

November 23, 2010

HIV/AIDS Bureau

Dear Ryan White HIV/AIDS Program Grantees:

The Affordable Care Act, Public Law 111-148, changed which out-of-pocket expenses count towards the Medicare Part D annual out-of-pocket threshold. Beginning January 1, 2011, AIDS Drug Assistance Programs (ADAPs) will become what the Centers for Medicare and Medicaid Services (CMS) refer to as “TrOOP (True-Out-Of-Pocket) eligible payers.”

Medicare Part D Plan sponsors will be required to include Ryan White HIV/AIDS Part B ADAP expenditures covered for Part D drugs towards the TrOOP limit of Medicare Part D enrollees.

Consequently, ADAP clients who are Medicare Part D enrollees will now be able to move through the coverage gap phase into the catastrophic coverage phase when Part D covered drugs will be available at a nominal cost (e.g., copayments of \$2.50 or \$6.30 or 5 percent coinsurance, whichever is greater). Prior to this change, it was difficult, if not impossible, for ADAP members to reach the catastrophic phase.

The Affordable Care Act changes will allow ADAPs to calculate individual client costs that can offset the Program, and the expenditures counting towards TrOOP will be different from State to State. Medicare Part D Plans are required to coordinate benefits with other providers of prescription drug coverage, such as ADAPs, as long as the payer participates in the online coordination of benefits (COB) process. TrOOP calculations will automatically happen at the time other payer claims are adjudicated at the pharmacy or point-of-sale by using the TrOOP Facilitation Contractor. This CMS process is already utilized by some ADAPs because of the infrastructure utilized for State Pharmacy Assistance Programs (SPAPs) and other secondary payers for Medicare Part D.

Payments for incurred costs during the coverage gap must be for covered Part D drugs and paid for by a TrOOP eligible payer such as a Part B ADAP under Part B of Title XXVI of the Public Health Service Act. These costs must be flagged as being from ADAP to ensure they are counted for TrOOP. This new provision in the Affordable Care Act treats ADAP funds the same as assistance provided by SPAPs. To ensure ADAP expenses are accurately accounted for in the TrOOP calculation, the ADAPs must participate in data sharing with the CMS COB contractor. In order to participate in the COB process, ADAPs must sign a data sharing agreement with CMS and submit electronic enrollment files with specific information that will be provided to the TrOOP facilitation contractor. The enrollment file must include a unique identification number or RxBIN/Processor Control Number for Medicare Part D enrollees. The specific steps ADAPs need to take are further explained in the enclosed letter from CMS.

Counting ADAP as TrOOP will get Medicare beneficiaries through the coverage gap phase of the Part D benefit more quickly, while allowing ADAP's limited resources to be used more effectively. We understand the importance of this provision to both Program Grantees and beneficiaries and encourage all ADAPS to develop the data systems necessary to take advantage of Part D TrOOP process in 2011. In order to help answer your questions and ensure a timely understanding of the changes, in the following weeks, the HIV/AIDS Bureau, in collaboration with CMS, will schedule a Webinar session for all Part B Grantees and ADAPs. This session will present the changes related to TrOOP and the specific technical requirements for participation.

Enclosed is a letter from CMS that includes specific technical information to the grantees, including the ADAP Data Sharing Agreement User's Guide and frequently asked questions. If you have additional questions, please contact your project officer.

Sincerely,

Deborah
Assistant
Associate

Parham Hopson, PhD, RN, FAAN
Surgeon General
Administrator

Enclosure

Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850



CENTER FOR MEDICARE

Deborah Parham Hopson, PhD, RN, FAAN
Assistant Surgeon General
Associate Administrator HIV/AIDS Bureau
Health Resources and Services Administration

Dear Dr. Parham:

This letter provides instructions for AIDS Drug Assistance Programs (ADAPs) to ensure Part D sponsors properly track their members' true out-of-pocket (TrOOP) drug costs in accordance with section 3314 of the Affordable Care Act. Section 3314 of Affordable Care Act amended 1860D–2(b)(4)(C) of the Social Security Act (the Act) to treat ADAP drug costs as incurred costs for the purpose of applying the TrOOP limit.

These instructions will familiarize ADAPs with the Part D coordination of benefit (COB) and TrOOP facilitation real-time and batch processes. While ADAPs may adopt either approach (batch or real-time), the Centers for Medicare & Medicaid Services (CMS) highly recommends that ADAPs consider processing their Part D secondary claims in real-time at the point-of-sale (pharmacy), if they have not already done so. When ADAPs process claims at the point-of-sale, Part D sponsors are mandated by Federal statute and regulation to automatically adjust ADAP claims as a result of retroactive changes to Part D primary claims (e.g., changes to a member's Federal low-income subsidy status). In other words, ADAPs that choose not to participate in the real-time COB process will have to pursue collection of any overpaid cost sharing instead of the Part D sponsor automatically refunding overpaid amounts.

Part D policy guidance related to the COB and TrOOP processes is detailed in regulation at 42 CFR 423.100 and 423.464, as well as Chapters 5 and 14 of the Medicare Prescription Drug Benefit Manual. CMS is currently updating the regulation to address the new ADAP policies.

Overview of the Medicare Prescription Drug Benefit (Part D) TrOOP Policy

The Medicare Prescription Drug Program (Part D) requires contracted sponsors of Part D plans to provide “qualified prescription drug coverage” to enrolled members. Regardless of the benefit structure utilized by the Part D sponsor to administer the qualified prescription drug coverage to its enrolled members, the sponsor is required to apply an annual out-of-pocket spending threshold (i.e., TrOOP limit) as part of the benefit. Once a beneficiary's TrOOP limit is met, the beneficiary enters the catastrophic coverage phase of the benefit and his/her covered Part D prescription drug costs are significantly reduced. Also, the Federal government subsidizes most

of the prescription drug claims during the catastrophic coverage stage, net the member's nominal cost sharing. For purposes of determining when a beneficiary meets this threshold, the Part D sponsor must track each member's unsubsidized spending or "true out-of-pocket" (TrOOP) costs against the TrOOP limit. In CY 2011, a beneficiary enters the catastrophic coverage stage when he/she incurs \$4,550 in TrOOP costs.

Prior to January 1, 2011, the costs that counted towards a beneficiary's TrOOP limit included those costs incurred by the beneficiary (or "person" on his/her behalf, including, for example, a family member or charity), costs of the Federal low-income subsidy, and costs incurred by state pharmaceutical assistance programs (SPAPs). These incurred costs must be for covered Part D drugs (Part D drugs included on the plan's formulary or treated as being included in a plan's formulary as a result of a coverage exception or appeal) and paid for by the beneficiary or a TrOOP-eligible entity or payer. Section 3314 of the Affordable Care Act amended 1860D–2(b)(4)(C) of the Act to treat the following costs as incurred costs for the purpose of applying TrOOP:

- Costs borne or paid by the Indian Health Service (IHS), an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or,
- Costs borne or paid for under an AIDS Drug Assistance Program (ADAP) under part B of title XXVI of the Public Health Service Act. CMS instructed Part D sponsors to begin updating their systems to ensure that TrOOP accumulators appropriately account for these costs beginning January 1, 2011.

TrOOP Accumulation and Coordination of Benefit (COB) Process in Real-Time

To assist Part D sponsors with correctly calculating the TrOOP amount for its members, CMS contracted with RelayHealth, a pharmacy switch, to facilitate the transfer of supplemental payer claim information to Part D sponsors. The primary function of the TrOOP facilitation contractor is to identify patient paid amounts remaining after other payers have wrapped around Part D claims so that Part D sponsors can identify these costs and accumulate TrOOP correctly for each of their members.

For the TrOOP facilitation process to work properly, Part D sponsors (or their processors), other payers, pharmacy switches (claims routers), and the TrOOP facilitator must interact to accurately track a patient's TrOOP costs in real-time. To ensure ADAP costs are accurately accounted for in the TrOOP calculation, and to permit ADAPs to automatically receive refunds due to retroactive adjustments to claims (e.g., as the result of changes in a member's low-income subsidy status), CMS highly encourages the ADAP to participate in real-time electronic claims processing. ADAPs must also sign a data sharing agreement with CMS and submit electronic enrollment files to CMS' COB contractor with specific information that will be provided to the TrOOP facilitation contractor. Each ADAP enrollment file must include a **unique** RxBIN or RxBIN/Processor Control Number (PCN) combination for its Medicare Part D enrollees. It is the unique RxBIN or RxBIN/PCN combination that allows the pharmacy switch to route the

ADAP secondary claims data to the TrOOP facilitator, who then provides this information to the Part D sponsors.

Using more technical terms, pharmacy claims to payers are transmitted via “B” transactions. These B transactions are submitted electronically by the pharmacy to their switch. The pharmacy switch forwards to the TrOOP facilitator the B transactions that are not rejected by the secondary payer and that contain a unique RxBIN or RxBIN/PCN combination for a plan that covers Medicare Part D beneficiaries. This identifier is the flag that pharmacy switches use to route the data to the TrOOP facilitator. The TrOOP facilitator uses the information contained in the B transaction to trigger the creation of a reporting transaction (N transaction) and delivers the N transaction to the Part D sponsor. All claims submitted to other payers must be processed through a pharmacy switch so that the pharmacy switch can deliver the transactions to the TrOOP facilitator enabling accurate TrOOP reporting at the Part D sponsor. An illustration of this process is provided in Attachment 1.

TrOOP Facilitator Batch Process

In order for the COB and TrOOP tracking processes to function as effectively as possible, ADAPs need to supply paid claims information to the Part D sponsor after making a payment that is supplemental to a Medicare payment. This will happen automatically if the ADAP participates in the real-time claims adjudication process and reports their coverage information to CMS in accordance with the processes above.

However, if the ADAP does not have electronic claims processing capability, the ADAP may alternatively submit a batch file of supplemental claims information or make arrangements to submit information in another format to the TrOOP facilitator. The supplemental claims data submitted to the TrOOP facilitator will then be supplied to Part D sponsors for TrOOP calculation. If the ADAP uses the batch process, it must still establish a unique RxBIN/PCN and participate in the data sharing exchange with CMS’ COB contractor. If the ADAP does not either support the on-line or batch process, no N transaction will be created and Part D sponsors will not be required to coordinate benefits if the claim(s) later adjust.

