

NCPDP GUIDANCE FOR SPAPS AND ADAPS MEDICARE PART D COORDINATION OF BENEFITS REQUIREMENTS AND RESPONSIBILITIES

VERSION 2.0

This document provides guidance for SPAPs and ADAPs in exchanging data with Medicare Part D Plan Sponsors for electronic coordination of benefits.

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NCPDP GUIDANCE FOR SPAPS AND ADAPS MEDICARE PART D COORDINATION OF BENEFITS REQUIREMENTS AND RESPONSIBILITIES

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1. PURPOSE

NCPDP has developed this technical document to outline the data exchanges necessary for State Pharmaceutical Assistance Programs (SPAPs) and AIDS Drug Assistance Programs (ADAPs) to have their dollars electronically post towards TrOOP (True Out-of-Pocket). This document also illustrates the steps necessary to ensure dollars are counting towards TrOOP when SPAPs or ADAPs initially begin using a Pharmacy Benefit Manager (PBM), enroll in Health Plan Management System (HPMS) for their annual attestation, transition between processors, or change their prescription drug routing information (4Rx data).

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1.1 RESOURCES

Medicare Prescription Drug Benefit Manual – Chapter 14

<http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter14.pdf>

CMS Data Sharing Information

<http://cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Prescription-Drug-Assistance-Programs/Coordinating-Prescription-Drug-Benefits/Coordinating-Prescription-Drug-Benefits-Page.html>

NCPDP Overview of the Medicare Part D Prescription Drug Coordination of Benefits (COB) Process

<http://ncdp.org/Resources/Medicare-Part-D>

Part D Transaction Facilitator

<http://medifacd.relayhealth.com/>

Application for Access to CMS Computer Systems form

https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/Downloads/EUA_AccessForm.pdf

SPAP ADAP HPMS Module

Note: A username and password is required to access the HPMS module.

<https://hpms.cms.gov/>

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2. ACRONYMS AND DEFINITIONS

The definitions of various terminology used within this document are provided for the reader to reference below.

AIDS DRUG ASSISTANCE PROGRAMS (ADAPs)

The AIDS Drug Assistance Program (ADAP) is a state and territory-administered program authorized under Part B that provides FDA-approved medications to low-income people living with HIV who have limited or no health coverage from private insurance, Medicaid, or Medicare.

4RX DATA

The four data elements are used to process a pharmacy claim. In Medicare Part D, these four elements uniquely identify the Medicare Part D Sponsor for the beneficiary and are identified by the sponsor during beneficiary enrollment and exchanged with CMS contracted entities. The set of four elements are exchanged via eligibility verification, claims processing, and information reporting transactions, as well as post adjudication claim reporting functions. The 4Rx data are:

"RxBIN(IIN)"	Bank Identification Number (Insurance Industry Number) ¹
"RxPCN"	Processor Control Number
"RxGRP"	Group ID
"RxID"	Cardholder ID defined by the plan

Read the NCPDP *Recommendations for Effective 4Rx Usage in Medicare Part D Processing* document for specific rules and usage for Part D Sponsors and plans supplemental to Part D.

BENEFITS COORDINATION & RECOVERY CENTER

The Benefits Coordination & Recovery Center (BCRC) is a federal contractor which consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The purposes of the COB program are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits. The BCRC does not process claims, nor does it handle any mistaken payment recoveries or claims specific inquiries. The Medicare intermediaries and carriers are responsible for processing claims submitted for primary or secondary payment.

COORDINATION OF BENEFITS (COB)

In this context, Coordination of Benefits (COB) occurs when Medicare beneficiaries have a private and commercial insurer or coverage in addition to their Medicare coverage. The coordination of activities that result when multiple payers exist for claims to ensure the appropriate costs are paid by the responsible payer is considered coordination of benefits.

HPMS SPAP/ADAP ATTESTATION

The SPAP/ADAP Attestation module in HPMS is used to assist with coordination of benefits for beneficiaries of state-based programs who are also enrolled in a Medicare Part D prescription drug plan. Part D plans are required to coordinate benefits for their enrollees with multiple sources of prescription coverage.

