital services. K = Medical coverage only plan – A plan which covers only non-inpatient medical services. A = Hospital and Medical coverage plan. **Note: COB derives this value from the coverage type submitted. Types of coverage that include drug coverage - W, X, Y, 4, 5, 6 - are converted to CWF values as follows:* *W is translated to A for CWF and U for MBD.* *X is translated to J for CWF and U for MBD.* *Y is translated to K for CWF and U for MBD.* *Z is translated to V for MBD (no translation to CWF).* *4 is translated to A for CWF and V for MBD.* *5 is translated to J for CWF and V for MBD.* *6 is translated to K for CWF and V for MBD.*		X

SP EDIT CODES	DESCRIPTION	No Partner Action Required	Agreeing Partner Action Required
*SP 25	Invalid Insurer Name. Place the name of the insurer in this field. Spaces are allowed between words in an insurer plan name. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ;. Field cannot be blank or contain numeric characters. If the MSP Insurers name is equal to SUPPLEMENT, SUPPLEMENTAL, INSURER, MISCELLANEOUS, CMS, ATTORNEY, UNKNOWN, NONE, N/A, UN, MISC, NA, NO, BC, BX, BS, BCBX, BLUE CROSS, BLUE SHIELD, or MEDICARE, SP 25 error will occur.		X
*SP 26	Invalid Insurer Address 1 and/or Address 2. Place the insurer address in this field. Spaces are allowed between words in a plan address. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ; Field cannot be blank.		X
*SP 27	Invalid Insurer City. Field cannot contain numeric characters. Spaces are allowed for multi-city word name. If field is not used, field must contain spaces. Field may contain alpha characters, commas, & - ' . @ # / : ;		X
*SP 28	Invalid Insurer State. Field may contain alpha characters. If field is not used, field must contain spaces. Alpha characters provided must match U.S. Postal State Abbreviation Table. When the MSP Insurers state does not match a state code on the U.S. Postal Service state abbreviation table, SP28 error will occur.		X
*SP 29	Invalid Insurer Zip Code. First five positions must be numeric; last four positions may be numeric or spaces.		X
*SP 30	Invalid Policy Number. If field is not used, field must contain spaces. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ;		X
*SP 31	Invalid MSP Effective Date (Mandatory). Field must contain numeric characters. Field cannot be blank, contain spaces, alpha characters or all zeros. The date must be in the following format-CCYYMMDD. Number of days must correspond with the particular month. For example, the date 19500230 is not acceptable (February cannot have 30 days). MSP effective date must be less than or equal to the current date and cannot be a future date. For example, today is 20030312 and an Agreeing Partner submits a record with an MSP effective date of 30000901. Since this is a future date, the agreeing partner will receive an SP 31.		X
*SP 32	Invalid MSP Termination Date (Mandatory). Field must contain numeric characters. The date must be in the following format-CCYYMMDD. Number of days must correspond with the particular month. For example, the date 19500230 is not acceptable (February cannot have 30 days). Plan termination date		X

SP EDIT CODES	DESCRIPTION	No Partner Action Required	Agreeing Partner Action Required
	cannot be earlier than the MSP effective date. If there is no termination date (coverage is still active), you must use zeros (not spaces) in this field. For Working-Aged beneficiaries, the termination date cannot be greater than the current date plus 6 months. For Disability beneficiaries, the termination date cannot be greater than the first day the beneficiary turned 65. Will accept future date for ESRD up to 30 months. Termination date must be greater than 30 days after the MSP effective date. If Contractor Number is that of the Internal Revenue Service/Social Security Administration/Centers for Medicare & Medicaid Services (IRS/SSA/CMS) Data Match project ('11102' or '77777'), the Term Date may be equal to, or greater than, the Effective Date.		
*SP 33	Invalid Patient Relationship (Mandatory). Field must contain numeric characters. First character must be zero and the second character can only be 1, 2, 3, or 4. Other characters used besides 01 - 04 are invalid and will result in an SP 33. Field cannot be blank or contain alpha characters. Acceptable numeric values are as follows: 01 = Beneficiary 02 = Spouse 03 = Child* 04 = Other 20 = Domestic Partner * Applies only for children covered under the ESRD provision or disabled adult children covered under the disability provision.		X
*SP 34	Invalid Subscriber First Name. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; If field is not used, field must contain spaces.		X
*SP 35	Invalid Subscriber Last Name. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; If field is not used, field must contain spaces.		X
*SP 36	Invalid Employee ID Number. Field may contain alpha and/or numeric characters, spaces, commas, & - ' . @ # / : ; If field is not used, field must contain spaces.		X
SP 37	Invalid Source Code. Field is not used; field must be blank. Internal CMS use only.	X	
SP 38	Invalid Employee Information Data Code. Internal CMS use only. Valid alphabetic values are 'F', 'M', 'P', and 'S'. If field is not used, field must contain spaces.	X	
*SP 39	Invalid Employer Name. Field must contain alpha and/or numeric		X

SP EDIT CODES	DESCRIPTION	No Partner Action Required	Agreeing Partner Action Required
	characters, commas, & - ' . @ # / : ;. If field is not used, field must contain spaces. (For those beneficiaries that are Working Aged or Disabled, this field should always contain the name of the actual employer.)		
*SP 40	Invalid Employer Address. Field must contain alpha and/or numeric characters, commas, & - ' . @ # / : ;. If field is not used, field must contain spaces. (For those beneficiaries that are working aged or disabled, this field should always contain the address of the actual employer.)		X
*SP 41	Invalid Employer City. Field may contain alpha and/or numeric characters. If field is not used, field must contain spaces. Valid characters include commas, & - ' . @ # / : ;		X
*SP 42	Invalid Employer State. Field must contain alpha characters. If field is not used, field must contain spaces. Field cannot be blank. Alpha characters provided must match U.S. Postal State Abbreviation Table.		X
*SP 43	Invalid Employer Zip Code. First five positions may be numeric; the last four positions may be spaces. If field is not used, field must contain spaces. Field cannot contain alpha characters. Must be within valid zip code range on zip code table. If a foreign country, use 'FC' for state code. The first five digits can be zeros, and last four can be blanks.		X
*SP 44	Invalid Insurance Group Number. If field is not used, field must contain spaces. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ;		X
*SP 45	Invalid Insurance Group Name. If field is not used, field must contain spaces. Field may contain alpha and/or numeric characters, commas, & - ' . @ # / : ;		X
SP 46	Invalid Pre-Paid Health Plan Date. Numeric, number of days must correspond with the particular month. Internal CMS use only.	X	
SP 47	Beneficiary MSP Indicator not on for delete transaction. An attempt was made to delete an MSP record where there is no MSP indicator on the beneficiary Medicare record. According to CMS records Medicare has always been the primary payer.		X
SP 48	MSP auxiliary record not found for delete data transaction. This edit occurs when an attempt is made to delete a non-existent MSP record.		X
SP 49	MSP auxiliary occurrence not found for delete data transaction. Where there is an existing MSP period, the incoming record must match on certain criteria so the system can differentiate among		X

SP EDIT CODES	DESCRIPTION	No Partner Action Required	Agreeing Partner Action Required
	various periods of MSP on the beneficiary's Medicare file. These criteria are: patient relationship, MSP effective date, MSP type, and insurer type. An SP 49 is received when a Partner attempts to delete an occurrence that is not on CWF, or one for which there is no "match" on CWF, or you send in a delete transaction for a record that has been previously deleted by the Partner or another entity and the record no longer exists.		
SP 50	Invalid function for update or delete. Contractor number unauthorized. Internal CMS use only.	X	
SP 51	MSP auxiliary record has 17 occurrences and none can be replaced. Internal CMS use only.	X	
*SP 52	Invalid patient relationship code ("PRC"). (Mandatory) The MSP Code must correspond with valid PRC as cited below. MSP Code — Patient Relationship Code A = Working Aged — 01 = Beneficiary; 02 = Spouse G = Disabled — 01 = Beneficiary; 02 = Spouse; 03 = Child; 04 = Other; 20 = Domestic Partner B = ESRD — 01 = Beneficiary; 02 = Spouse; 03 = Child; 04 = Other; 20 = Domestic Partner For example, you will receive this edit when the MSP Code is equal or determined to be "A" "G" or "B" by the COBC and one of the following occurs: 1) If the MSP Code is equal to "A" and the MSP patient relationship does not equal "01" or "02," or 2) the MSP code is equal to "G" and the patient relationship does not equal '01' '02' '03' , or "04."		X
SP 53	MSP Code G or B overlaps another Code A, G, or B. Internal CMS use only.	X	
SP 54	MSP Code A or G has an effective date that is in conflict with the calculated date the beneficiary reaches 65 years old. For MSP Code A, the effective date must not be less than the date at age 65. For MSP Code G, the effective date must not be greater than the date at age 65.		X
SP 55	MSP effective date is less than the earliest beneficiary Part A or		X