Further information on the batched claims process is available on the TrOOP facilitator’s website https://medifacd.relayhealth.com/Payers/MediFacD_TroopPayers.htm. Choose “Establish Batch Account” under the drop down menu.

Steps to Ensure Proper TrOOP Calculation for Part D ADAP Members

Below are the steps that should be taken by the ADAP in order to fully participate in the COB and TrOOP facilitation process:

1. Consider obtaining the services of an on-line claims processor to process claims electronically at the point-of-sale. **(Not required for batch TrOOP facilitation process)**

Obtaining services of a processor or Pharmacy Benefit Manager (PBM) for real-time claims adjudication is not a requirement to ensure TrOOP is calculated correctly, and CMS understands that for some ADAPs, the expense of a processor or setting up a system for real-time claims adjudication may not be worth it, especially for smaller ADAPs. However, Pharmacy Benefit Managers (PBMs) or processors are extremely knowledgeable about the point-of-sale, real-time claims adjudication process. These organizations likely participate on industry workgroups such as the National Council for Prescription Drug Programs (NCPDP) to ensure electronic claims process industry standards are followed. They will also provide the needed assistance to ensure TrOOP facilitation and claims reconciliation is performed correctly as part of the real-time process. If your ADAP would like to pursue real-time claims adjudication, we suggest the ADAP contact its State Medicaid agency or SPAP to find out if your program can contract with the same processor. The ADAP may also consult the Pharmaceutical Care Management Association (PCMA) or Pharmacy Benefit Management Institute (PBMI) for a list of member PBMs/processors.

2. Sign a data sharing agreement (DSA) and participate in the COB enrollment file exchange with CMS's COB contractor. **(Required for TrOOP facilitation)**

ADAPs are required to sign a data sharing agreement (DSA) and follow the instructions contained in the attached user guide when participating in the COB enrollment data file exchange. The information the ADAP provides via its enrollment file to the COB contractor, in particular, the unique RxBIN or RxBIN/PCN, is sent to both the TrOOP facilitator and the Part D sponsors. The DSA and User Guide are found in Attachments 2 and 3.

3. Establish a unique RxBIN or RxBIN/PCN combination for their Part D members and submit this information as part of the COB contractor enrollment file exchange. **(Required for TrOOP facilitation)**

As explained above, the unique RxBIN/PCN allows the claim to be routed to the TrOOP facilitator so that the TrOOP facilitator may build an "N" transaction which will provide the Part D sponsor with the supplemental payer information that is necessary to calculate TrOOP correctly.

4. Ensure that the ADAP or its processor, when processing secondary claims, accepts and processes only those claims that use the same 4Rx information submitted on the ADAP's input file (4Rx – BIN/PCN/Group ID/Member ID) to the COB contractor. **(Required for TrOOP facilitation)**

CMS found that when SPAPs accepted and processed claims using only some of the 4Rx information submitted on their input file to the COB contractor file, the Part D sponsor was unable calculate TrOOP correctly.

If the ADAP grantees have any questions regarding the TrOOP facilitation process, do not hesitate referring them to one of the individuals below:

Christine Hinds (TrOOP policy) (410)786-4578 or christine.hinds@cms.hhs.gov

Bill Decker (COB Data Sharing Agreement and Enrollment file exchange) (410)786-0125 or william.decker@cms.hhs.gov

Reynold Mercado (COB Contractor – GHI) 646-458-6797 or mercado@ehmedicare.com

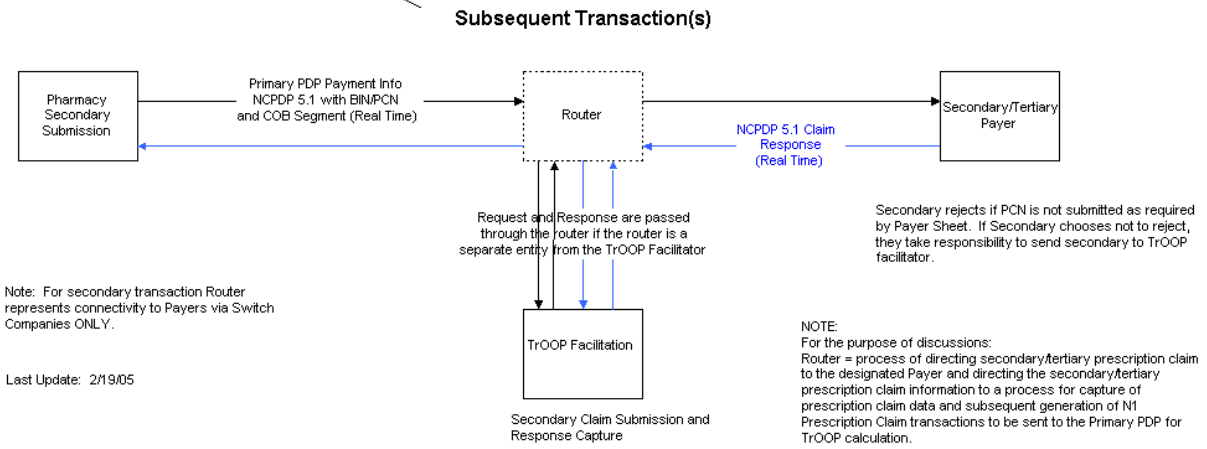
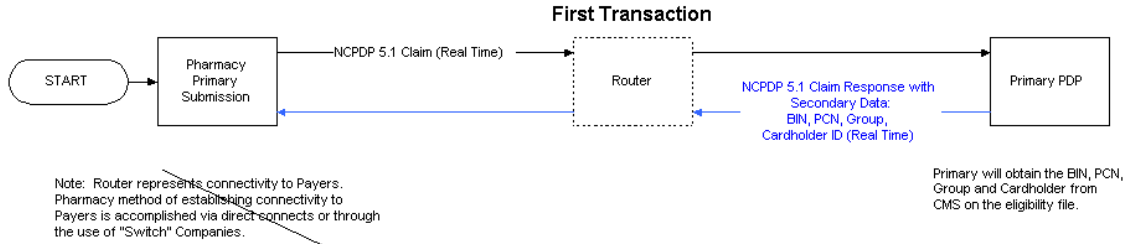
Sincerely,

Cynthia

G. Tudor, Ph.D.,
Director
Medicare Drug Benefit and C&D Data Group

Attachment 1

NCPDP v5.1 B1 Transaction Flow



ADAP DATA SHARING AGREEMENT
Supplemental Drug Program Data Sharing
USER GUIDE

For Use by State AIDS Drug Assistance Programs (ADAPs)

Version Effective Date:
July 12, 2010

INTRODUCTION

This ADAP Data Sharing Agreement **USER GUIDE** is the body of information and instructions state AIDS Drug Assistance Programs (ADAPs) will find useful as they implement and manage the information sharing process with CMS. In particular, the ADAP Data Sharing Agreement (DSA) and the information in this document will allow ADAPs to coordinate Medicare Part D drug benefit coverage with CMS under the terms of the Medicare Modernization Act (MMA).

PERIODICALLY, THE INFORMATION PROVIDED IN THIS USER GUIDE WILL CHANGE. As current requirements are refined and new processes developed, our ADAP partners will be provided with new and up-to-date sections of this Guide. These updated versions should replace any older versions of the Guide that you might have. Please contact the CMS should you have any questions regarding this User Guide.

If you would like more general information about the current ADAP data exchange process, please E-mail william.decker@cms.hhs.gov. Remember to provide us with the E-mail address, phone number and other contact information for any individuals you would like to have added to our distribution list.

RECENT CHANGES: Updates to this edition of the User Guide

- We have revised this DSA throughout to reflect all ADAP DSA requirements current as of July, 2010.
- We have updated the section titled Contact Protocol for Data Exchange Problems; Page 21.

SECTION A: COMPLETING AND SIGNING AN ADAP DSA

Before the CMS – ADAP relationship can become operational, the potential ADAP Data Sharing Agreement partner and CMS have to sign and exchange completed copies of the ADAP Data Sharing Agreement (DSA). This section has the instructions for completing an ADAP DSA for signature.

The DSA signature package consists of two documents: The DSA itself, and the ADAP DSA *Implementation Questionnaire*. The DSA partner will return three signed copies of the DSA and one completed copy of the Implementation Questionnaire to CMS. CMS will not consider an ADAP DSA to be in force until the DSA partner has provided CMS with a completed copy of the Implementation Questionnaire. The ADAP DSA will be countersigned by CMS and a completed copy will be returned to the new DSA partner. Further DSA implementation procedures will also be provided at that time.

1. In the first paragraph on Page 1 of the ADAP DSA, insert all of your specific identifying information where indicated. The date that the partner completes the signature process will be entered here, and will be the “Effective Date.” However, if you wish, the date you enter may be prospective or retroactive. For example, some ADAP DSA partners prefer to enter the first day of the month in which they expect the DSA to be signed. But bear in mind that if you enter a prospective date, CMS cannot begin full implementation of the DSA until we reach it.
2. Enter the date that is requested on Page 4 of the ADAP DSA, in Section C, 1. This is the starting date for health plan enrollment information that is entered on the first regular production Initial Input File you provide to CMS.
3. On Page 9, in Section M, enter the ADAP partner’s Administrative and Technical contact information.
4. Page 9, Section N: Upon receipt of an ADAP DSA 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 of the Implementation Questionnaire, Attachment C, insert the partner’s business name.

To avoid unnecessary processing delays, we strongly recommend that you use an overnight delivery service and send your signed ADAP Data Sharing Agreement copies and the Implementation Questionnaire to:

William F. Decker
Centers for Medicare and Medicaid Services
Office of Financial Management
Division of Medicare Benefit Coordination
Mail Stop: C3-14-16
7500 Security Boulevard

SECTION B: THE ADAP DATA FILES – Standard Reporting Information

The CMS has contracted with GHI, Inc. in New York City to provide technical support for all of the data sharing partnership agreements CMS has entered into. GHI has been designated the DSA Coordination of Benefits Contractor (COBC). ADAP partners will be exchanging data files with the COBC directly, while CMS will remain responsible for overall DSA program management.

Standard Data Files: The data exchanged through the ADAP process is arranged in two different file formats (sometimes referred to as record layouts). An ADAP partner electronically transmits a data file to the COBC. This *input file* is the method through which the ADAP data sharing partner will submit its covered ADAP enrollee population. The COBC processes the data in this *input file*, then at a prescribed time electronically transmits a *response file* to the partner. The response file to the partner will contain Medicare Part D enrollment information for all ADAP enrollees who also have Part D.