INFORMATION REPORTING (N) TRANSACTIONS

The Part D Transaction Facilitator transmits supplemental coverage information from payer-to-payer. The Transaction Facilitator process is triggered by the submission of a transaction by a pharmacy to a payer supplemental to a Part D Sponsor. The Information Reporting transactions (Information Reporting (N1), Information Reporting

¹ The term Bank Identification Number (BIN) is no longer supported. The number is now called an Issuer Identification Number (IIN).
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Reversal (N2), and Information Reporting Rebill (N3)) are used in this process and defined further in this document. These are transactions in the NCPDP *Telecommunication Standard Implementation Guide*.

N1 - INFORMATION REPORTING

This transaction is used to transmit a record of supplemental coverage information related to a Part D beneficiary's liability. Information Reporting (N1) is a transaction request and a response.

N2 - INFORMATION REPORTING REVERSAL

This transaction is used to reverse a previously submitted N1 (Information Reporting) transaction. Information Reporting Reversal (N2) is a transaction request and a response.

N3 - INFORMATION REPORTING REBILL

This transaction is an Information Reporting submission with an implied reversal. It is used by the Originator to cancel an Information Reporting transaction submitted that had been processed previously and submit a new Information Reporting transaction in the same transaction. Information Reporting Rebill (N3) is a transaction request and a response.

OTHER HEALTH INFORMATION (OHI)

Other Health Information data provides the beneficiary's coordination of benefits detail information. CMS, through the Benefits Coordination & Recovery Center (BCRC), provides a data sharing partner with medical or prescription coverage from a beneficiary's other payer(s) and refers to this as data that identifies "other health insurance."

PART D SPONSOR

Part D sponsors are organizations contracted with CMS to provide Part D coverage. Most are Prescription Drug Plans (PDPs) or Medicare Advantage Plans that provide qualified prescription drug coverage (MAPDs). Plans may offer the following benefits: Defined Standard (DS); Actuarially Equivalent (AE); Basic Alternative (BA); Enhanced Alternative (EA). For more information about Part D Sponsors see www.cms.gov.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)

A state pharmaceutical assistance program (SPAP) to help their residents pay for prescription drugs. Each program works differently. Some states offer programs that can help people with certain illnesses pay for their prescription drugs. The states that offer SPAPs often coordinate their SPAPs with Medicare's drug benefit (Part D).

PART D TRANSACTION FACILITATOR

The Part D Transaction Facilitator is a federal contractor which is responsible, in conjunction with CMS, for establishing procedures for facilitating eligibility queries (E1 transactions) at point of sale (POS), identifying costs reimbursed by other payers (Information Reporting (Nx) transactions) and alerting Part D sponsors about such transactions, and facilitating the transfer of TrOOP-related data (financial information reporting (FIR) transactions) when a beneficiary changes plan enrollment during the coverage year.

PHARMACY BENEFIT MANAGER (PBM)

Typically a third-party administrator of prescription drug programs, PBMs can assist a plan sponsor to achieve the most effective utilization of prescription drug expenditures through benefit design, formulary management, rebate contracting, retrospective Drug Utilization Review (DUR), prospective DUR, network administration, and disease management. The PBM may also be a payer/processor or other entity that receives prescription drug claims, makes a decision regarding the level of reimbursement and sends the appropriate message or reject code back to the pharmacy/provider for action.

PROCESSOR

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A Processor may be an insurer, a governmental program or another financially responsible entity or a third-party administrator or intermediary contracted on the behalf of those entities which receives prescription drug claims, makes a decision regarding the level of reimbursement to the provider, and transmits a response to the provider submitting a claim.

SUPPLEMENTAL PAYERS

A payer that is supplemental to Part D offers benefits or coverage after Part D benefits have been determined. These benefits are usually in the form of copay/coinsurance reduction.

SWITCH/SERVICE INTERMEDIARY

A switch/service intermediary is an entity that connects pharmacies to processors in a standard manner in order to transmit transactions or files. The switch accepts an electronic transaction from another organization and electronically routes the transaction to a receiving entity. A switch/intermediary may perform value added services including detailed editing/messaging of input/output data for validity and accuracy and translating data from one format to another.