SP EDIT CODES	DESCRIPTION	No Partner Action Required	Agreeing Partner Action Required
	Part B entitlement date. MSP can only occur after the beneficiary becomes entitled to Medicare Part A or Medicare Part B. An MSP Effective Date that is an invalid date will also cause SP 55 error.		
SP 56	MSP pre-paid health plan date must equal or be greater than the MSP effective date or less than MSP termination date. Internal CMS use only.	X	
SP 57	Termination date greater than 6 months before date of accretion. Internal CMS use only.	X	
*SP 58	Invalid insurer type, MSP code, and validity indicator combination. Insurer type must equal J, K, or A.		X
*SP 59	Invalid insurer type and validity indicator combination. Partners should not receive this edit. Internal CMS use only.	X	
SP 60	Other insurer type for same period on file (non "J" or "K"). Partner submits a "J" or "K" insurer type, but Medicare's CWF shows "A" insurer type. Insurer type does not match previously submitted insurer type. **Note**: Edit only applies to MSP codes. A - Working Aged B - ESRD EGHP G - Disability EGHP	X	
SP 61	Other insurer type for same period on file ("J" or "K"). Partner submits an "A" insurer type, but Medicare's CWF shows "J" or "K" insurer type. Insurer type does not match previously submitted insurer type. Note: Edit only applies to MSP codes A - Working Aged B - ESRD EGHP G - Disability EGHP	X	

SP EDIT CODES	DESCRIPTION	No Partner Action Required	Agreeing Partner Action Required
SP 62	Incoming termination date is less than MSP effective date. MSP termination date provided must be greater than the MSP effective date. The Partner sent a termination date prior to the MSP effective date. This edit occurs when a Partner fails to note CMS' modification of the Partner's MSP effective date to correspond with the commencement of the Medicare entitlement date. The Partner should go back to its previous response file and identify the correct MSP effective date for this record. If the termination date is earlier than the MSP effective date on the previous response file, this indicates that there was no MSP and the Partner should send a transaction to delete the record.	X	
SP 66	MSP Effective Date is greater than the Effective Date on matching occurrence on Auxiliary file. SP 66 occurs when the Effective Date on the maintenance record is greater than the Effective Date on the Auxiliary record to be updated, and Effective Date plus 30 is greater than "+30."	X	
SP 67	Incoming Term Date is less than posted Term Date for Provident. SP 67 occurs when the Termination Date on the maintenance record is less than the Termination Date on the Auxiliary record that is to be updated.		
SP 69	Updating contractor number is not equal to the header contractor number. CMS assigns the contractor number.	X	
SP 71	Attempting to change source code P-S. Internal CMS use only.	X	
SP 72	Invalid transaction attempted. Internal CMS use only.	X	
SP 73	Invalid Termination Date/Delete Transaction attempted. Internal CMS use only. SP 73 occurs when a FI or Carrier attempts to change a termination date on an MSP Auxiliary record with an 'I' or 'Y' Validity Indicator that is already terminated, or trying to add a Termination Date to an "N' record.	X	
SP 74	Invalid - cannot update 'I' record. SP 74 occurs when a contractor submits a transaction to update/change an 'I' record. Internal CMS use only.	X	
SP 75	Invalid transaction. Beneficiary does not have Medicare Part A benefits for the time period identified in the Partner's update file. If there is no Part A entitlement, there is no MSP.		X

Drug Records

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

Error Code	Description
*SP 12	Invalid HIC Number. Field must contain alpha or numeric characters. Field cannot be blank or contain spaces.
*SP 13	Invalid Beneficiary Surname. Field must contain alpha characters. Field cannot be blank, contain spaces or numeric characters.
*SP 14	Invalid Beneficiary First Name Initial. Field must contain alpha characters. Field cannot be blank, contain spaces, numeric characters or punctuation marks.
*SP 15	Invalid Beneficiary Date of Birth. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Day of the month must be correct. For example, if month = 02 and date = 30, the record will reject.
*SP 16	Invalid Beneficiary Sex Code. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Acceptable numeric characters include the following: 1 = Male 2 = Female
*SP 19	Invalid Transaction Type. Field must contain numeric characters. Field cannot be blank, contain alpha characters or spaces. Acceptable numeric characters include the following: 0 = Add Record 1 = Delete Record 2 = Update Record
*SP 24	Invalid Coverage Type. Field may contain alpha or numeric characters. Field cannot be blank. Applicable values are: A, J, K, U, V, W, X, Y, Z, 4, 5, 6 for MSP layout; U, V, W, X, Y, Z, 4, 5, 6 for Non-MSP layout.
*SP 31	Invalid Effective Date. Field must contain numeric characters. Field cannot be blank, contain spaces, alpha characters or all zeros. Number of days must correspond with the particular month.
*SP 32	Invalid MSP Termination Date. Field must contain numeric characters. Date must correspond with the particular month – CCYYMMDD. For example, 02/27/1997 is acceptable, but not 02/30/1997. Cannot be earlier than the MSP effective date. If there is no termination date (coverage is still active), must use zeros (not spaces) in this field.

Error Code	Description
*SP 34	Invalid Subscriber First Name. Field may contain alpha characters. If field is not used, field must contain spaces. Field cannot be blank or contain numeric characters. Only alpha characters used when subscriber is identified.
*SP 35	Invalid Subscriber Last Name. Field may contain alpha characters. If field is not used, field must contain spaces. Field cannot be blank or contain numeric characters. May use spaces instead of apostrophe. Only alpha characters may be used when subscriber is identified.
SP 49	No valid record exists for delete request. Attempt to delete a nonexistent MSP record will cause a reject.
*SP 52	Invalid patient relationship code
SP 62	Incoming termination date is less than effective date. MSP termination date must be greater than the effective date.

Additionally, the COBC will provide specific RX coding errors:

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

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

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

V. The VDSA Implementation Questionnaire

The *VDSA Implementation Questionnaire* is not a file layout like those above. Instead, the Implementation Questionnaire is a document to be filled out by the VDSA partner that provides information to be used to assure both the VDSA partner and CMS that agreement on essential operational questions has been reached. VDSA partners must complete and return a copy of this document to CMS with their signed VDSA. The Employer and Insurer versions of the Questionnaire are available on the VDSA Web sites, www.cms.hhs.gov/EmployerServices and www.cms.hhs.gov/InsurerServices .

SECTION C: WORKING WITH THE DATA

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

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

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

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

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

Part D Eligibility Start Date. This will be the first date a Medicare beneficiary has the right to enroll in Part D. It is almost always the effective date of coverage for the beneficiary's Part A or Part B participation. Information in this data field does not show that a beneficiary has enrolled in Part D. It simply gives the date the beneficiary became eligible to enroll. It is Field 60 in the MSP Response File; Field 35 in the Non-MSP Response File.

Part D Eligibility Stop Date. This is the date that a Medicare beneficiary has lost the right to enroll in Part D, for any reason. It is Field 61 in the MSP Response File; Field 36 in the Non-MSP Response File.

Current Medicare Part D Enrollment Date. This is the effective date of a Medicare beneficiary's most recent enrollment in Part D. It is the current first date the beneficiary can receive Part D benefit coverage. It is Field 58 in the MSP Response File; Field 42 in the Non-MSP Response File.

The beneficiary's current Part D Plan is identified in Current Medicare Part D Plan Contractor Number. It is Field 57 in the MSP Response File; Field 41 in the Non-MSP Response File.

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

MSP Fields 58, 59 and Non-MSP Fields 42, 43 tell you whether a beneficiary has actually chosen Part D coverage, and the period of time the current benefit coverage is in force. For most VDSA partners, on a routine basis these two sets of fields are the most immediate Indicators of Part D coverage.

II. Establishing Electronic Data Exchange

A number of methods of electronic data transmission are available when a partner is ready to exchange files with the Coordination of Benefits Contractor (COBC) in test or production modes. Following is an overview of the most common. The Partner's assigned Electronic Data Interchange Representative (EDI Rep) at the COBC will address a Partner's specific questions and concerns.

CMS' preferred method of electronic transmission is Connect:Direct (formerly known as Network Data Mover [NDM]) via the AT&T Global Network System (AGNS). Because AGNS is capable of transporting multiple protocol data streams to its members world wide, AGNS service removes the need to support a separate electronic link to each Partner. In addition, for encryption AGNS uses triple DES as its default.

Use of either SNA or TCP/IP is available to submitters connected to the AGNS network. FTP via TCP/IP on either a dial or dedicated basis via AGNS is also supported.

In addition, CMS has available two secure Internet transmission options. We recommend either of these options for Partners that anticipate having a low volume of data transmissions, that have access to the Internet, and that find it is a burden to secure an AGNS connection.

- SFTP: Using SFTP permits automated data transmission and management. For this transmission method, CMS has extensive experience using the Sterling Connect:Enterprise Secure Client. A Partner's cost to acquire use of this program is under $200. A Partner may use another client as long as it is SSH v2 capable.

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

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

Establishing AGNS Connectivity with the COBC

Electronic submitters that currently do not have an existing AGNS account and plan to send and receive information using this telecommunications link should contact one of the well-established resellers of AT&T services to obtain a dedicated or a dial-up access line to the AGNS VAN. CMS and the COBC strongly encourage Partners to activate new accounts as early as possible in order to quickly comply with the COBC's technical requirements.

III. Testing The Data Exchange Process

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

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

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

file. After receiving the test Response File in return, the partner will take the steps necessary to correct the problems that were reported on it.

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

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

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

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

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

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

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

There are two important conditions that apply throughout this section:

- The only record "Action Type" that will never have an "Add," "Update," or "Delete" Transaction Type applied to it is an 'N' Record.
- Files submitted subsequent to the first production files (the initial Input Files) are deemed Update Files.

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

Example: 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 discovered that the individual did not have current employment status and that Medicare should have been a primary payer. The partner sends this information in the next update tape and CMS "deletes" the incorrect record from its files.