Current versions of the Standard Data Files immediately follow. Once again we remind you that details of the information provided here are likely to change from time to time. You will be notified of any changes.

I. The Input and Response File Data Layouts

The ADAP Input File: This is the data set transmitted from an ADAP partner to the COBC on a monthly basis. It is used to report information regarding the ADAP enrollees – people who are eligible for and enrolled in an ADAP and receive coverage through such a program. We use *full file replacement* as the method to update eligibility files. Each month’s Input File from the ADAP will fully replace the previous month’s file. The business rules for use of the ADAP Input File immediately follow the data file layout itself.

Table 1: ADAP Input File Layout

ADAP Input File Layout for Part D – 249 bytes					
Field	Name	Size	Displacement	Data Type	Description
1.	SSN	9	1-9	Numeric	Social Security Number – Required Populate with spaces if unavailable.
2.	HIC N	12	10-21	Alpha-Numeric	Medicare Health Insurance Claim Number Required if SSN not provided. Populate with spaces if unavailable.
3.	Surname	6	22-27	Text	Surname of Covered Individual - Required

ADAP Input File Layout for Part D – 249 bytes					
Field	Name	Size	Displacement	Data Type	Description
4.	First Initial	1	28-28	Text	First Initial of Covered Individual - Required
5.	DOB	8	29-36	Date	Date of Birth of Covered Individual - Required CCYYMMDD
6.	Sex Code	1	37-37	Numeric	Sex of Covered Individual - Required 0: Unknown 1: Male 2: Female
7.	Effective Date	8	38-45	Date	Effective Date of ADAP Coverage - Required CCYYMMDD
8.	Termination Date	8	46-53	Date	Termination Date of ADAP Coverage - Required CCYYMMDD – Use all zeros if open-ended
9.	NPlanID	10	54-63	Filler	Future use for National Health Plan Identifier. Fill with spaces only
10.	Rx ID/Policy Number	20	64-83	Text	Covered Individual Pharmacy Benefit ID for ADAP Rx ID Required if Coverage Type = U Policy Number Required if Coverage Type = V
11.	Rx Group	15	84-98	Text	ADAP Pharmacy Benefit Group Number
12.	Part D RxPCN	10	99-108	Text	Part D specific ADAP Pharmacy Benefit Processor Control Number
13.	Part D RxBIN	6	109-114	Text	Part D specific ADAP Pharmacy Benefit International Identification Number. Required when Coverage Type (Field 16) = U
14.	Toll-Free Number	18	115-132	Text plus “(“ and “)”	Pharmacy Benefit Toll-Free Number
15.	Document Control Number	15	133-147	Text	Document Control Number, Assigned by ADAP - Required
16.	Coverage Type	1	148-148	Alpha-Numeric	Coverage Type Indicator - Required U: Network (electronic, point-of-sale benefit) V: Non-Network (other type of benefit)

ADAP Input File Layout for Part D – 249 bytes					
Field	Name	Size	Displacement	Data Type	Description
17.	Insurance Type	1	149-149	Alpha-Numeric	Insurance Type - Required N: Non-qualified State Program O: Other P: PAP Q: SPAP (Qualified – Send LIS Data) R: Charity S: ADAP
18.	Filler	100	150-249	Alpha-Numeric	Unused Field Fill with spaces only
<i>HEADER RECORD – All fields required</i>					
1.	Header Indicator	2	1-2	Alpha-Numeric	Should be: ‘H0’
2.	AD AP-ID	5	3-7	Alpha-Numeric	ADAP Identifier
3.	Contractor Number	5	8-12	Alpha-Numeric	Should be: ‘S0000’
4.	File Date	8	13-20	Date	CCYYMMDD
5.	Filler	229	21-249	Alpha-Numeric	Unused Field Fill with Spaces.
<i>TRAILER RECORD – All fields required</i>					
1.	Trailer Indicator	2	1-2	Alpha-Numeric	Should be: ‘T0’
2.	AD AP-ID	5	3-7	Alpha-Numeric	ADAP Identifier
3.	Contractor Number	5	8-12	Alpha-Numeric	Should be: ‘S0000’
4.	File Date	8	13-20	Date	CCYYMMDD
5.	Record Count	9	21-29	Numeric	Number of records on file
6.	Filler	220	30-249	Alpha-Numeric	Unused Field Fill with Spaces.

The ADAP Response File: This is the data set transmitted from the COBC to the ADAP partner after the information supplied in the partner’s ADAP Input File has been processed by the COBC. It consists of the same data elements in the Input File, with any corrections applied, and disposition and edit codes which let you know what we did with the record. The response will also contain new information for the partner regarding the submitted ADAP enrollees, including Medicare enrollment information if an ADAP client is found on the Medicare database.

Table 2: ADAP Response File Layout

ADAP Response File Layout for Part D – 417 bytes					
Field	Name	Size	Displacement	Data Type	Description
1.	SSN	9	1-9	Alpha-Numeric	Social Security Number
2.	HIC N	12	10-21	Alpha-Numeric	Medicare Health Insurance Claim Number
3.	Su rname	6	22-27	Alpha-Numeric	Surname of Covered Individual
4.	First Initial	1	28-28	Alpha-Numeric	First Initial of Covered Individual
5.	D OB	8	29-36	Alpha-Numeric	Date of Birth of Covered Individual CCYYMMDD
6.	Sex Code	1	37-37	Alpha-Numeric	Sex of Covered Individual 0: Unknown 1: Male 2: Female
7.	Ef fective Date	8	38-45	Alpha-Numeric	Effective Date of ADAP Coverage CCYYMMDD
8.	Term ination Date	8	46-53	Alpha-Numeric	Termination Date of ADAP Coverage CCYYMMDD *All zeros if open-ended
9.	NPI anID	10	54-63	Alpha-Numeric	Future use for National Health Plan Identifier
10.	R x ID	20	64-83	Alpha-Numeric	Covered Individual Pharmacy Benefit ID for ADAP
11.	R x Group	15	84-98	Alpha-Numeric	ADAP Pharmacy Benefit Group Number
12.	Part D RxPCN	10	99-108	Alpha-Numeric	Part D specific ADAP Pharmacy Benefit Processor Control Number
13.	Part D RxBIN	6	109-114	Alpha-Numeric	Part D specific ADAP Pharmacy Benefit International Identification Number
14.	Toll-Free Number	18	115-132	Alpha-Numeric	Pharmacy Benefit Toll-Free Number
15.	Ori ginal Document Control Number	15 1	33-147	Alpha-Numeric	Document Control Number, Assigned by ADAP
16.	COBC Document Control Number	15 1	48-162	Alpha-Numeric	Document Control Number Assigned by COBC

ADAP Response File Layout for Part D – 417 bytes					
Field	Name	Size	Displacement	Data Type	Description
17.	Coverage Type	1	163-163	Alpha-Numeric	Coverage Type Indicator U: Network (Electronic, Point-of-Sale Benefit) V: Non-Network (Other type of Benefit)
18.	Insurance Type	1	164-164	Alpha-Numeric	N: Non-qualified State Program O: Other P: PAP Q: SPAP (Qualified – Send LIS Data) R: Charity S: ADAP
19.	Rx Current Disposition Code	2	165-166	Alpha-Numeric	Rx Result (Action taken by COBC)
20.	Current Disposition Date	8	167-174	Alpha-Numeric	Date of Rx Result (CCYYMMDD)
21.	Edi t Code 1	4	175-178	Alpha-Numeric	Error Code
22.	Edi t Code 2	4	179-182	Alpha-Numeric	Error Code
23.	Edi t Code 3	4	183-186	Alpha-Numeric	Error Code
24.	Edi t Code 4	4	187-190	Alpha-Numeric	Error Code
25.	Part D <i>Eligibility Start Date</i>	8	191-198	Alpha-Numeric	Earliest Date that Beneficiary is eligible to enroll in Part D. Refer to Field 46 for Part D Plan <i>Enrollment Date</i> CCYYMMDD
26.	Part D <i>Eligibility Stop Date</i>	8	199-206	Alpha-Numeric	Date Beneficiary is no longer eligible to receive Part D Benefits – Refer to Field 47 for Part D <i>Plan Termination Date</i> CCYYMMDD
27.	Medicare Beneficiary Date of Death	8	207-214	Alpha-Numeric	Medicare Beneficiary Date of Death CCYYMMDD
28.	Filler	8	215-222	Alpha-Numeric	Unused Field
29.	Filler	8	223-230	Alpha-Numeric	Unused Field
30.	Filler	3	231-233	Alpha-Numeric	Unused Field

ADAP Response File Layout for Part D – 417 bytes					
Field	Name	Size	Displacement	Data Type	Description
31.	Filler	8	234-241	Alpha-Numeric	Unused Field
32.	Filler	1	242-242	Alpha-Numeric	Unused Field
33.	Filler	1	243-243	Alpha-Numeric	Unused Field
34.	Filler	1	244-244	Alpha-Numeric	Unused Field
35.	Filler	1	245-245	Alpha-Numeric	Unused Field
36.	Filler	1	246-246	Alpha-Numeric	Unused Field
37.	Filler	1	247-247	Alpha-Numeric	Unused Field
38.	Filler	1	248-248	Alpha-Numeric	Unused Field
39.	Filler	1	249-249	Alpha-Numeric	Unused Field
40.	Filler	1	250-250	Alpha-Numeric	Unused Field
41.	Filler	1	251-251	Alpha-Numeric	Unused Field
42.	Filler	2	252-253	Alpha-Numeric	Unused Field
43.	Filler	9	254-262	Alpha-Numeric	Unused Field
44.	Filler	8	263-270	Alpha-Numeric	Unused Field
45.	Current Medicare Part D Plan Contractor Number	5	271-275	Alpha-Numeric	Contractor Number of the Current Part D Plan in which the Beneficiary is Enrolled
46.	Current Part D Plan Enrollment Date	8	276-283	Alpha-Numeric	Effective Date of Coverage Provided by Current Medicare Part D Plan CCYYMMDD
47.	Current Part D Plan Termination Date	8	284-291	Alpha-Numeric	Termination Date of Coverage Provided by Current Medicare Part D Plan CCYYMMDD
48.	Filler	8	292-299	Alpha-Numeric	Unused Field