TRUE OUT OF POCKET (TRPOP)

TrPOP includes incurred costs for covered Part D drugs that are paid by the beneficiary, or by specified third parties on the beneficiary's behalf, up to the specified annual out-of-pocket threshold. Amounts that count toward TrPOP include:

- The amount a person pays for covered prescriptions before his or her drug plan begins to pay (the annual deductible, if applicable)
- The amount a person pays for each covered prescription after his or her drug plan begins to pay (copayments or coinsurance during initial coverage period)
- Any payments a person makes for a covered prescription drug during his or her plan's coverage gap, if the plan has a coverage gap
- Payments made by qualified third parties on the beneficiary's behalf, including qualified State Pharmaceutical Assistance Programs (SPAPs), qualified charities and manufacturer Patient Assistance Programs (PAPs), the Indian Health Service (IHS), AIDS Drug Assistance Programs (ADAPs), or by family, friends or other individuals.
- Low income cost sharing amounts ("Extra Help") paid by Medicare.

TrPOP excludes:

- The share of the cost of the drug paid by a Medicare drug plan
- Monthly drug plan premium
- Drugs purchased outside the U.S. and its territories
- Drugs not covered by the plan
- Drugs that are excluded from the definition of Part D drug, even in cases where the plan chooses to cover them as a supplemental benefit (like drugs for hair growth)
- Over-the-counter drugs or most vitamins (even if they're required by the plan as part of step therapy) Cost paid by a group health plan such as the Federal Employees Health Benefit Program (FEHBP) or employer or union retiree coverage
- Cost paid by a government-funded health program such as Medicaid, TRICARE, Workers' Compensation, the Department of Veterans Affairs (VA), Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), the Children's Health Insurance Program (CHIP), and black lung benefits
- Cost paid by another third-party group with a legal obligation to pay for the person's drug costs
- Cost paid by a Patient Assistance Program (PAP) operating outside the Part D benefit
- Cost paid by other types of insurance

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If a beneficiary switches Medicare Part D Sponsors during the plan year, their TrOOP and drug spend will be transferred to their new plan -- it travels with the beneficiary.

3. CMS REQUIREMENTS FOR COORDINATION OF BENEFITS

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) was enacted in 2003. The MMA introduced a new concept called “True Out-of-Pocket” (TrOOP) costs. TrOOP refers to the incurred out-of-pocket costs a Medicare Part D beneficiary must spend annually on Part D covered drugs to reach the catastrophic coverage. Any payments made by a qualified SPAP or an ADAP on behalf of a Part D beneficiary will be considered as “incurred costs” by the Part D beneficiary and will therefore count towards the beneficiary’s TrOOP.

In accordance with Medicare Prescription Drug Benefit Manual Chapter 14 - Coordination of Benefits and Federal Register 423.464(f), Part D sponsors are required to coordinate benefits with State Pharmaceutical Assistance Programs (SPAPs), AIDS Drug Assistance Programs (ADAPs), and other entities providing prescription drug coverage.

CMS requires Part D sponsors electronically coordinate benefits with supplemental payers that adhere to the CMS Data Sharing Agreement (DSA) and transmit their eligibility data to CMS. Those supplemental payers that use the established on-line or batch process will receive the benefits associated with the creation of N (Information Reporting) transactions and their transmission to the beneficiary’s Part D sponsor. SPAPs and ADAPs that do not comply with the on-line or batch COB process and CMS Data Sharing process will forfeit electronic coordination of benefits and the benefits associated to their programs.

For SPAPs and ADAPs to adhere to the new CMS Data Sharing process they will need to use the HPMS module of the Centers for Medicare & Medicaid Services (CMS) to submit their attestations for SPAPs and ADAPs. The HPMS module requires a user name and password and is accessed at <https://hpms.cms.gov/>.

When SPAPs/ADAPs complete all the steps necessary for electronic coordination of benefits, Part D sponsors are required to coordinate benefits with the SPAP/ADAP.

By statute, coordination of benefits relates to the following:

- Enrollment file sharing;
- Claims processing and payment;
- Claims reconciliation reports;
- Application of protection against high out-of-pocket expenditures by tracking TrOOP expenditures; and
- Other processes that CMS determines.