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

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

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

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

- The first initial of the first name;
- The first 6 characters of the last name;
- The date of birth (DOB);
- The sex 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 where CMS changed the coverage effective date to the MSP effective date on the response record, the partner should submit the effective date previously provided by CMS on the response record.

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

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

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

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

- *Group Health Plan Number* – Number assigned by claim processor identifying the Group Health Plan.
- *Policy Number* – Plans are required to populate this field if the Coverage Type is V, Z, 4, 5, or 6.
- *Effective and Termination Dates* – These fields are populated in the same way they are on the MSP file.
- *Plan ID* – This field is populated in the same way as on the MSP file.

- *Rx ID* - This is the ID for the individual's drug coverage. It may be the same as the hospital/medical individual ID. This field is required when the Coverage Type is U, W, X, and Y.
- *Rx Group* - This is the group policy number for the drug coverage. It may be the same as the hospital/medical group policy number.
- *RxBIN* - Pharmacy Benefit International Identification Number used for pharmacy routing. All network pharmacy payers have an RxBIN. This field is required when the Coverage Type is U, W, X, and Y.
- *PCN* - Pharmacy Benefit Processor Control Number used for pharmacy routing. Some, but not all, network pharmacy payers use this for network pharmacy benefit routing along with the BIN. This number, if it is used, is required when the Coverage Type is U, W, X, and Y.
- *Toll-free Number*- This is the toll-free telephone number commonly found on an insurance card. CMS asks for this so that if there is confusion at the point of sale, the pharmacist or the covered individual can call the Plan for assistance.
- *Person Code* – This is the code the Plan uses to identify specific individuals on a policy. It is policy specific.
- *Relationship Code* – Covered Individual's relationship to the Policy Holder.
- *Coverage Type* – The coverage type codes used on the non-MSP file will be consistent with those used on the MSP file, but not all MSP file coverage types will be relevant. CMS needs supplemental drug coverage on the non-MSP file. If the partner is describing a network (EDI) pharmacy benefit the coverage type will be U, W, X, or Y. If the partner is describing a non-network pharmacy benefit the coverage type will be V, Z, 4, 5, or 6.
- *Insurer Name*- This is the name of the private insurer providing prescription drug coverage. CMS asks for this to facilitate proper billing at point of sale.

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

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

Current regulations specifically authorize the use of a VDSA as an alternative method of providing retiree drug subsidy enrollment files to the RDS Contractor. After enrollment with the RDS program an employer can use the VDSA program for its necessary data transfer and management of enrollment files with the RDS Center. Employers wishing to receive the Employer Subsidy for retiree drug coverage must submit an initial application to the RDS Contractor, a requirement separate from the VDSA process. For more information about the employer subsidy please visit: http://rds.cms.hhs.gov/ .

As part of the application process, the employer must send an initial enrollment file of all retirees and dependants for whom they wish to claim the subsidy. The initial enrollment file will be followed by regularly scheduled update files containing adds, updates and deletes.

VDSA partners submitting initial enrollment files and subsequent update files for the Employer Subsidy may opt to do so as part of their regular quarterly VDSA filing using a Non-MSP Input File with the 'S' Action Type. 'S' records require the same data elements required for 'D' records, with the addition of the RDS ID, a data element the RDS Contractor will assign to an employer at the start of the application process.

The COBC will send S' records directly to the RDS Contractor for processing. The RDS Contractor will determine whether the covered individuals included on the file are eligible for the Subsidy (Part D eligible, but not enrolled). On a response, 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. In most situations these responses will be populated by the RDS Contractor, and the contractor will return whatever information was included in the incoming (input) record, as well as the disposition code. Using the Non-MSP Response layout the RDS Contractor will transmit a response to the COBC, and the COBC will then populate the RDS response record with Medicare Part A, B and D Entitlement information. The COBC will then return the completed response file to the partner, as a regular VDSA Non-MSP Response File.

When the VDSA process was first implemented to include RDS reporting capabilities, the COBC converted the RDS Reason Codes to existing VDSA Disposition Codes that appear in Field 29 (S Disposition Code) of the Non-MSP Response File. RDS has since added new RDS Reason Codes that cannot be cross-walked to existing VDSA Disposition Codes. Therefore, in addition to continuing to receive the 'S' Disposition Code in Field 29, the VDSA Non-MSP Response record layout includes the actual RDS Reason Code in Field 54 and the RDS Determination Indicator in Field 50. These are the same codes you would receive if you submitted your RDS enrollment files directly to the RDS Center and not through the VDSA process.

Changes in 'S' Record Data: When a partner receives an Unsolicited notice from the Retiree Drug Subsidy (RDS) Contractor of a change in an individual's subsidy status, the partner should note that the RDS Contractor and the COBC do not use the same Disposition Codes when describing equivalent events, as described in the paragraph above. Please note that the COBC simply passes the RDS Reason codes from the RDS Contractor to the VDSA partner; the COBC does not produce them itself. For questions about the RDS codes please contact the RDS Contractor directly. Following is a table providing a crosswalk between the RDS Reason Codes and COBC code sets.

RDS Reason Code to VDSA Disposition/Reason Table			
		Maps To	
RDS Reason Code	**Description**	**VDSA 'S' Disposition**	**VDSA Error Code**
Spaces	*RDS Coverage Period Accepted*.	01	Spaces
10	*Enrolled in Part D*. The retiree cannot be covered under the RDS program because (s)he is/was enrolled in Medicare Part D during the coverage period provided by the Plan sponsor.	04	Spaces
11	*Not eligible for Medicare*. The retiree cannot be covered under the RDS program because (s)he is/was not enrolled/entitled to Medicare during the coverage period provided by the Plan sponsor.	05	Spaces
12	*Beneficiary is deceased*.	08	Spaces
20	*Beneficiary attempted to enroll in Part D and received an initial rejection*. The retiree tried to enroll in Medicare Part D when (s)he was already covered under the RDS program and as a result this initial attempt to enroll in Part D was denied. The VDSA employer partner may counsel that the beneficiary has equal or better prescription drug coverage through the RDS program. The VDSA employer partner will not be able to claim the subsidy for the beneficiary if (s)he overrides the denial and enrolls in Part D.	10	Spaces
21	*New Medicare information has been received – resend record*. After an initial rejection of the retiree's record, the RDS Center has now been notified of a change in the retiree's Medicare enrollment/entitlement status. The Plan sponsor should resubmit the retiree data on its next monthly update to determine if the retiree is now eligible for RDS program coverage.	11	Spaces

These codes are generated by Retiree Drug Subsidy (RDS) activity. Accordingly, the codes discussed here appear only in the Non-MSP Response File.

When a partner gets the VDSA "S" Disposition code of 01 – "Add" or "Change" – in Field # 29 of the Non-MSP Response File it means that the previously approved subsidy period has been truncated as a result of the information the RDS Contractor has received from the Medicare Beneficiary Database (MBD). Look at Field # 54 to see the RDS Reason Code associated with this record to determine why the subsidy period has changed. The partner should replace all current coverage records for the subject individual(s) with the subsidy period(s) provided in the RDS notification record.

When a partner gets an S Disposition code of 04, 05 or 08 in Field # 29 it means that the previously approved subsidy period has been completely cancelled for the reason given in the table above. The RDS Reason code in Field # 54 should correspond to the VDSA Disposition code in Field # 29. The Plan sponsor should remove all subsidy coverage for this beneficiary.

When a partner gets an S Disposition code of 10 or 11 in Field # 29, there is no change to coverage – at this time. The table above gives the corresponding RDS Reason code for a description of the action the partner should take, as does Field # 54.

Because of the possibility that an individual can have one or more splits in eligibility for the employer subsidy, a plan sponsor may get more than one change record for a given beneficiary/retiree. (See also the first paragraph on Page 50.)

The RDS Contractor recommends that the plan sponsor use this documentation in combination with the "Download Weekly Notification File" information found in the "Manage Retiree Files" section of the "How To..." document on the RDS Public Web Site, which can be found at http://rds.cms.hhs.gov .

Please note that a partner may be sent an "Unsolicited Response" with changes in 'S' Record data for particular individuals. *Unlike an ordinary response file, an "Unsolicited Response" will not include a partner's original Document Control Number (DCN), since none exists.* Partners are urged to integrate data from unsolicited responses into their regular databases as soon as possible.

Prior to transmitting the Non-MSP Response File back to the VDSA partner, when the COBC receives responses from the RDS Contractor it will screen those responses for covered individuals who do not qualify to support an employer drug subsidy because they are enrolled in Part D. These individuals will be considered to have other drug coverage relevant to the facilitation of Part D. The 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. The Non-MSP Response File includes fields for the original Action Type and the COBC Action Type when it has been changed from 'S' to 'D' 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' Record Type.

Special Note About The "ID" Disposition Code

Partners may see the term "ID" as a value in the Rx Disposition Code field in their MSP Response Files (Field 69) and in the D/N Disposition Code field on their Non-MSP Response Files (Field 48). This "ID" Disposition Code is being caused by an identification error at the CMS Medicare Beneficiary Database (the MBD).

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

'N' – Non-Reporting Query Record and Response

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

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

VI. Obtaining a TrOOP Facilitation RxBIN or PCN To Use with Non-MSP Records

VDSA 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 VDSA 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 Web 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 .