ADAP Response File Layout for Part D – 417 bytes					
Field	Name	Size	Displacement	Data Type	Description
49.	Filler	8	300-307	Alpha-Numeric	Unused Field
50.	Filler	2	308-309	Alpha-Numeric	Unused Field
51.	Filler	2	310-311	Alpha-Numeric	Unused Field.
52.	PBP	3	312-314	Alpha-Numeric	Part D Plan Benefit Package (PBP)
53.	Filler	3	315-317	Alpha-Numeric	Unused Field
54.	Filler	1	318	Alpha-Numeric	Unused Field
55.	Filler	99	319-417	Alpha-Numeric	Unused Field.
HEADER RECORD					
1.	Header Indicator	2	1-2	Alpha-Numeric	Should be: 'H0'
2.	AD AP-ID	5	3-7	Alpha-Numeric	ADAP Identifier
3.	Contractor Number	5	8-12	Alpha-Numeric	Should be: 'S0000'
4.	File Date	8	13-20	Alpha-Numeric	CCYYMMDD
5.	Filler	397	21-417	Alpha-Numeric	Unused Field
TRAILER RECORD					
1.	Trailer Indicator	2	1-2	Alpha-Numeric	Should be: 'T0'
2.	AD AP ID	5	3-7	Alpha-Numeric	ADAP Identifier
3.	Contractor Number	5	8-12	Alpha-Numeric	Should be: 'S0000'
4.	File Date	8	13-20	Alpha-Numeric	CCYYMMDD
5.	Record Count	9	21-29	Alpha-Numeric	Number of records on file
6.	Filler	388	30-417	Alpha-Numeric	Unused Field

Data Type Key

Conventions for Describing Data Values. The table below defines the data types used by the COBC for its external interfaces (inbound and outbound). The formatting standard defined for each data type corresponds to the data type identified for each field within the interface layout.

This key is provided to assist in the rules behind the formatting of data values contained within layout fields for ADAP Data Exchange Layouts.

Table 3: Data Type Key

Data Type / Field	Formatting Standard	Examples
Numeric	<ul style="list-style-type: none"> • Zero through 9 (0 → 9) • Padded with leading zeroes • Populate empty fields with spaces 	<ul style="list-style-type: none"> • Numeric (5): "12345" • Numeric (5): "00045" • Numeric (5): " "
Alpha	<ul style="list-style-type: none"> • A through Z • Left justified • Non-populated bytes padded with spaces 	<ul style="list-style-type: none"> • Alpha (12): "TEST EXAMPLE" • Alpha (12): "EXAMPLE "
Alpha-Numeric	<ul style="list-style-type: none"> • A through Z (all alpha) + 0 through 9 (all numeric) • Left justified • Non-populated bytes padded with spaces 	<ul style="list-style-type: none"> • Alphanumeric (8): "AB55823D" • Alphanumeric (8): "MM221 "
Text	<ul style="list-style-type: none"> • Left justified • Non-populated bytes padded with spaces • A through Z (all alpha) + 0 through 9 (all numeric) + special characters: • Comma (,) • Ampersand (&) • Space () • Dash (-) • Period (.) • Single quote (') • Colon (:) • Semicolon (;) • Number (#) • Forward slash (/) • At sign (@) 	<ul style="list-style-type: none"> • Text (8): "AB55823D" • Text (8): "XX299Y " • Text (18): "ADDRESS@DOMAIN.COM" • Text (12): "800-555-1234" • Text (12): "#34 "
Date	<ul style="list-style-type: none"> • Format is field specific • Fill with all zeroes if empty (no spaces are permitted) 	CCYYMMDD (e.g. "19991022") Open ended date: "00000000"
Filler	<ul style="list-style-type: none"> • Populate with spaces 	
Internal Use	<ul style="list-style-type: none"> • Populate with spaces 	
Above standards should be used unless otherwise noted in layouts		

II. The ADAP Data Exchange Process

The information following describes the data review process used by the Coordination of Benefits Contractor (COBC).

ADAP Processing Requirements

1. The System shall be able to receive an external file from an ADAP via Secure File Transfer Protocol (FTP) or a dedicated T-1 line (AGNS).
2. The System shall be able to confirm the external ADAP file format.
3. The System shall check enrollee records received on the ADAP file for the mandatory fields.
4. The System shall match enrollee records received on the ADAP file to the Benefits Master Table.
5. The System shall be able to provide information pertaining to all prescription drug coverage information for Part D beneficiaries as stored on the Part D database (the MBD).
6. The System shall be able to create and transmit a file for the MBD containing ADAP enrollees with their specific Part D plan information.
7. The system shall be able to update the Beneficiary Part D table with information received on the ADAP records.
8. The System shall be able to create and transmit a return file to the ADAP containing response records. A response record is only generated when an add, update, or delete transaction is detected. The ADAP partner will not receive response records for input records that provide no changes.
9. The System shall be able to process a full-file replacement of the ADAP records on a monthly basis.

DSA Program Description

The purpose of the ADAP data sharing agreement process is to coordinate the prescription drug benefits between Medicare Part D plans and ADAPs, as specifically required by the MMA and subsequent law. This collection of all prescription drug related benefits will facilitate the tracking of TrOOP (True Out-of-Pocket) expenses incurred by each Medicare beneficiary.

In order to coordinate benefit information, data must be collected from each ADAP on each of its enrollees. This information will be transmitted to the COBC where it will be edit-checked, and matched against Medicare Program eligibility data. When a match is found, the COBC will be able to combine the beneficiary's ADAP information and Medicare Part D specific information to create a complete record of the beneficiary's state and federal prescription drug benefits. The combined drug benefits information will be loaded into the Medicare Beneficiary Database

(MBD). Beneficiary data will be sent from the MBD to the TrOOP Facilitation contractor and to Part D plans.

A response file will also be created to send to the ADAP. This file will contain one status record for each record initially submitted by the ADAP to the COBC. Records in the response file will indicate whether or not the ADAP enrollee is a Part D beneficiary; whether or not the COBC applied the record to the Medicare Beneficiary Database (MBD); if the record was not applied to the MBD, why (e.g., the record contained errors or the record did not provide enough information about the enrollee); what Part D plan the beneficiary is in enrolled in; and other Part D enrollment information.

Listed below are the disposition codes that the COBC may provide to each ADAP Partner in the updated Response File.

Table 4: Disposition Codes

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

The COBC will perform edit checks of the ADAP input file which will generate the following error codes as necessary. The COBC will supply the results to the Partner. The ADAP will be expected to correct any errors, or update any missing information on its enrollees, and re-transmit this data on the following month’s file. The SP errors that would apply for drug records are as follows:

Table 5: SP Errors

Error Code	Description
SP 12	Invalid HIC Number or SSN. Field must contain alpha or numeric characters. Field cannot be blank or contain spaces.

Error Code	Description
SP 13	Invalid Beneficiary Surname. Field must contain alpha characters. Field cannot be blank, contain spaces or numeric characters.
SP 14	Invalid Beneficiary First Name Initial. Field must contain alpha characters. Field cannot be blank, contain spaces, numeric characters or punctuation marks.
SP 15	Invalid Beneficiary Date of Birth. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Day of the month must be correct. For example, if month = 02 and date = 30, the record will reject.
SP 16	Invalid Beneficiary Sex Code. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Acceptable numeric characters include the following: 1 = Male 2 = Female
SP 18	Invalid Document Control Number. Field cannot be blank. ADAP must assign each record a unique number in the event questions concerning a particular record arise and need to be addressed.
SP 24	Invalid Coverage Type. Field must contain alpha characters. Field cannot be blank or contain numeric characters. Valid values are: U: Network V: Non-network
SP 31	Invalid ADAP 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 ADAP Coverage Termination Date. Field must contain numeric characters. Date must correspond with the particular month – CCYYMMDD. For example, 02/27/1997 is acceptable, but not 02/30/1997. Cannot be earlier than the ADAP effective date. If there is no termination date (coverage is still active), must use zeros (not spaces) in this field.
SP 62	Incoming termination date is less than effective date.

Additionally, the COBC will provide RX specific errors:

Table 6: RX Specific 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 07	Missing Part D Effective date

NOTE: These are the standard error, edit and disposition codes used by the COBC for processing drug records. However, some of these codes are not applicable to the ADAP data sharing process.

ADAP Data Processing

1. Each month the ADAP submits an electronic input file of all enrollees to the COBC over the Internet using Secure FTP or HTTPS or via an existing T-1 line.
2. The COBC edits the input file for consistency, and attempts to match those enrollees with Medicare Part D enrollment.
3. Where the COBC determines that an enrollee on the ADAP file is a Medicare Part D beneficiary, the COBC updates that record to the CMS Medicare Beneficiary Database (MBD), which holds prescription drug coverage information on all Medicare Part D beneficiaries. The MBD will send daily updates of all prescription drug coverage of Part D beneficiaries to the TrOOP Facilitation Contractor and to the Part D plan that the beneficiaries are enrolled in.
4. The COBC then submits a response file to the ADAP via the same method used to submit the input file. This file contains a response record for each input record the ADAP submitted. The response record shows if the ADAP enrollee is a Part D beneficiary, if the COBC applied the record to the MBD, if the record was not applied to the MBD, and why (e.g., the record contained errors or the record did not provide enough information about the enrollee), in which Part D plan the beneficiary is enrolled, and other Part D enrollment information.
5. The ADAP then examines the response file to determine whether: The records were applied; the COBC was not able to match the ADAP enrollee in the CMS systems; or the records were not applied because of errors. (The ADAP must correct any records so that from subsequent full replacement input files the corrected records can be applied to the MBD.)
6. The ADAP updates its internal records on the Part D enrollment of its enrollees.

7. When the ADAP submits the next monthly full input file, it also sends corrections of all the errors from the previous submission.

Business Rules

1. The monthly file submitted by the ADAP is a full-file-replacement. The entire base of enrollees must be submitted each month on this file, including any corrections from the previous month's file. Each month's input file will fully replace the previous month's input file.
2. One response file will be returned to each ADAP, containing a response record for each input record received. The disposition of the input record will be provided on the corresponding response record, indicating if the record was accepted.
3. The COBC will attempt to create one drug record for each ADAP enrollee record received.
4. The COBC will not send incomplete drug records to MBD; consequently, incomplete drug records will not get sent to the TrOOP facilitator.
5. The required fields for ADAP records are SSN or HICN, Surname, First Initial, Date of Birth, Sex Code, Network Indicator, ADAP Effective Date, ADAP Termination Date, Coverage Type Indicator, Insurance Type Indicator, and ADAP -ID.