VII. Using BASIS For Queries

When a partner has an immediate need to access Medicare entitlement information, BASIS – the Beneficiary Automated Status and Inquiry System – permits a partner to make a limited number of on-line queries to CMS to find if it is possible that an individual is eligible for or enrolled in Medicare. Using a private, Web-based host, the VDSA partner can use BASIS to access the MBD up to 500 times a month. Access to BASIS is contingent on the partner having submitted its Initial MSP and Non-MSP Input Files and its most recent MSP and Non-MSP Update Files during its last quarterly production cycle.

In overview, BASIS operates as follows:

1. CMS (through its designated contractor) assigns each partner its own personal identification number. This number is delivered to the designated VDSA contact persons within 30 days of submission of the partner's initial MSP and Non-MSP Input Files (see Sections I, A and I, C, above). At this time, the partner will also receive information concerning the designated telephone line to be used for the BASIS application.

2. CMS shall notify the partner when the BASIS application is operational and will provide detailed instructions on how to use the BASIS application.

3. The partner will dial a designated telephone line to access the BASIS application, using its assigned EPIN. For each Covered Individual for whom the partner is requesting Medicare entitlement information, the partner will enter the following data elements that identify the subject of the query:

    - Social Security Number
    - Last Name
    - First Initial
    - Date of Birth
    - Sex

4. CMS will post the results of inquiry(s) to BASIS as soon as the partner submits its inquiry(s) to the BASIS application.

VIII. Contact Protocol for Data Exchange Problems

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

If after working with your EDI Rep you think your problem could benefit from help at a higher level, please contact the EDI Supervisor, William Ford, at 646-458-6613. His email address is wford@ghimedicare.com.

If you feel further escalation is necessary contact the EDI Manager, Alberta Smythe, at 646-458-6694, Ms. Smythe's email address is asmythe@ghimedicare.com.

The COBC Project Director, with overall responsibility for the EDI Department, is Sherri McQueen. Ms. McQueen can be reached at 646-458-6615. Her email address is smcqueen@ghimedicare.com.

You can also contact any of the CMS administrative contacts listed in the SPAP Data Sharing Agreement if you feel that the issues you are experiencing are ones that CMS should also be aware of.

V: 2/20/08

FREQUENTLY ASKED QUESTIONS

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General

Q1: Why is a Voluntary Data Sharing Agreement (VDSA) beneficial for an Employer or Insurer?

A1: A VDSA allows an employer or insurer to identify situations where Medicare is the primary payer of benefits, so that the employer plan can avoid making mistaken – and costly – primary payments that are already being correctly paid by Medicare. An employer or insurer can also use the VDSA to transmit retiree files needed to participate in the Retiree Drug Subsidy (RDS) program and receive additional Medicare entitlement information not available through the regular RDS web portal submission process. Employer plan coverage data provided to CMS via the VDSA process enables for point-of-sale coordination of the new Part D prescription drug benefit with the employer's benefit coverage.

A VDSA is also beneficial because it provides a way to exchange insurance coverage for Medicare entitlement information on a regularly scheduled basis, so that both CMS and the employer health plan pay health benefit claims correctly. Using a VDSA prevents mistaken secondary payments when an employer should be the primary payer, and supports the obligation to notify Medicare when an insurer has made a primary payment for health care services. The VDSA permits payers and CMS to effectively and efficiently coordinate health care benefit

payments in support of employer or insurer obligations under Medicare Secondary Payer (MSP) laws and regulations.

Q2: How does the VDSA process work generally? What is entailed in this data sharing arrangement?

A2: The VDSA data management process is a periodic, scheduled electronic exchange of Medicare entitlement, group health plan (GHP), and individual policy coverage information. A VDSA enables CMS and Employers and Insurers to determine payment responsibility order (primary, secondary, etc.) and to appropriately coordinate health care benefits. Using the VDSA process, GHPs provide eligibility data for policy holders/employees and their spouses to CMS. In exchange, CMS provides Insurers and GHPs with Medicare entitlement information for identified Medicare beneficiaries.

Q3: How flexible is CMS in administering the terms of the Agreement?

A3: CMS's ultimate goal is to ensure timely and accurate coordination of benefits with our VDSA partners. To achieve this goal, CMS has built considerable flexibility into the VDSA process. We want to help all our VDSA partners meet their obligations under the Agreement as efficiently and accurately as possible, and to do so within a time frame that is mutually acceptable to CMS and our many, varied VDSA partners.

Q4: Give me a high level explanation of the kinds of health plan coverage information you are capturing in order to better coordinate benefits between my health plan and Medicare?

A4: VDSA partners and CMS exchange two primary databases on a regular basis.

The MSP File (Medicare secondary payer file) is used to report hospital, medical and drug coverage that is primary to Medicare (including but not limited to active covered workers and their covered spouses and dependents). This file will be used when Medicare is the secondary payer.

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

Q5: My company is one of the original VDSA partners. In late 2005 CMS introduced a new version of the VDSA. Will we need to sign and use the "new" VDSA starting in 2006?

A5: Yes. Part D has made it necessary for us to revise our VDSA reporting requirements. All VDSA partners using the original (pre-August 2005) VDSAs are expected to have migrated to the new VDSA by March 31, 2006, and to then be using the new data reporting file layouts that are part of this User Guide.

Q6: What is BASIS, and how does it work?

A6: The Beneficiary Automated Status and Inquiry System (BASIS) allows VDSA partners to make a limited number of on-line queries to CMS (up to 500 times a month) when the partner needs access to Medicare entitlement information prior to the next regularly scheduled data exchange with CMS. In order to use the BASIS system, the partner must have already submitted initial MSP or Non-MSP Input Files, as well as its current MSP or Non-MSP Input Files for the most recent production cycle.

Q7: Please provide Internet resources I can go to for additional information about the VDSA program?

A7: For employers please visit the Coordination of Benefits (COB) page of the CMS Web site located at:

www.cms.hhs.gov/EmployerServices/03_employervdsa.asp#TopOfPage

For insurers please visit the Coordination of Benefits (COB) page of the CMS Web site located at:

www.cms.hhs.gov/InsurerServices/02_insurervdsa.asp#TopOfPage

TERMS OF THE VOLUNTARY DATA SHARING AGREEMENT

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

A1: No. However, the VDSA must be signed before we can begin accepting files. For all those who are interested, CMS began executing a new (that is, revised) VDSA agreement in August 2005.

If you have not already asked to be included, we can add you to our VDSA distribution list. Then, look for e-mails from COBVA@ghimedicare.com regarding the VDSA program. We host occasional informational VDSA conference calls and will continue to do so. We also provide you new and updated written VDSA materials as they are published.

Q2: I'm not sure I understand the definition of Active Covered Individual, and who I should include on the MSP file?

A2: An Active Covered Individual is someone with Medicare eligibility who is working, or the spouse or dependent of a worker and is covered by the worker's employer group health benefit plan. Medicare would be a secondary payer for any of these individuals. On the MSP Input File, CMS is asking you to include all of the individuals covered by your GHP for whom, if they had Medicare, Medicare would be a secondary payer of their GHP benefits.

"Active Covered Individual" is defined in the VDSA itself. While many of our definitions in the Agreement include legal citations, they aren't meant to be restrictive. However, they do define the minimum MSP data reporting requirements under the terms of the VDSA.

Q3: The definition of Active Covered Individuals in the Agreement seems restrictive. What about ESRD beneficiaries who are not working and still in the 30-month coordination period? Don't you want to know about these individuals? Can we include them on the MSP Input File?

A3: Yes. Although the definition of Active Covered Individual in the Agreement references the definition of "Active" in 42 C.F.R. § 411.104, there are MSP situations where an individual is not covered through their "Active" work status, such as when the 30-month ESRD coordination period is in effect. As noted above, the definition of an Active Covered Individual in the Agreement is not all-inclusive. The MSP data Input File covers this particular case: Field 20 – "Employee Status" – allows you to tell us whether the plan is primary for the individual because of "1. – Current Employment Status" or "2. – Another Reason." Non-working ESRD beneficiaries would be entered as "2."

Q4: Although the VDSA asks for Active Covered Individuals at least 55 years of age, we provide family coverage to one of our active workers who is only 39 years old and we are fairly certain that his wife, who is also 39 years old, has Medicare due to disability. Can we include these individuals on the MSP Input File?

A4: Yes. Although the minimum data set we require on the MSP Input File is for all Active Covered Individuals and their covered spouses and dependents aged 55 and over, we encourage VDSA partners to include Active Covered Individuals younger that 55 where they are fairly certain MSP status applies.

Q5: Since there can be MSP situations for workers younger than 55, why do you only require information about beneficiaries who are at least 55?

A5: CMS has found that 97% of MSP situations occur in the Medicare beneficiary population aged 55 and older. To reduce the processing burden on our VDSA partners, some of which have a generally younger enrollee population, CMS does not require a full file of all Active Covered Individuals on the MSP Input File. VDSA partners can include younger that 55 year old Active Covered Individuals

on their MSP Input File if they wish, but the minimum requirement is that they include all Active Covered Individuals aged 55 and over.

Q6: We are an existing VDSA partner and we send you data on plan membership for people age 40 and over. Can we add to that and send additional membership under age 40 where we have identified ESRD diagnosis on claims and identified possible disability? If we do this, do we have to have the agreement formally changed?

A6: That is not a problem, and in fact if you suspect younger people might be entitled to Medicare we encourage you to include them on your file. The VDSA does not need to be changed formally if you add these individuals who you suspect may have Medicare. We will follow normal processing procedures in order to determine a match for the records that you submit and will pass back a response letting you know whether any individual was in fact matched to Medicare entitlement.

Q7: What functions does the Non-MSP file support?

A7: Use the Non-MSP record layout when reporting information about Medicare eligible people for whom Medicare is not a secondary payer. VDSA partners can use the Non-MSP Input File layout: To report drug coverage information that is supplemental to Medicare and to support the TrOOP facilitation process; to report required employer subsidy information to the RDS Contractor, and; to query CMS in order to obtain Medicare entitlement information. These various purposes are identified on the Non-MSP Input File Layout by the Action Type designation in Field 20, namely as 'D,' 'S' and 'N' records.

Q8: We are an insurer representing hundreds of plan sponsors (employers) and do not know whether to submit individuals on either the MSP Input File or the Non-MSP Input File. We would like to develop information regarding the Active or Inactive work status of all of our enrollees. Can we use the "N" record submission process to query for Medicare entitlement data so that we can focus our development activities toward the small percent of our enrollment population that has Medicare?

A8: Yes, under two conditions. First, CMS expects all new VDSA partners to fully test their required MSP and Non-MSP file submission processes before we will allow for the exchange of any production data, including 'N' Action Type data. Second, when CMS provides Medicare entitlement data in response to an 'N'-type query, CMS expects the VDSA partner to complete its development (coverage analysis) within a commercially reasonable time, and to begin reporting on found individuals, as appropriate, using either the MSP or Non-MSP Input File. Failure to meet these two conditions will result in termination of the VDSA by CMS.

Q9: Would you clarify for me what inactive means. Does this mean inactive as in cancelled members?

A9: No. "Inactive" means that a covered individual is not working. He or she has health insurance benefit coverage but does not meet the regulatory definition of an "Active" (working) covered individual. What used to be called the "Inactive File" is now the Non-MSP File. CMS is eliminating all references to the "Inactive" file.

Q10: What does CMS consider to be a successful completion of the data exchange testing process?

A10: At a minimum CMS requires the VDSA partner to be able to (1) submit an initial test MSP and Non-MSP Input File that can be processed to the satisfaction of the COB contractor, (2) receive and process a test MSP and Non-MSP Response File from the COB contractor, and (3) be able to submit a test Update MSP and Non MSP file to the COB contractor. We have delegated the authority to determine whether or not the VDSA partner has successfully completed the testing process to the COB contractor.

Q11: How long does the testing process take?

A11: Testing can begin as soon as a VDSA is executed by both Parties, and it takes place on a scheduled weekly basis. Under ideal circumstances, each testing cycle takes about a full week before the VDSA partner can be ready to submit the next test file. Testing will take place at the VDSA partner's preferred pace and can take a month or more to complete, depending on how quickly the VDSA partner can gather the necessary resources to meet the implementation requirements. VDSA partners should note that CMS's goal throughout the testing and implementation process is to ensure that the VDSA partner's first real production file is as accurate as possible. The accuracy of data on the first production file is more important then how quickly the VDSA partner can produce it.

Q12: Other than stating that files can be exchanged quarterly with the option of exchanging non-MSP files on a monthly basis, there is no mention of the actual reporting schedule we would use.

A12: The COB contractor will work with each VDSA partner during the Preparatory Period to set up reporting and data production schedules.

Q13: Are there any implementation or maintenance fees charged by CMS to VDSA partners?

A13: There are no fees charged by CMS to participate in the VDSA process.

Q14: In addition to various physical media, such as CDs and tapes, and the ability to send data via a T-1 line, what Internet-based Secure FTP protocol will DSA partners be offered by CMS?

A14: CMS has available two secure Internet transmission options. We recommend either of these options for Partners that anticipate having a low volume of data transmissions, that have access to the Internet, and that find it is a burden to secure an AGNS connection.

SFTP: Using SFTP permits automated data transmission and management. For this transmission method, CMS has extensive experience using the Sterling Connect:Enterprise Secure Client. A Partner's cost to acquire use of this program is approximately $150. A Partner may use another client as long as it is SSH v2 capable.

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

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

Q15: Are rules that allow subscribers to cover a parent or in-law, and that apply in the working aged provisions any different than coverage for a spouse? All of this is active coverage. The disability provision of the MSP rules has the term "family member" but the working aged provision uses "spouse."

A15: The working aged rules only apply to the employee and spouse, but the disability rules apply to family, which also includes parents and in-laws. An excellent, detailed summary of the MSP rules in fairly plain language is in the IRS/SSA/CMS data match instruction booklet, which you can download from the COB Web site. Visit www.cms.hhs.gov/IRSSSACMSDataMatch and follow the link at the bottom of the page to view a pdf file of the "Instructions for Completing the Group Health Plan Report."

Q16: Why do you ask for the employer and insurer Tax Identification Numbers (TINs)?

A16: We ask for TINs and a TIN reference file for several reasons:

First, for employers with a VDSA, providing your Tax Identification Numbers (TINs) is what allows CMS to suppress the mailing of IRS/SSA/CMS Data Match questionnaires to your organization.

Second, collecting TIN numbers on each record – instead of a firm's actual name and address – reduces the size of each record and speeds up the processing of the millions of VDSA records we receive.

Third, TINs allow our VDSA partners to easily manage the addresses they provide to CMS for benefit coordination. Example: Large employer XYZ Inc. has a VDSA with CMS. They have 200,000 covered lives reported under 50 different TINs, representing the parent company and its many subsidiaries. But since all of XYZ's health care benefits are managed by one department at one address, XYZ submitted their TIN reference file using the same address for every TIN. If the address of the benefits department changes, XYZ will only have to submit a new TIN reference file, and not update every single individual beneficiary's record. Producing a new TIN reference file is much easier than would be changing the tens of thousands of individual records.

RECORD LAYOUT AND FILE SUBMISSIONS

Q1: How will you use the TINs you are collecting?

A1: Use of TINs provides for a more efficient method of coordinating benefits on the "front end." Not having TINs increases recovery costs to both CMS and the Treasury, and can lead to an inefficient recovery process that adds administrative burden to the debtor. CMS routinely uses TIN numbers to aggregate demands for recovery of mistaken Medicare payments; without the TINs, administrative costs go up.

The Debt Collection and Improvement Act of 1996 required CMS, as part of the government's debt recovery process, to collect the TINs of potential debtors to Medicare and provide them to the Treasury Department. Because TINs are the main Employer and Insurer identifier CMS uses in its COB and debt recovery efforts, CMS has made the TIN the primary identifier for all potential debtors to Medicare.

Q2: We are a large employer that is also self-insured, but we contract with a Third Party Administrator (TPA) to administer our plan benefits. In the MSP Input File you ask for an Insurer TIN and an Employer TIN. Should we use our Employer TIN for both?

A2: Since you use a TPA to handle the day-to-day administration of your plan benefits, we would suggest that you include your third party administrator's TIN in Field 22 (Insurer TIN). That way we can directly involve both you and your TPA in any Medicare coordination of benefits issues that affect your plan enrollees.

Q3: I noted in the TIN File record layout that if we don't have or can't get the real TIN of all of the entities related to the Active Covered Individuals we will be reporting on in the MSP Input File, we can supply "pseudo TINs." Can you clarify?

A3: For some of our larger insurer partners that deal with hundreds and even thousands of employers, getting the TINs from all of them could prove challenging. In order to allow VDSA partners to report all of their Active Covered Individuals as soon as possible, the partner can supply pseudo numeric TINS on records that they don't yet have the real TINs. Pseudo TINs will not be treated like real TINS, and used for other CMS coordination of benefit and recovery purposes. We expect all trading partners who use pseudo TINs to eventually eliminate them.

Q4: Employer and Insurer TIN data fields are labeled as numeric in both the MSP and TIN Input Files. But if I want to use a pseudo TIN, can it be Alpha-Numeric – a Group Number, for example?

A4: No. Any TIN data field must be a numeric fill. Using an alpha-numeric fill to report a pseudo TIN will produce an error. The pseudo TIN will not be accepted, and all MSP records that referenced the pseudo TIN would not have any other employer or insurer information populated as a result. In most situations this will result in an SP error.

Q5: If we can just make up "Pseudo" TINs, why should a VDSA partner bother developing for the real TINs?

A5: Pseudo TINS will not be used to perform any of the functions involving CMS front-end coordination of benefits and recovery processes. More importantly, we cannot suppress IRS/SSA/CMS Data Match Mailings to employers unless we receive their real TINs.

Q6: We are a large employer with 37 TINs for subsidiaries scattered across the country, but all of our health care benefits are administered out of one location. Since you ask for the addresses associated with our health care benefits administration, can we use the same address on every TIN?

A6: Yes. That is the benefit of the TIN reference file. It allows you to provide us with the one address to which you would want CMS or any of our mutual partners involved in health care coordination of benefits to direct their inquiries. So, for your example, in addition to containing the appropriate insurer TINs, your TIN reference file would include thirty-seven employer TINs, each with the same address.

Q7: As an insurer, we cover employer groups that may have multiple TIN numbers. However, for our purposes they are only one entity. We would

like to use only one TIN for the entire company, even though the company may have many TINs for tax purposes. Is the TIN used just to identify the name/address, or is it actually used to identify the actual taxing entity?

A7: If you deal with one plan sponsor that has multiple TINs, such as a large parent company with many subsidiaries, you only need provide the TIN and address for the plan sponsor. If you service multiple unrelated employers as members of one group, we would need the TIN and associated address for each employer in that group, because each individual plan employer is a separate plan sponsor. In any case, it is important to provide the TIN for each plan sponsor you do business with, based on its responsibilities under the MSP rules. We would encourage you to provide as many additional TINs as possible to ensure efficient coordination of benefits.