III. 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.

1. CMS has available two secure Internet transmission options, SFTP and HTTPS. We recommend either of these options for Partners that anticipate having a relatively low volume of data to transmit and that might find it is a burden to secure an AGNS connection. The ADAP partner's assigned EDI Rep at the COBC can advise you on this option.
2. For larger reporters 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.

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

Special Information for Small AIDS Drug Assistance Programs (ADAPs)

We have added a data exchange option to accommodate small ADAPs, those submitting Input Files consisting of 50 or fewer records. These small ADAPs will be able to submit the Input File in a text (txt) or ASCII format. The file must still adhere to the SPAP Input File Layout for Part D – 249 bytes including the Data Type Key provided. Response files will be returned in a text (.txt) format. Refer to the SPAP Response File Layout for Part D for information on the response file. We stress that this option is only available to ADAPs submitting 50 or fewer input records.

IV. ADAP Implementation Questionnaire

The *ADAP Implementation Questionnaire* asks a series of questions of the data sharing partner that helps the CMS and the partner set up the data sharing exchange process. These questions are intended to help you think through some of the issues which need to be addressed before you begin the data exchange and to assure that both the CMS and the ADAP partner are in agreement as to the operational process involved. When sending their signed ADAP Data Sharing Agreement to the CMS, ADAP partners must also send a completed copy of the Implementation Questionnaire. The Questionnaire is listed as Attachment C in the included materials that accompany the Agreement sent out to new ADAP data sharing partners.

SECTION C: WORKING WITH THE DATA

I. Obtaining a TrOOP Facilitation RxBIN or RxPCN

TrOOP is the acronym for "true out-of-pocket" – spending by or on behalf of a Medicare beneficiary that counts toward the beneficiary's Part D cost sharing. ADAP partners that offer a network drug benefit (electronic at point-of-sale) are required to obtain and use a unique TrOOP facilitation RxBIN and RxPCN. These unique code numbers will identify, to the benefits coordination network, the ADAP partner's drug benefits which are supplemental to Part D. The ADAP's use of unique TrOOP Facilitation routing numbers will enable the TrOOP Facilitation Contractor to capture any paid claims that are supplemental to Part D and to send a copy of this information to the Medicare beneficiary's Part D Plan. The Part D Plan will use this supplemental paid claims information to help calculate the enrollee's TrOOP. To be sure these drug claims are routed through the TrOOP Facilitation Contractor, ADAP partners must use a separate and unique RxBIN and RxPCN, in addition to their existing standard RxBIN or RxPCN codes.

If your ADAP needs to acquire a new RxBIN and RxPCN to use for TrOOP facilitation purposes you may contact either of the following two entities. The organization that issues the RxBIN is the American National Standards Institute, or ANSI. ANSI can be contacted through its Web address: www.ansi.org . The National Council for Prescription Drug Programs (NCPDP) issues the RxPCN. The NCPDP can be contacted through its Web address: www.ncdp.org .

II. Testing the Data Exchange Process

Once the partner's ADAP DSA is in place the partner and the COBC will begin working together closely. At this point the COBC will assign the partner with its own COBC EDI Representative.

The partner's EDI Rep will be the partner's primary point of contact with the ADAP data exchange process, from testing through full production.

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

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

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

In order to test the process for creating an Update File, a test “Update” will be prepared by the partner; it will "update" data on individuals included in the Test Input File. The partner shall submit the test Update File within ninety (90) days after receipt of the test Response File. The test Update File shall include any corrections made in the previous Test Response File sent to the partner by the COBC. In full file replacement, any corrections made to a file will fully replace what was previously submitted by the partner. Upon completion of its review of the test Update, the COBC will provide the partner a Response for every record on the Test Update File that matched to information in CMS databases. The COBC will provide a test Update Response File to the partner, ordinarily within a week, but no longer than forty-five (45) days after receipt of the partner’s test Update Input File.

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

III. Using Basis for Queries

When a partner has an immediate need to access Medicare eligibility and enrollment information, BASIS – the Beneficiary Automated Status and Inquiry System – permits a partner to make on-line queries to CMS to find out if it is possible that an individual is eligible for or enrolled in Medicare. Using a private, Web-based host, the ADAP data sharing partner can use BASIS to access Medicare Part D enrollment data. Access to BASIS will be limited to 500

queries per month. Access to BASIS is contingent on the partner having submitted its Initial Input Files and its most recent Update Files during its last quarterly production cycle.

In overview, BASIS operates as follows:

1. The COBC assigns each partner its own ADAP Personal Identification Number (“SPIN”). The SPIN delivered to the designated ADAP Contact Person within 30 days of submission of the partner’s initial Input Files. At this time, the partner will also receive information concerning the designated telephone line to be used for the BASIS application.
2. The COBC will 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 use a designated telephone line to access the BASIS application, using its assigned SPIN. For each ADAP Enrollee for whom the partner is requesting Medicare enrollment 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. The COBC will post the results of inquiry(s) to BASIS as soon as the partner submits its inquiry(s) to the BASIS application.

IV. ADAP File Processing

On a monthly basis, ADAPs will transmit full file submissions in the file format specified in the agreement. Full file processing requires the ADAP to submit a complete file of enrollees every month. Each month's transmitted file will fully replace the previous month's file.

File Level Editing

Upon receipt of the ADAP Input File, the COBC performs high-level file edits to verify the format and validity of the Input File, including Header and Trailer data and record counts. The size of the ADAP Input File (that is, the number of records contained in the file) is compared to the size of the previous monthly file submitted. *With full file replacement the method for deleting enrollees is to not include previously submitted enrollee files in the current Input File.* If the most recent Input File size has less than 70% of the records included in the previous month's file, the current Input File will be placed on hold (processing will be suspended) and the COBC will ask the ADAP partner to verify that the high number of delete records in the current submission is correct before processing resumes.

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

Adds

Once a HICN is identified, the incoming record is compared to CMS databases to match on previously submitted records. The initial matching criteria consist of the HICN, plus the Effective Date of ADAP eligibility, the Insurance Type, and the ADAP ID. If a match of these fields cannot be located on the database, the incoming record is considered an "add."

Updates

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

Deletes

Any records that were part of the previous month's file, but that are not included in the current month's submission, are processed as deleted records.

Deletes should only be used to remove a record that never should have been sent to CMS in the first place. Routine Input Files should contain records of all ADAP Enrollees whose ADAP enrollment terminated up to twenty-seven (27) months prior to the first day of the month in which the Input File is generated, or whose ADAP enrollment terminated after December 31,

2005, whichever date is most recent. Failure to continue submitting these older valid records will cause them to be erroneously deleted from the CMS database.

Errors

Records containing errors are returned to the ADAP with the error code given in the error number field on the response record. The ADAP will correct the error and resubmit the record on the next month's file.

Notification to the Medicare Beneficiary Database (MBD)

After ADAP Input File processing is completed a separate new file is created and transmitted to the MBD. It contains the add, update, and delete records generated by the COBC from the Input File submitted by the ADAP. After processing this input file the MBD sends a response file to the COBC containing Part D enrollment information on ADAP clients who matched to CMS databases.

Response files

Within 15 days of the ADAP input file submission, the COBC generates and transmits a response file to the ADAP. The file contains responses for any records that were added, updated, or deleted. The file does not contain responses for records where no change was made. However, the response file will also contain new or updated Part D enrollment information for all records, even those resubmitted as unchanged.

V. The Distinction between Part D Eligibility and Enrollment

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

Part D Eligibility Start Date: This refers to the first date a beneficiary can enroll in a Part D Plan. It does not mean that the beneficiary has actually enrolled yet, just that through their current Part A or B coverage that they can (they are able to) enroll in a Part D Plan.

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

Current Part D Plan Enrollment Date: Refers to the start date of Part D coverage for an eligible Medicare beneficiary that has applied for, enrolled, and now has coverage through a Part D Plan.

Current Part D Plan Termination Date: Refers to the date that beneficiary is no longer enrolled in and receiving benefits through a Part D Plan.

In the response files CMS sends you, the Current Part D Plan Enrollment Date provides the effective date of coverage for the Part D benefit by the specific Part D Plan listed as the Current Medicare Part D Plan Contractor Number. The Current Part D Plan Termination Date is the date that beneficiary is no longer receiving benefits under that Part D Plan. These dates are the most important for our data sharing partners because they let you know whether the beneficiary has actually elected coverage under Part D and the time period in which the Part D coverage became effective. In summary, a Medicare beneficiary can be eligible for Part D, but unless the beneficiary is enrolled in a Part D Plan, the beneficiary is not receiving Part D benefits.

VI. 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, Jeremy Farquhar, at 646-458-6614. His email address is jfarquhar@ghimedicare.com.

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

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

SECTION D: FREQUENTLY ASKED QUESTIONS

ADAP DATA SHARING AGREEMENT

TABLE OF CONTENTS

General 25

Data Specific Questions 26

General Questions

Q1: When will an ADAP ID be assigned?

A1: The ADAP ID will be assigned by the COBC it has received a copy of the signed DSA from the ADAP data sharing partner.

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

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

Q3: The COBC-ADAP data exchange is a monthly process. What is the schedule for this process? Will the data exchange happen at the beginning, middle or end of month?

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

Q4: Why is it necessary for the ADAP to send records on beneficiaries for up to 27 months after eligibility has been terminated in the ADAP?

A4: If a record is sent one month, but not the next, the record of that beneficiary will be deleted from the CMS databases. Recall that the ADAP should only delete a record that should not have been added in the first place. 27 months is the period of time a Medicare claim can be filed after the last date of service.

Q5: In our state we have two ADAPs, one that has about 7,200 clients while the other has fewer than 600 clients. For the sake of minimizing paperwork and maximizing efficiency, can we combine these two programs for the purposes of the ADAP - CMS data sharing agreement?