Q8: Why does CMS insist we fill the "DCN" field on Input Files?

A8: The "Document Control Number" (DCN) is an ID number assigned by the VDSA partner, for its own use as a tracking code. While other information in an input record may have changed in the response record, the DCN will not. Consequently, using the DCN will always allow a VDSA partner to match and link an input record with its corresponding response record. Supplying a DCN on an input record is mandatory. On the MSP Input File record layout the DCN field is Number 6. On the Non-MSP Input File record layout the DCN field is Number 19.

Q9: Throughout the record layouts there is a field for HIC Number (HICN). Some of the data field descriptions state that the HICN is not required if the SSN is provided. This is not explicitly stated in others. Please confirm that an SSN is an acceptable substitute for the HICN in all the layouts.

A9: To confirm a beneficiary data match we always need either the HIC Number (HICN) or the SSN. Having one of these numbers is necessary to determine if a Covered Individual you submit is also entitled to Medicare. We encourage you to send us both numbers in case one contains a keystroke or other error.

Q10: We don't have all of the SSNs for all of our covered individuals (and we don't supply HICNs). Should we include a record with no SSN or HICN on the file anyway?

A10: No. Without either the SSN or HICN, do not submit a record for that individual. The SSN and HICN are the primary identifiers we use to confirm Medicare entitlement. Without one or both of those numbers, a record will not process.

Q11: What should we do for records that do not have the SSN?

A11: See if you have a HICN for that individual. If you do not, don't send the record. (This is why it is important that you routinely collect SSNs.)

Q12: Is just the SSN enough to make a match in your database?

A12: Almost. To confirm the individual on a submitted record is a Medicare beneficiary we require the SSN (or HICN), the first 6 characters of the person's surname, first name initial, date of birth, and sex code.

Q13: What if we have the SSN or HICN but not all of the personal identifying information (first 6 characters of the person's surname, first name initial, date of birth, and sex code) that you need to confirm Medicare entitlement?

A13: You should include as much of the personal identifying information as possible. It is often possible to find Medicare entitlement even if not all of the personal identifying information exists or is correct on the record you submit. We use a matching algorithm that accepts a match when at least 3 of the 4 personal identifying information (first 6 characters of the person's surname, first name initial, date of birth, and sex code) for the submitted SSN or HICN is correct.

Q14: Many of our enrollees are concerned about identity theft and are wary about giving us their Social Security Numbers (SSNs). How can we assure them that an individual's SSN will be protected and used appropriately?

A14: The collection and use of individual SSNs is now limited by an evolving body of federal and state law and regulation. When an SSN is to be used as personal health information, management of the SSN (who can collect it; for what reason; with what other entity or person can it be shared) is directed by regulations required by the federal Health Insurance Portability and Accountability Act (HIPAA). These are called the HIPAA privacy rules. They are quite strict, and after they were fully implemented in 2004, measures to protect personal health information seem to have become stronger. Collection of SSNs for purposes of coordinating benefits with Medicare is a legitimate use of the SSN under Federal law.

Q15: Don't recently passed state laws prohibit the use and collection of SSNs?

A15: There are state laws that restrict when SSNs can be collected and how they can be used. But these state initiatives do not preempt the provisions of the Medicare Secondary Payer (MSP) or Medicare Modernization Act (MMA) regulations or the "permitted use" provisions of the HIPAA privacy rules. These federal laws allow the collection and use of SSNs to help providers and insurers manage their operations. However, state laws frequently augment the federal regulations. Some states now restrict how SSNs may be displayed, prohibiting a health plan from including an SSN on an individual's plan ID card for example. These state initiatives are not affected by the federal rules.

Q16: Many insurers are dropping the SSN as their subscriber ID number. Are you concerned about getting changed numbers?

A16: That is fine, as long as we receive the necessary updated subscriber ID information.

Q17: The Non-MSP Input File has an "Action Type" code field (Field 20) with values of 'D' for Drug Reporting Record, 'S' for Subsidy Reporting Record, and 'N' for Non-Reporting Record. Please clarify when a partner would submit an 'N' (non-reporting) record.

A17: The 'N' record is a *query* record where you are merely asking for Medicare entitlement information. We do not store the information you submit on an 'N' record, which is why we call it a non-reporting record.

Q18: Can we submit 'N' records on potential MSP "Active Covered Individuals" as well as for our retirees or other "Non-MSP" covered individuals?

A18: Yes. You can submit 'N' records on any of your plan's Covered Individuals. Because data submitted on 'N' records is not used or stored by CMS, when necessary you must still submit information about your Covered Individuals on either the MSP Input File or as a 'D' record on the Non-MSP Input File.

Q19: Which coverage type would an Insurer be classified under if the Insurer offers an integrated package of benefits with medical, surgical, pharmacy coverage and most drug claims are administered and adjudicated at the point of sale, electronically?

A19: The Insurer would carry a coverage type of 'W'.

Q20: Would you clarify for me what inactive means? Is someone who is "inactive" a cancelled (former) plan member?

A20: No. For CMS, "Inactive" means only that an individual is not working. He or she has health insurance benefit coverage but does not meet Medicare's definition of an "Active" (working) covered individual.

Q21: What is the difference between the "Relationship Code and the "Person Code?"

A21: The Relationship Code is assigned by CMS, and references the cardholder, spouse, and dependents. It is a two digit code, running from 01 through 04. (See Field 12 on the MSP Input File Layout, Field 18 on the Non-MSP Input File Layout.) The Relationship Code is independent of the Person Code.

Person Codes are assigned by insurers and are not defined by CMS. The insurer is always the source of the Person Code. They identify family members and consist of three digits. The person code follows an NCPDP format and most insurers assign codes following a set pattern: Cardholder is usually "001"; Spouse is usually "002"; dependents are usually numbered “003” to “099” (See Field 29 on the MSP Input File Layout). Usually, the dependents are numbered according to the age of the dependent. The oldest dependent will be “003.” The Person Codes assigned within a specific family are usually not reassigned as dependents lose coverage status (as defined by the insurer). The Person Code is used for drug claim routing and family order relationship identification. Again, the Person Code is policy specific and the insurer is always the source of the correct person code for each individual covered by the policy.

Q22: We offer GHP (group health plan) coverage to domestic partners. What relationship code should we use to list a domestic partner? Is he or she considered a spouse?

A22: Federal regulations do not recognize domestic partners as spouses, but they are recognized as family members. Therefore enter ‘20’ (Domestic Partner) in the field asking for the Relationship Code. (MSP Input File, Field 12; Non-MSP Input File, Field 18.) Note that under the Working Aged rules, MSP only applies to workers and their spouses, so there is no MSP if the only Medicare Entitlement Reason is ‘A’ (Working Aged). However, MSP does apply to domestic partners if the Medicare Entitlement Reason is also ‘B,’ or ‘G’ (ESRD or Disabled).

Q23: There are many MSP situations where the Active Covered Individual works for a small employer (less than 20 employees) but is part of a multi-employer plan where another employer sponsor of that plan has more than 20 employees. Do we report these individuals? How do we complete Field 16 (Employer Size)?

A23: If the individual works for an employer that has less than 20 employees, but is part of a multi-employer plan where another employer in that plan has 20 or more employees, enter ‘1’ (20 to 99 employees) in Field 16 (Employer Size). If the other employer has more than 100 employees enter "2" (100 or more employees) in this unique situation.

Q24: I got back a match on one of my records in the response file but the date of birth I originally submitted was changed. Why? Should I store this changed information?

A24: The birth date CMS had on its Medicare Beneficiary Database conflicted with the birth date you submitted, but the rest of the information you provided was enough to make a match to a Medicare beneficiary. It is common to receive a data element that doesn't result in a 100% match but find that the whole data set is still accurate enough to be considered matching; this can happen for a number of

reasons. In any case, using our data we correct your records and return them to you. The corrected data originates from the Social Security Administration (SSA), and is linked to a particular beneficiary's SSN and HICN. This SSA data set constitutes the Federal Government's official set of beneficiary identifiers. Consequently, we expect you to update and store the corrections in your own records, to better ensure that they will match again when you have to update the same individual's record. Incidentally, CMS cannot update SSA data. Only a beneficiary has the authority to seek corrections in his or her own SSA data.

Q25: I notice that I have the option of submitting the Non-MSP file on a monthly basis or a quarterly basis, but that I can only submit the MSP file on a quarterly basis. Why?

A25: For MSP records, the editing program logic used by Medicare's Common Working File (CWF) is very comprehensive, and is designed to attempt to resolve errors generated as the file is processed. Records that "error out" are recycled (reprocessed) for up to 30 days in an attempt to resolve as many errors as possible before the Response File is sent back to the VDSA partner. On the other hand, records submitted in a Non-MSP file can usually be processed and returned within a week, thus making it possible to offer a VDSA partner the option of submitting Non-MSP Files monthly or quarterly.

Q26: What are the benefits of submitting the Non-MSP file every month versus every quarter?

A26: Many entities using a VDSA to move enrollment files to the RDS contractor may wish to submit on a short turnaround, so that they can receive RDS payments on a monthly basis. Others may wish to receive Medicare entitlement data on a frequent basis. These partners can choose to submit Non-MSP Files monthly. Conversely, there are VDSA partners that will want to have a longer time to evaluate Non-MSP Response Files and more time to build their next submission files. They may be concerned that the extra resources needed to perform a monthly exchange will be cost prohibitive, or that rushing to meet a monthly deadline may produce erroneous or incomplete data. They can choose to submit Non-MSP files on a quarterly basis.