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

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

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

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

A7: For the ADAP partner the minimum CMS requirements are to be able to: (1) submit an initial test Input File that can be processed to the satisfaction of the COBC; (2) receive and process a test Response file from the COBC, and; (3) be able to submit a test update file to the COBC. The COBC has the authority to determine whether or not the ADAP partner has successfully completed testing and can move on to production data exchange.

Data Specific Questions

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

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

Q2: Should we exclude previously matched records?

A2: No, you must include previously matched records.

- Q3: Are “errors” just data discrepancies (e.g., a mismatched HICN and SSN)?**
- A3:** Errors encompass a number of anomalies. They can be data that is intrinsically defective or that contains an invalid value, such as an alpha character in a field requiring a numeric, or the error could be due to a programming mistake. In such case, the Response File will identify the particular error for the ADAP, using our standard error codes.
- Q4: Will we be receiving only Medicare Part D enrollment information, or will we receive information on all the other sources of prescription coverage carried by the enrollee?**
- A4:** You will receive only Medicare Part D enrollment information for your ADAP clients. We are not permitted to identify other sources of coverage.
- Q5: What field identifies Medicare D enrollment?**
- A5:** The Current Medicare Part D Plan Effective Date (field 46 in the ADAP Response File Layout) provides current Medicare Part D enrollment information.
- Q6: What field identifies the Medicare D insurer?**
- A6:** The Current Part D Plan Contractor Number (field 45 in the ADAP Response File Layout) identifies the particular Part D plan the beneficiary is enrolled in.
- Q7: We currently do not mandate collection of an SSN from the participant, although most of our participants have an SSN. In the cases where we do not have a SSN, should we just send the other information we have on the input file? If so, do we zero fill the SSN data field or leave it blank?**
- A7:** We must have either the Medicare Health Insurance Claim Number (HICN) or the SSN for every individual you submit in order to be able to determine their Medicare entitlement information. If you do not have either one of these numbers to include on a particular individual's record you should not submit that record.
- Q8: Is the Part D RxBIN and RxPCN the information that is identifying the Part D Plan (carrier) or is it being used to identify other insurance as well?**
- A8:** This information does not identify the Part D Plan. The Part D RxPCN and Part D RxBIN – usually known as the TrOOP RxBIN or TrOOP RxPCN – are code numbers used to enable electronic routing of network pharmacy benefit information. While an ADAP might already have a standard RxBIN or RxPCN to help electronically pay network claims, a separate Part D specific RxBIN or RxPCN is required for the support of the TrOOP facilitation process. These Part D-specific code numbers are used to permit the TrOOP Facilitator to capture and route claims that have been paid secondary to Part D.

Q9: What does "network" refer to? Is it a type of coverage, such as HMO or PPO?

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

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

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

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

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

Q12: Are PDPs eligible for the NPlanID?

A12: The "National Health Plan Identification" – or NPlanID – field is available as a placeholder for anticipated future use. All payers of health care coverage, including Medicare HMOs and Part D Plans will be required to use an NPlanID when it is eventually implemented. But the field is not used at this time.

Q13: Will the COBC ADAP response files include retroactive eligibility/enrollment information for a beneficiary?

A13: Yes, but the earliest Part D Plan enrollment date is 01/01/06.

Q14: What is the difference: COBA ID vs. ADAP ID vs. Contractor ID?

A14: The ADAP ID is your own DSA ID number. A COBA ID is used by our COB partners that have claims processing "crossover" agreements with us. A state agency (usually Medicaid) that has both a COBA and ADAP DSA with CMS would have both a COBA

ID and an ADAP ID, but the two IDs could not be used interchangeably. The Contractor ID number (Field 45 in the ADAP Response File) is the code number (ID) assigned by CMS to approved Part D Plans.

Q15: The data layout indicates space for four Rx error codes, yet the user guide lists six Rx error codes, and several error codes starting with SP.

A15: The Response File has space for only four error codes. These fields may contain either the SP or the RX error code. CMS does not anticipate that an ADAP partner will ever receive more than 4 error codes for a particular individual.

Q16: Will BASIS access be available immediately?

A16: BASIS access is provided after the partner has signed the DSA and production file exchanges have begun. BASIS is described in this User Guide, and complete information about the program is included in the welcome packet which is sent by the COBC once the partner's agreement is in place.

Q17: Is the new TrOOP RxBIN or RxPCN for our Medicare Part D claims payments the RxBIN/RxPCN that we will always be sending in the monthly input? In what circumstances would we not know what the correct RxBIN/RxPCN would be?

A17: We need your Part D specific RxBIN and or RxPCN in order to pass TrOOP data on to the TrOOP facilitator and the Part D Plan. Since you will not necessarily know which of your enrollees are Medicare beneficiaries, we are asking you to populate the TrOOP RxBIN and RxPCN fields with the Part D specific TrOOP RxBIN or RxPCN for those individuals *as if* they were Part D beneficiaries. As described earlier, you have to designate your TrOOP Rx BIN or RxPCN to the COBC in the Implementation Questionnaire.

Q18: Are we to send all of the ADAP enrollees in the input file (including non-Medicare clients), or only those who have told us that they have Medicare and therefore are eligible for a Part D plans?

A18: You send all of your enrollees. We respond with data indicating: Those that Medicare matched on and that we applied to our databases; those we matched on but didn't apply because of errors in the record you supplied; or those who we could not match on and who therefore are not Medicare beneficiaries. We do not expect you to know who among your clients are Medicare beneficiaries or enrolled in a Part D Plan. Essentially, the files you send us are finder files.

Q19: Is there any indicator on the response file that tells us if a person is ineligible for Part D and a reason? I think that there are various reasons for being ineligible. There would be some that do not have Medicare Parts A or B but there would also be those whose employers accepted the subsidy and they cannot enroll. How would we determine this?

A19: Generally, someone who is a Medicare beneficiary and enrolled in Part A or Part B (or both) is eligible to enroll in Part D. Even if the beneficiary is part of a group for which an employer is claiming the employer subsidy the beneficiary is still permitted to enroll in a Part D Plan – although that beneficiary would then almost surely lose his or her employer-sponsored coverage.

10/05 – 1/08 – 3/09 – 12/09 – 7-10

ADAP DATA SHARING AGREEMENT

Supplemental Drug Program Data Sharing

For Use by State AIDS Drug Assistance Programs (ADAPs)

Version Effective Date:

July 12, 2010

This Data Sharing Agreement (the "Agreement") for the exchange of enrollment information is entered into between [*Insert Data Sharing Partner Name*], with its principal address at [*Insert Data Sharing Partner Address of Record*] and the United States Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services ("CMS") (the "Parties") on this ___th day of _____, 20__ (the "Effective Date").

RECITALS

I. Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and Subsequent Regulations, and Their Impact on Supplemental Drug Program Data Sharing Partners

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) was enacted in 2003. It includes a prescription drug benefit, referred to as Medicare Part D. Part D insurance plans, which include private prescription drug plans (PDPs) and Medicare Advantage plans (MAPDs), administer the Medicare Part D prescription drug benefit. The MMA introduced a concept called "true out-of-pocket" (TrOOP) costs. TrOOP refers to the incurred out-of-pocket costs a Medicare Part D beneficiary must spend in a calendar year on Part D covered drugs in order to reach the Part D catastrophic coverage threshold. Any payments made by an ADAP, as defined in Section IV, on behalf of a Part D-enrolled beneficiary supplement the Part D Plan benefit. For the Part D-enrolled beneficiary these ADAP supplements are considered incurred costs and therefore count toward the beneficiary's Part D TrOOP. The Part D Plan has the responsibility to keep the record of the Plan member's TrOOP spending. As a consequence, Part D Plans require up-to-date, validated information about financial support of the benefits being provided to an enrollee in the Part D Program.

II. Purpose of the Agreement

The purpose of this Agreement is to establish conditions under which (1) an AIDS Drug Assistance Program (ADAP) Data Sharing Partner, as defined in Section IV, agrees to provide prescription drug coverage data to the CMS, as more specifically set forth in Attachment A and in the User Guide; and (2) the CMS agree to provide the Data Sharing Partner with Medicare Part D enrollment data, as more specifically set forth in Attachment B and the User Guide, on Enrollees for whom the ADAP Data Sharing Partner provides prescription drug coverage.

ADAPs that offer prescription drug coverage that supplements Medicare Part D are to be included in the point-of-sale coordination of benefits process which was developed to support administration of the Medicare Part D benefit. As a result, there is a need by both Medicare and ADAPs to exchange beneficiary eligibility information. This will facilitate the coordination of benefit coverages among the programs and help to assure accurate TrOOP accounting. The parties to the agreement seek to more efficiently coordinate the payment of prescription drug benefits and premiums with Medicare Part D plans in accordance with applicable law and regulations.

III. ADAP Data Sharing Agreement User Guide

An "ADAP Data Sharing Agreement User Guide" has been produced to accompany this Agreement, and is incorporated herein by reference. This ADAP User Guide is designed to also accommodate the ordinary process changes and revisions that result from monthly program operations. Current operational versions of the input and response data illustrated in Attachments A through C can be found in the User Guide.

IV. Definitions

1. "AIDS Drug Assistance Program (ADAP)" – a program funded under the Ryan White Care Fund and administered by state governments which provides drug coverage assistance for HIV/AIDS patients.
2. "Covered Individual" – an individual who is eligible for and enrolled in an ADAP and who receives coverage through such a plan.
3. "Medicare Part D Enrollment" – information about the Medicare Part D plan enrollment of a Medicare Part D enrollee.
4. "Medicare Part D Enrollee" – a Medicare beneficiary who is enrolled in a Medicare Part D Plan and who receives Part D Plan coverage.
5. "Medicare Part D Plan" – a PDP or MAPD, a Medicare Pace Plan which includes qualified prescription drug coverage, or a Medicare Cost Plan offering incorporating prescription drug coverage.
6. "TrOOP Facilitation RxBIN or RxPCN" – unique code numbers used in the electronic network routing of pharmacy claims information. "TrOOP Facilitation" codes are used by network pharmacy payers to identify benefit coverage that is supplemental to Medicare Part D.
7. "Standard RxBIN or RxPCN" – unique code numbers used in the electronic network routing of pharmacy claims information. "Standard" codes are used by network pharmacy payers to identify their own primary benefit coverage.

8. “Agent” – an individual or entity authorized by the Data Sharing Agreement partner to act on the partner’s behalf for purposes of administering this Agreement. All actions undertaken by the agent in administering this Agreement on behalf of the data sharing partner shall be binding on the data sharing partner.