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

Q27: We do not find a header or trailer record for the Query Only HEW Response File. Did we overlook it or is one not needed?

A27: The Query Only HEW Response File has no header or trailer. For this particular response file neither a header nor trailer is necessary, and so we don't include them. VDSA partners do provide include a header and trailer as part of the Input

File submission since the header/trailer allows us to identify the sender. We can then route our response back to the DSN specified by the partner.

Q28: "*The Query Only HIPAA Eligibility Wrapper (HEW) Input File.*" You say that this is a Non-MSP File that is not accompanied by information about drug coverage – it only serves as a query file regarding Medicare entitlement of potential Medicare beneficiaries. Using a CMS-provided program, the VDSA partner will translate ("wrap") the Non-MSP file into a HIPAA-compliant 270 eligibility query file format. Can you explain in more detail how this works? Is there more information on this somewhere else?

A28: If you are not going to be submitting 'D' or 'S' records – you only want to submit a "lookup" or query – you must use this program format because the lack of 'D' or 'S' records makes this an "inquiry only" – a pure inquiry file. The "HIPAA Eligibility Wrapper (HEW)" program must be applied to all "inquiry only" file exchanges because these particular data transfers are subject to HIPAA privacy regulations. More information about Query Only HEW Input Files can be found in Section C, "Working With The Data," starting on Page 64 of the User Guide.

PART D AND VDSAs

Q1: How do the MSP provisions impact Part D?

A1: The MSP laws found at 42 U.S.C. § 1395y(b) were extended to Part D in § 1860D-2(a) (4) of the MMA and are applicable to group health plan (GHP) prescription drug coverage according to the same rules that apply to GHP hospital and medical coverage.

Q2: I recognize edits that the CWF (Common Working File) passes back when editing MSP records for hospital and medical coverage. Where are the MBD (Medicare Beneficiary Database) edits for drug records?

A2: MBD does not edit drug records so no Rx edits originate from the MBD. Instead, the COBC does minimal front-end editing of the data. The contractor passes back any edits (RX Error Codes) for drug records submitted by the VDSA partner. The MBD does generate Disposition Codes, so an Rx Disposition Code can be passed back from the MBD.

Q3: In the MSP Response File, why are there fields labeled Disposition Code (Field 8) and Rx Disposition Code (Field 69)? What is the difference between these two codes?

A3: Hospital/Medical coverage and Drug coverage information is currently stored on two different CMS databases – the Common Working File, or CWF, and the Medicare Beneficiary Database, or MBD. The two databases have separate

coding instructions, so we have separate Disposition (and Error) codes to distinguish Medicare Parts A and B from Part D activity.

When a record containing both hospital/medical and drug coverage comes in, we split the record to process the hospital/medical coverage to the CWF, and to process the drug record to the MBD. When the two sets of information have finished processing, CMS merges both sets of processed data into one response record. Because data analysis procedures were carried out on both databases, the response record can include a number of similar but separate Disposition and Error codes.

Q4: In the Implementation Questionnaire, why do you ask for a list of the Standard and TrOOP RxBINs and PCNs, when we include those data on the individual record?

A4: The COB contactor will use that RxBIN and PCN list to perform informal edits of the data you submit on both the MSP Input File and the Non-MSP Input File, to ensure that we are receiving the appropriate RxBIN and PCN data in the records you forward to us.

Q5: Are the RxBIN and PCN required fields, given that we are submitting for an employer-sponsored plan and not an insurer? If so, is this information that we should obtain from our PBM (Pharmacy Benefit Manager)?

A5: If the coverage type your plan offers includes a prescription drug benefit that utilizes an electronic (EDI) pharmacy data network, we require those numbers. Not everyone using a pharmacy network uses a PCN, but everyone using a pharmacy network will have an RxBIN, so the RxBIN is always required when a coverage type of U, W, X or Y is entered in the Input File. The PCN should be supplied if your drug plan uses it. Many plans contract with a PBM to run their drug benefit and, if so, the PBM will be able to supply these numbers to you.

Q6: The VDSA states that everyone who uses the RxBIN and/or PCN will have to get a separate TrOOP Facilitation RxBIN and/or PCN. The new one will be for reporting and coordinating drug coverage that is secondary to Medicare Part D coverage. It will ensure that these drug claims are routed through the TrOOP Facilitator. If so, do we have to apply for an additional RxBIN or PCN number?

A6: Yes, you will have to apply for an additional TrOOP Facilitation RxBIN and (or) PCN that will supplement your current "standard" RxBIN and (or) PCN. Benefit managers have to apply for a TrOOP Facilitation RxBIN and (or) PCN for supplemental drug benefit coverage that has to be reported to Part D Plans. A benefit manager can apply for an additional RxBIN or PCN for TrOOP Facilitation through ANSI or the NCPDP. Please refer to "VI. Obtaining a

TrOOP Facilitation RxBIN or PCN to Use with Non-MSP Records," on Page 81 in the User Guide, above.

Q7: As an employer, how do I obtain a TrOOP RxBIN or PCN?

A7: You will need to instruct whoever is responsible for paying your drug claims electronically at the pharmacy point of sale (usually your insurer or Pharmacy Benefit Manager) to obtain a TrOOP RxBIN or PCN that will supplement the Standard RxBIN or PCN they already have for your population. (See the preceding answer to Question 7.)

Q8: We do not use a PCN for electronic routing of drug claims. What happens if we do not enter a PCN?

A8: All drug payers that process claims electronically have an RxBIN, but not all use, or need to use, a PCN. The only two Rx-specific identifiers that are always required when reporting a network pharmacy benefit, indicated by Coverage Type U, W, X or Y, are the RxBIN and Rx Insured ID Numbers. But please include all other Rx-specific information on the record that your drug plan uses to pay claims, so that benefits can be efficiently coordinated.

Q9: I am an insurer that has signed both a Coordination of Benefits Agreement (COBA) and a VDSA. As far as I can determine, both projects support MMA and Medicare Part D by requiring the submission of prescription drug coverage information that is secondary (supplemental) to Medicare. Do I have to submit in on one or the other or on both? Does CMS have a preference?

A9: If you have both a COBA and a VDSA you only need to submit supplemental drug coverage information through one of those processes. Therefore, if you have a VDSA and a COBA and decide to report prescription drug coverage information that is secondary (supplemental) to Medicare through your COBA, you would only have to submit coverage information that is primary to Medicare using the VDSA's MSP Input File, and you would not have to submit coverage information that is secondary (supplemental) to Medicare on the VDSA Non-MSP Input File.

Q10: What are the reporting requirements of prescription drug coverage information for payers signing either a COBA or a VDSA?

A10: Payers that sign a COBA are required to report Retiree/Supplemental Drug coverage to CMS. Payers that sign a VDSA with CMS are also required to report Retiree/Supplemental Drug coverage to CMS. Consequently, payers that have signed both a COBA and a VDSA have the option of reporting Retiree/Supplemental Drug coverage through either process.

Q11: Is it necessary for us to send a separate file containing "Drug" (Action Type D) records when we will be sending the data for those who are enrolled in Part D on our 'S' Records?

A11: If you are sending everyone in for subsidy, then no. But remember that there are more data elements required for a complete 'D' transaction. If you don't want to have to send additional 'D' records when people are rejected for the employer subsidy because they are enrolled in a Part D plan, then you need to include all the data needed for building a 'D' record with your 'S' records.

Q12: In the MSP Input File (Field 28) and the Non-MSP Input File (Field 17) there are data fields for "Rx Toll Free Number." How is this information used? Is this a required field? If I don't provide a toll free number, will I get an edit notification?

A12: An "Rx Toll Free Number" is often included on a pharmacy benefit insurance card. It is the number a pharmacist can call if he or she has questions about a prescription or about coverage issues, and it can be useful information to have available at point-of-sale. We encourage all VDSA partners to provide this number. However, it is not a required data element. If this data field is filled with spaces no edits are generated.

RETIREE DRUG SUBSIDY (RDS) INFORMATION

NOTE: Questions in this section generally address issues regarding the RDS file submission process using a VDSA. *Your questions specific to the requirements of the RDS program would best be answered by the RDS Center directly, at* **http://rds.cms.hhs.gov.**

Q1: When will the new VDSA agreement be available and when can new employers start submitting information for the RDS?

A1: Employers may use the new VDSA to start submitting files to the RDS Center now. If you would like to receive more information about the VDSA process you can visit: www.cms.hhs.gov/EmployerServices/03_employervdsa.asp#TopOfPage

Q2: Can we use the "old" VDSA for this purpose?

A2: No. All "old" VDSAs, signed prior to August, 2005, do not contain the layouts needed to submit information to the RDS Center. To use a VDSA to move data to RDS, you need to have signed the new (current) VDSA, originally released in August, 2005.

Q3: If we decide to submit our Non-MSP files on a quarterly basis and we are submitting 'S' records for the subsidy, can we still request Subsidy Payment on a monthly basis?

A3: Yes. And you should direct this and similar questions on the subsidy payment process directly to the RDS Center.

Q4: What are the definitions of the RDS Start Date and RDS End Date fields (Fields 51 and 52) in the Non-MSP Response File?

A4: These two dates define the time period during which the RDS Center determines the employer can claim the subsidy.

Q5: If we use the Non-MSP file to submit 'S' records that will be passed to RDS for processing, will we have to submit 'N' records to receive Medicare entitlement data?

A5: No. All record types submitted on either the MSP File or Non-MSP file will be returned with Medicare entitlement data. This is an advantage to using the VDSA process to submit enrollment files to the RDS Center rather than using the RDS Center's Web portal. Using a VDSA, the response that includes RDS data also provides the VDSA partner with Parts A, B and D Medicare entitlement data, while responses available through the RDS Center's Web portal do not.

Q6: Is it necessary for us to send a separate file containing "Drug" (Action Type D) records when we will be sending the data for those who are enrolled in Part D on our 'S' Records?

A6: If you are sending everyone in for subsidy, then no. But remember that there are more data elements required for a complete 'D' transaction. If you don't want to have to send additional 'D' records when people are rejected because of subsidy, then you need to include all the data needed for building a 'D' record with your 'S' records.

Q7: Section D.2. of the VDSA states that for "S" records, "If the Non-MSP Covered Individuals submitted by the Employer are found by CMS to be enrolled in Medicare Part D, CMS shall convert the records of those individuals into secondary prescription drug coverage reporting – D Records..." What happens if we don't include all of the data elements required to build a 'D' record?

A7: You will receive an 'S' disposition code of '04' in Field 29 of the Non-MSP Response File, meaning the beneficiary is already enrolled in Part D, a 'D' disposition code in Field 48 – and at least one Error Code with the reason the 'D' record was not built.

Q8: If an 'S' record we submit is rejected because the individual has enrolled in Part D and we get the beneficiary to immediately disenroll from Part D, can we resubmit the individual on our next file as an 'S' record?

A8: Yes. However, we do expect you to submit a 'D' record reporting drug coverage that was secondary while the individual was enrolled in Part D. If a 'D' record had already been successfully created when the individual was rejected by RDS for Part D entitlement, then you would need to submit an Update record (Transaction Type 2) with a Termination date being equal to the day the beneficiary disenrolled in Part D. If a 'D' record had not been previously accepted by the COBC, please submit the 'D' record as an Add record (Transaction Type 0).

Q9: We are an insurer that has an employer customer that has chosen to take the Retiree Drug Subsidy. It will be filing two separate applications for RDS IDs because it has two separate plans. If the customer decides to use the VDSA for the retiree list submission, how will the two groups be identified? Will a response file distinguish between the two separate groups?

A9: Each RDS file will have a separate RDS ID in the VDSA Non-MSP Input File and Response File header record. For example, an employer has two plans of 100 members each. Each plan will get its own RDS ID. All 100 members of each plan would be submitted in separate files identified by the unique RDS number in the header record. Using the VDSA process, the RDS Contractor will pass back each file of 100 response records as they complete processing.

Q10: In using a quarterly VDSA feed, will the employer be entitled to subsidy payments monthly, or will quarterly be the most frequent payment option?

A10: We accept the Non-MSP feed, which is the file that contains drug subsidy records, on a monthly basis. Please refer to the RDS Center for payment schedule options.

Q11: Should we expect to receive a monthly <u>Unsolicited</u> Response File from RDS via the VDSA Non-MSP Response Process/Format?

A11: Yes. When RDS begins sending unsolicited responses, we will too. Check with the RDS Center directly for more information.

Q12: Will the unsolicited response come to us only in the VDSA <u>quarterly</u> file process, or could we receive miscellaneous monthly response files when the RDS Start or End Dates are changed.

A12: We are planning to send the unsolicited responses out on a monthly basis even if your normal VDSA submissions are quarterly. Plan sponsors sending in their retiree files via VDSA will get the unsolicited notifications. You will get these

notices through the VDSA process using the same response file format as in the retiree responses that were "solicited." We will use reason codes to indicate what has changed.

Q13: Do you know if Congress extended the MSP laws to the new RDS program?

A13: No, the MSP laws do not extend to the new RDS program, because beneficiaries enrolled in the RDS program are not enrolled in Medicare Part D. MSP laws are not applicable when the beneficiary is not receiving a Medicare benefit.

Q14: I am an employer claiming the RDS for a retiree beneficiary. The retiree tries to enroll in Part D, and is rejected as a current subsidy beneficiary. The retiree then enrolls in Part D anyway. How do I learn this?

A14: You will receive notification directly from the RDS Center that the retiree tried to enroll in Part D and was initially rejected. You will also receive the notification from the RDS Center when the retiree overrides the initial rejection and signs up for Part D. Use the data in these notifications and update your internal files accordingly.

Q15: The CMS says that if a beneficiary signs up for Part D but also appears to have employee drug coverage, CMS will notify the employer. Does that happen in a way not connected to the RDS feed? Would that happen with a VDSA?

A15: Everything that the RDS Center offers is available to an employer whether the employer reports enrollment information to RDS directly or uses a VDSA. In either case, all employers claiming the retiree drug subsidy will be notified by the RDS contractor via e-mail when someone enrolls in Part D. However, one of the additional benefits of using the VDSA is that it allows for a query of Parts A, B, and D entitlement information between regular submissions, using our telecommunications application called BASIS. (See Section VI, Page 73.) RDS data alone does not provide you with that level of detail.

Q16: We are planning to continue to offer pharmacy benefit coverage to our post-age 65 retirees and will be applying for the employer subsidy. In doing so, we will need to supply claims data to CMS. Do you have information regarding the data requirements that will be needed for this task?

A16: Please visit http://rds.cms.hhs.gov/ for more information regarding submission of Subsidy claims data. The Retiree Drug Subsidy contractor is not the Medicare Coordination of Benefits contractor that is responsible for the administration of the VDSA program, but the two contractors work together exchanging enrollment information to support the RDS contractor's responsibilities.

Q17: We are an insurer who will soon be offering to submit Enrollment files to the RDS Center on behalf of many of our plan sponsors (employers). Although we won't be able to submit their files on their behalf immediately, should plan sponsors still check the VDSA block on their application or should they check whatever method is being utilized for submission of the original retiree list and then modify the information later?

A17: Plan sponsors should check what method they will use initially, and then modify the application later when their insurer is ready to submit enrollment files on their behalf.

Q18: What if an employer wants to switch from using the RDS Web portal to using the VDSA process?

A18: This is OK. The employer GHP will make the change in their Application documentation on the RDS Secure Website. After the employer makes the necessary change, you would work out the technical data transmission details with the VDSA contractor and begin file transfers using the VDSA process.

Q19: Can you please confirm that the payment request information can not be sent via the VDSA, so plan sponsors will still need to select another method for transmitting this information?

A19: Yes. The VDSA process can only be used to submit monthly or quarterly enrollment files to the RDS Center. All other data must be exchanged through the RDS Center's Web portal. In particular, at the Web portal review "How To...Manage Payment Information."

Q20: If I can only submit enrollment files to the RDS Center via the VDSA and will still have to submit other information to the RDS Center via their Web portal, why should I use the VDSA process?

A20: The VDSA process allows for complete and timely coordination of benefits with all members of your health plans, working or retired. Enrollment files submitted to the RDS Center via the VDSA process are returned to the submitter with valuable Medicare Parts A, B and D entitlement data that the RDS Center cannot provide via its Web portal. Through a mutual exchange of health plan coverage data for Medicare entitlement information, claims can be processed correctly the first time, thus eliminating many of the administrative expenses associated with dispute resolution and follow-up.

Q21: What are the benefits of submitting the Non-MSP file every month versus every quarter?

A21: Many entities using a VDSA to move enrollment files to the RDS contractor may wish to submit on a short turnaround, so that they can receive RDS payments on a

sooner basis. Others may wish to receive Medicare entitlement data on a frequent basis. These partners can choose to submit Non-MSP Files monthly. Conversely, there are VDSA partners that will want to have a longer time to evaluate Non-MSP Response Files and more time to build their next submission files. They may be concerned that the extra resources needed to perform a monthly exchange will be cost prohibitive, or that rushing to meet a monthly deadline may produce erroneous or incomplete data. They can choose to submit Non-MSP files on a quarterly basis.

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

Q22: The "Description" for Field 14 of the Non-MSP Input file – Rx Group Number – states that this field is required with action types 'D' and 'S.' What if we don't use an Rx Group Number?

A22: As stated in the "Description" for that Field in the record layout, the RDS Center requires this field be populated with the "Unique Benefit Identifier," and has instructed employers to make up a number for this field, if necessary, to allow the record to process at the RDS Center. Please contact the RDS Center for additional information.

Q23: If we receive a Disposition Code stating that a beneficiary is not entitled to Medicare, does this mean that RDS found the beneficiary in the Medicare Beneficiary Database (MBD), but that they are not currently entitled to Part D, as opposed to the reason "Beneficiary Record Not Found"?

A23: "Not Entitled" means the retiree was found on the MBD, but was not entitled to Medicare benefits during the identified coverage period. "Not Found" means the retiree could not be found on the MBD at all and that there is no record of the person ever having had Medicare or that we couldn't find them because the SSN or HICN you provided did not match the personal characteristics (Name, DOB, Sex) provided on your Input record.

Q24: Please provide internet resources I can go to for more information about the Retiree Drug Subsidy program.

A24: The RDS Center has a web site at:

http://rds.cms.hhs.gov/

This is the primary internet address for the RDS Center. You may also call 1-800-737-4357.