V. Terms and Conditions

In consideration of the mutual promises and representations set forth in this Agreement, the Parties agree as follows:

A. Medicare Part D Enrollment Determination for ADAP Covered Individuals

In accordance with the process described in “C,” below, the AIDS Drug Assistance (ADAP) Data Sharing Partner shall identify those ADAP covered individuals, as defined in Section IV of this Agreement, and the CMS shall identify the ADAP covered individuals who are Medicare Part D enrollees. The ADAP Data Sharing Partner further agrees that a completed copy of the ADAP Implementation Questionnaire will accompany the copies of this agreement delivered to CMS.

B. Preparatory Period and Test Procedures for Continuing Electronic Data Exchange for ADAP Covered Individuals

Within ten (10) business days after the effective date of the Agreement, the CMS, the CMS Coordination of Benefits Contractor (COBC) and the ADAP data sharing partner will begin to discuss the operational terms of the Agreement. This shall include discussions on data requirements, file submissions, review of error codes and any other issues. This Preparatory Period shall be completed within thirty (30) business days after the effective date of the agreement. If the ADAP Data Sharing Partner is unable to meet the specified timeframe of the Preparatory Period, the ADAP Data Sharing Partner shall notify the CMS in writing of this delay. Within five (5) business days of receipt of this notice from the ADAP Data Sharing Partner, the CMS will contact the ADAP Data Sharing Partner to agree on a mutually acceptable time frame in which to complete the Preparatory Period.

Prior to submitting its Initial Input File, the ADAP Data Sharing Partner shall conduct tests of its ability to provide to the CMS a “Test” Initial Input File, receive a “Test” Response File, and correct errors identified in the Test Initial Input File and add new ADAP Data Sharing Partner Covered individuals in a “Test” Monthly Input File. This Test process is described in detail in the User Guide.

After successfully completing the Test process, the Initial Input File shall be submitted in accordance with the provisions of Section C hereof.

C. Continuing Electronic Data Exchange for ADAP Covered Individuals

1. Within forty-five (45) days of the completion of the process described in Section B hereof (the "Preparatory Period"), the ADAP Data Sharing Partner shall provide to the CMS a file containing the data elements listed in Attachment A, in the record layout prescribed in the User Guide, with respect to ADAP covered individuals ("Initial Input File"). The data provided by the ADAP in the Initial File shall cover all the periods of coverage for the above-mentioned ADAP covered individuals from [insert date] through the first day of the month following the Initial File Date.
2. The CMS shall search its Medicare enrollment files for the ADAP covered individuals identified on the ADAP's Initial Input File. Where a match occurs, the CMS shall annotate its Medicare Part D enrollment files to identify the ADAP as a supplemental payer to the Medicare Part D plan for these ADAP covered individuals.
3. Within fifteen (15) days of the CMS's receipt of the ADAP's Initial Input File, the CMS shall provide to the ADAP a file containing the data elements listed in Attachment B, in the record layout prescribed in the User Guide, for individuals identified under the electronic match conducted pursuant to ¶ B.2 ("Response File").
4. Within fifteen (15) days of the ADAP's receipt of the CMS's Response File, the ADAP shall submit the next monthly Input File, having:
 - a. examined the Response File to determine whether the CMS was able to apply the ADAP's prescription drug coverage contained in the Input Records to the CMS enrollment files;
 - b. examined the Response File to determine whether there were errors in the Input Records that prevented the CMS from determining the Medicare Part D enrollment of the ADAP's covered individuals or from applying the ADAP's prescription drug coverage contained in the Input Records to the CMS enrollment files;
 - c. corrected all errors contained in the Input Records so that the CMS can determine the Medicare Part D enrollment of the ADAP's covered individuals and apply all ADAP prescription drug coverage contained in the Input Records where the ADAP's covered individual was identified as a Medicare Part D enrollee in subsequent Input Files; and
 - d. updated the ADAP's internal records with all corrections made by the CMS during processing of the Input File and by the ADAP after receiving the Response File.

Monthly Input Files shall contain records of all ADAP covered individuals whose ADAP enrollment terminated up to twenty-seven (27) months prior to the first day of the month

in which the Monthly Input File is generated, or whose ADAP enrollment terminated after December 31, 2005, whichever date is most recent.

D. Correction of Error Records

Upon receipt of the ADAP's Initial and Monthly Input Files, in the course of its standard processing activity the CMS shall analyze the files to identify any errors and defects in the data provided (e.g., data that is not readable or data that does not comply with the terms of the Agreement). If it detects errors and/or defects with submitted data, in the regular Response File the CMS shall provide to the ADAP the data elements listed in Attachment B and in the record layout prescribed in the User Guide, and will identify the errors detected on the Initial or Monthly Input Files. The ADAP shall undertake the steps necessary to correct any error records identified in a Response File, provided such records can be corrected by the Parties, and resubmit the corrected records on the next Input File.

E. RxBIN and RxPCN Codes

Both the RxBIN and RxPCN are codes used in the electronic routing of pharmacy benefit reimbursement information. The prescription Benefit Identification Number (RxBIN) and the pharmacy benefit Processor Control Number (RxPCN) are assigned to network pharmacy payers by national standards setting organizations. All point-of-sale network pharmacy payers have an RxBIN. Many, though not all, also have an RxPCN. The Input and Response Files used by the ADAP Data Sharing Agreement program include data fields for RxBIN and RxPCN reporting.

To participate in the TrOOP Facilitation process, ADAPs must obtain a unique, TrOOP-specific RxBIN or RxPCN number to code for coverage that is supplemental to Medicare Part D. This unique coding will assure that a copy of the supplemental paid claim is captured by the TrOOP Facilitation Contractor as the claims data moves through the health care billing and reimbursement EDI networks. "TrOOP Facilitation" RxBIN(s) and RxPCN(s) are required, and must be separate and distinct from the ADAP's standard RxBIN(s) and RxPCN(s).

On an Input file, when CMS identifies an ADAP-covered individual as a Medicare Part D enrollee, the prescription drug coverage and TrOOP Facilitation RxBIN and RxPCN routing information will be made available to the Part D Plan and the TrOOP Facilitation Contractor. By signing this Agreement, the ADAP agrees to obtain a TrOOP Facilitation RxBIN or RxPCN. In addition, the ADAP must provide CMS with a list of all its Standard and TrOOP Facilitation RxBINs and RxPCNs no later than ten (10) business days prior to the submission of the Initial Input File. (See Number 13, in Section O.)

F. Beneficiary Automated Status Inquiry System (BASIS)

When an ADAP has an immediate need to query for Medicare Part D enrollment, the BASIS application allows the ADAP to make a limited number of on-line queries of the Medicare Part D enrollment of its ADAP covered individuals using a private web-based host. Access to BASIS is contingent on the ADAP having submitted its Initial Input File and its

Monthly Input File during the last monthly production cycle. Refer to the ADAP User Guide for a detailed description of the BASIS application and its operation.

G. Duty to Obtain Data

The ADAP may be in possession of some, but not all, of the data elements identified in Attachment A and the User Guide. With respect to data not now in its possession, the ADAP shall use its best efforts to obtain such data as soon as reasonably possible. With respect to data not now in its possession or incorrect, where the data cannot be obtained because an enrollment, re-enrollment or renewal date of the ADAP will not occur in the next six (6) months, the ADAP shall individually contact each program client from whom data is missing or incorrect, to obtain or correct such data within thirty (30) days of becoming aware, or being notified, that the information is missing or is incorrect. The ADAP shall include data corrections received in response to such contact in the next Monthly Input File delivered to the CMS.

If, after following the procedures detailed above for collection/correction of data, the ADAP is still unable to obtain a certain data element, excluding the Social Security Number or Medicare Health Insurance Claim Number, one of which is always mandatory, the ADAP should still provide the CMS with as many of the other data elements as it can obtain for the program client. The ADAP shall follow up requests for data that remain unresolved for more than thirty (30) days.

H. Term of Agreement

The ADAP and the CMS are dedicated to developing and implementing a process for exchanging data that provides the CMS with monthly Input Files and the ADAP with monthly Response Files on a regular and consistent basis with minimal interruption to the administration of the ADAP or CMS. Accordingly, the initial term of this Agreement shall be twenty-four (24) months from the Effective Date unless earlier terminated as set forth below, and shall automatically renew for successive twelve (12) month terms unless, not less than ninety (90) days prior to the end of any term, a Party provides the other Party with written notice of its intent not to renew the Agreement. During the initial term of the Agreement, the parties shall diligently and in good faith evaluate the data exchange process and discuss and endeavor to implement modifications to the process in order to achieve the efficiency described in Section II hereof as a principal purpose of the agreement.

During the initial term or any succeeding term of this Agreement, the CMS may terminate this Agreement upon sixty (60) days prior written notice to the ADAP of the ADAP's repeated failure to perform its obligations pursuant to this Agreement, and the ADAP's failure during such sixty (60) day period to cure such breach of its obligations by satisfying the conditions set forth in such notice.

During the initial term or any succeeding term of this Agreement, the ADAP may terminate this Agreement upon sixty (60) days prior written notice to the CMS of the CMS's repeated failure to perform its obligations pursuant to this Agreement, and the CMS's failure during such sixty (60) day period to cure such breach of its obligations by satisfying the conditions set forth in such notice.

Except as the parties may otherwise agree, this Agreement shall terminate in the event of enactment of any new Medicare Part D legislation which contradicts or is inconsistent with the terms of the data exchange portions of this Agreement.

I. Safeguarding and Limiting Access to Exchanged Data

The Parties agree to establish and implement proper safeguards against unauthorized use and disclosure of the data exchanged under this Agreement. Proper safeguards shall include the adoption of policies and procedures to ensure that the data obtained under this Agreement shall be used solely in accordance with Section 1106 of the Social Security Act [42 U.S.C. § 1306], Section 1874(b) of the Social Security Act [42 U.S.C. § 1395k(b)], Section 1862(b) of the Social Security Act [42 U.S.C. § 1395y(b)], and the Privacy Act of 1974, as amended [5 U.S.C. § 552a]. The ADAP shall establish appropriate administrative, technical, procedural, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized access to the data provided by the CMS. The ADAP agrees that the authorized representatives of the CMS shall be granted access to the premises where the Medicare data is being kept for the purpose of inspecting security arrangements and confirming whether the ADAP is in compliance with the security requirements specified above.

Access to the records matched and to any records created by the matching process shall be restricted to authorized employees, agents and officials of the CMS and the ADAP who require access to perform their official duties in accordance with the uses of the information as authorized in this Agreement. Such personnel shall be advised of (1) the confidential nature of the information; (2) safeguards required to protect the information, and (3) the administrative, civil and criminal penalties for noncompliance contained in applicable Federal laws.

The CMS and the ADAP agree to limit access to, disclosure of and use of all data exchanged between the Parties. The information provided may not be disclosed or used for any purpose other than to implement the Part D coordination of benefits provisions of the MMA and subsequent applicable law and regulations, and coordinate benefit payments between the ADAP and the Medicare Part D plans. The Parties agree that the enrollment files exchanged by the Parties shall not be duplicated or disseminated beyond updating the Parties' current enrollment files.

J. Privacy Act

Data that are protected in a Privacy Act System of Records (SOR) shall be released from the CMS in accordance with the Privacy Act (5 U.S.C. §552a) and the CMS data release policies and procedures. There appropriate Privacy Act disclosure exception for these releases is found in System No. 09-70-0536 (Medicare Beneficiary Database).

The parties agree and acknowledge that they are performing “covered functions” as that term is defined in the Standards for Privacy of Individually Identifiable Health Information (the “Privacy Rule”) under the HIPAA at 45 C.F.R. § 164.501. The parties further agree that the use and disclosure of Protected Health Information between the parties pursuant to this Agreement is for payment as defined in the Privacy Rule. The Parties further agree that the Protected Health Information be used or disclosed pursuant to this Agreement is the minimum necessary to accomplish the intended purposes of this Agreement. The parties agree to abide by all requirements of the Privacy Rule with respect to Protected Health Information used or disclosed under the Agreement.

K. Restriction on Use of Data

All data and information provided by the Parties shall be used solely for the purposes outlined in Section II of the Recitals. If the ADAP wishes to use the data and information provided by the CMS under this Agreement for any purpose other than those outlined above, the ADAP shall make a written request to the CMS outlining the additional purposes for which it seeks to use the data. If the CMS determines that the ADAP’s request to use the data and information provided hereunder is acceptable, the CMS shall provide written approval to the ADAP of the additional purpose for use of the data.

The terms of this Section K. shall not apply to the ADAP with respect to data contained in any Monthly Input Files, excluding any Medicare data which are provided by CMS to the ADAP in any Response Files.

L. Penalties for Unapproved Use of Disclosure of Data

The ADAP acknowledges that criminal penalties under section 1106(a) of the Social Security Act [42 U.S.C. § 1306 (a)], including possible imprisonment, may apply with respect to any disclosure of data received from the CMS that is inconsistent with the purposes and terms of the Agreement. The ADAP acknowledges that criminal penalties under the Privacy Act [5 U.S.C., § 552a (I) (3)] may apply if it is determined that the ADAP, or any individual employed or affiliated therewith, knowingly and willfully obtained the data under false pretenses. The ADAP also acknowledges that criminal penalties may be imposed under 18 U.S.C. § 641 if the ADAP, or any individual employed or affiliated therewith, has taken or converted to its own use data file(s), or received the file(s) knowing that (it) they were stolen or converted. The ADAP further acknowledges that civil and criminal penalties under HIPAA (PL 104-191) may apply if it is determined that a person wrongfully discloses protected health information/individually identifiable health information.

M. AIDS Drug Assistance Program Contacts

Administrative Contact: The ADAP designates the individual listed below as the contact person for administrative or other implementation coordination issues under this Agreement. The contact person shall be the point of contact for the CMS for any administrative questions that may arise during the term of this Agreement. If the ADAP changes its administrative contact person, the ADAP shall notify the CMS in writing within thirty (30) working days of the transfer

and provide the information listed below for the new contact person.

Name: (Insert Name)
Address: (Insert mailing address)
Phone #: (Insert Phone #)
Fax #: (Insert Fax #)
E-mail: (Insert E-mail address)

Technical Contact: The ADAP designates the individual listed below as the contact person for technical or other implementation coordination issues under this Agreement. The contact person shall be the point of contact for CMS for any technical questions that may arise during the term of this Agreement. If the ADAP changes its technical contact person, the ADAP shall notify the CMS in writing within thirty (30) working days of the transfer and provide the information listed below for the new contact person.

Name: (Insert Name)
Address: (Insert mailing address)
Phone #: (Insert Phone #)
Fax #: (Insert Fax #)
E-mail: (Insert E-mail address)

N. CMS Contact

Administrative Contact: The CMS designates the individual listed below as the contact for administrative or other implementation coordination issues under this Agreement. The individual shall be the point of contact for the ADAP for any administrative questions that may arise during the term of this Agreement. If CMS changes the administrative contact person(s), CMS shall notify the ADAP in writing within thirty (30) working days of the transfer and provide the information listed below for the new contact person.

Name: William Decker
Phone #: (410) 786-0125
Fax #: (410) 786-7030
E-mail: william.decker@cms.hhs.gov

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

Technical Contact: Upon implementation of this agreement through signature by both parties, CMS will designate a Coordination of Benefits Contractor (COBC) Electronic Data Interchange (EDI) Representative as the COBC contact for technical or other implementation coordination

issues under this Agreement. The EDI Rep shall be the point of contact for the ADAP for any technical questions that may arise during the term of this Agreement. If CMS changes the technical contact, the COBC shall notify the ADAP within thirty (30) working days of the transfer and provide contact information for the new EDI Rep.

O. Miscellaneous

1. The Parties agree that their respective representatives, whose signatures appear below, have the authority to execute this Agreement and to bind each of the Parties, respectively, to every promise or covenant contained in this Agreement. The Effective Date of this Agreement shall be the last date of execution by the Parties.

2. No alteration, amendment, modification or other change to the Agreement shall be effective without the written consent of the affected Party or Parties. No waiver of this Agreement or of any of the promises, obligations, terms, or conditions contained herein shall be valid unless it is written and signed by the Party against whom the waiver is to be enforced. This applies only to alterations, amendments, modifications or other changes to information contained in this Agreement and not to the User Guide.

3. The Parties agree that this Agreement, together with the User Guide, includes all material representations, understandings, and promises of the Parties with respect to this Agreement. This Agreement shall be binding upon the Parties, their successors, and assigns.

4. In the interest of protecting confidentiality of ADAP-covered individual data, information received by the Parties hereto that does not result in a match relevant to this Agreement shall be destroyed within twelve (12) months following a Party's completion of the matching process. Each Party to this Agreement shall provide written confirmation to the other that all data and information that does not result in a match has been destroyed within that time frame if requested by either Party. The Parties further agree that if "hard media" (e.g., round reel tapes, cartridges, CDs, etc.) were used to exchange data, such media shall be destroyed within twelve (12) months of receipt.

5. The Parties may transmit the data required to be exchanged under this Agreement electronically, provided the Parties agree on a methodology and format within which to exchange such documentation as required by the User Guide, and the transmission is secure.

6. The ADAP shall provide a header and trailer for each file submitted using the data elements in the record layout as prescribed in the User Guide.

7. The ADAP agrees that it will inform its related entities to the extent necessary to pay prescription drug claims in accordance with the MMA provisions. The ADAP shall share the Medicare Part D entitlement information, identified as a result of this data exchange, with these entities for their use in paying prescription drug claims in accordance with the Medicare Part D provisions.

8. No fees are payable by either party with respect to this Agreement.

9. Except as specifically provided herein, the rights and/or obligations of either party to this Agreement may not be assigned without the other party's written consent. This agreement shall be binding upon and shall inure to the benefit of and be enforceable by the successors, legal representatives and permitted assigns of each party hereto.

10. If either party cannot release its respective file in a timely manner, it must notify the other party at least one week prior to the scheduled release of the file that the submission shall be late. A date as to when the file will be released shall be provided at that time.

11. The ADAP agrees to provide to the CMS a list of all its standard and TrOOP facilitation RxBINs and RxPCNs no later than ten (10) days prior to submission of the Initial Input File. The ADAP further agrees to update this list no more than thirty (30) days after receiving any new coding numbers.

P. SIGNATURES

IN WITNESS WHEREOF, the Parties have signed this Agreement on the date indicated below.

Centers for Medicare and Medicaid Services

By: GERALD WALTERS
Director, Financial Services Group
Office of Financial Management

DATE

Duly Authorized Representative

(Insert ADAP Name)

By: *(Insert ADAP Representative Name)*
(Insert Title)

DATE

Duly Authorized Representative

V: 8/9/05(c); 7/27/07(d); 1/22/08(e); 7/12/10(f)

*Implementation Questionnaire
For AIDS Drug Assistance Programs*

Data Sharing Agreement

Version 7/22/10

**AIDS Drug
Assistance Program DSA Implementation Questionnaire**

ADAP Name: _____

Date: _____

Please check all that apply:

I. ADAP Specific Information

- ADAP offers a network prescription drug benefit.
- ADAP offers a network prescription drug benefit and shall provide its RxBIN and/or RxPCN below. (If you have more than one RxBIN or PCN, please submit all of these numbers to the CMS in a separate attached Word document).

RxBIN _____
RxPCN _____

- ADAP offers a network prescription drug benefit and shall provide its TrOOP Specific RxBIN and RxPCN below. (If you have more than one TrOOP RxBIN or RxPCN, please submit all of these numbers to the CMS in a separate attached Word document).

TrOOP RxBIN _____
TrOOP RxPCN _____

II. Questions regarding how the ADAP will submit prescription drug coverage of its Program Enrollees:

- ADAP will satisfy its Data Sharing Agreement requirement to submit prescription drug coverage of its SPAP Enrollees using the Input file of the SPAP Data Sharing Agreement.
- ADAP contracts with a Pharmacy Benefit Manager (PBM) to pay prescription drug benefits in the pharmacy network. Please provide the name of the PBM _____.
- ADAP's PBM, named above, has (1) signed a Data Sharing Agreement with CMS and (2) signed an agreement with the ADAP stating they will satisfy the Supplemental Drug Program's Data Sharing Agreement requirement to submit prescription drug coverage of its Supplemental Drug Program Enrollees.