4. ESSENTIAL STEPS FOR SUCCESSFUL ELECTRONIC COORDINATION OF BENEFITS

To participate in electronic coordination of benefits, SPAPs and ADAPs need to perform the following:

1. **Obtain a Bank Identification Number (Industry Identification Number)/Processor Identification Number (BIN(IIN)/PCN) combination for TrOOP Eligible beneficiaries and re-card where necessary.**

Note:

The SPAP/ADAP BIN(IIN)/PCN combination must be unique to Medicare Part D eligible beneficiaries in that State. The PBM for the State must not co-mingle the BIN(IIN)/PCN with other lines of business or use it for any other purpose.

If the unique BIN(IIN)/PCN combination has ever been used for SPAP/ADAP purposes by the processor, it should not be reused for any other lines of business.

2. **Obtain access to the HPMS SPAP/ADAP module.**

Download and submit the Application for Access to CMS Computer Systems form.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/Downloads/EUA_AccessForm.pdf

3. **Use the SPAP/ADAP module to manage program attestation data; upload supporting documents as needed; certify and attest to the conditions of the program; review, update, and electronically sign the attestation which generates a Data Sharing Agreement.** The HPMS module requires a user name and password and is accessed at <https://hpms.cms.gov/>.

Note:

At least one individual from each state, or each SPAP or ADAP program, must register for HPMS signatory access. To obtain access, users must submit a letter from a senior official at the state indicating the individual is authorized to complete the attestation information and DSA.

Each SPAP/ADAP is responsible, on an ongoing basis, for communicating any changes in contact information to CMS. Failure to do so will jeopardize the SPAP/ADAP's knowledge of, and thus compliance with, key program requirements and deadlines. Starting in CY 2018, CMS will no longer accept updated contact information through email.

Please direct questions about this guidance to SPAP@cms.hhs.gov.

If you already have a Data Sharing Agreement but are changing processors, contact the Benefits Coordination & Recovery Center (BCRC) Electronic Data Interchange (EDI) Representative assigned to your program for further steps.

4. **Send Electronic Eligibility Data to CMS**

Data is exchanged between the SPAP/ADAP and CMS monthly. SPAPs and ADAPs send a full file of all enrollment records for TrOOP eligible members in their programs. All eligibility coverage timelines must be sent through the Data Sharing file. For TrOOP expenses to be applied by Part D sponsors

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correctly, the SPAP/ADAP must timeline any changes to the member's ID number, RxGrp, RxBIN(IIN), or RxPCN on this file.

The 4Rx data (RxBIN(IIN)/RxPCN/RxGrp/RxID) on SPAP or ADAP ID cards and the 4Rx data a pharmacist enters must be the same as what is sent to CMS in the Data Sharing file.

For SPAP/ADAP payments to be applied correctly, the 4Rx data on the SPAP or ADAP claim must match the 4Rx eligibility data that was sent to CMS in the SPAP or ADAP Data Sharing file.

The requirement is to send 36 months of eligibility data.

5. SPAP/ADAP supplemental claims payments must be routed to the Part D Transaction Facilitator for SPAP/ADAP dollars to electronically count towards TrOOP.

Two options will allow this to happen:

- Using an online processor to electronically process claims at the point-of-sale will allow claims to route automatically to the Part D Transaction Facilitator.
- Sending a batch file of supplemental claims payments to the Part D Transaction Facilitator and performing the other steps of coordination of benefits will help apply SPAP/ADAP dollars to count towards TrOOP.

SPAP and ADAP can monitor acceptance rates of TrOOP dollars at <http://medifacd.relayhealth.com/> and <http://medifacd.relayhealth.com/nx/supplemental-payers/nx-batch-transactions>

6. SPAP/ADAP Processor Requirements

- Performs exact matching for 4Rx data submitted on the real-time claim.
If the 4Rx data is missing or does not match, reject the claim.
- Reject claims where Medicare Part D is identified as the primary payer for beneficiaries.
SPAP/ADAP Processors can identify these beneficiaries by using the information returned on the CMS SPAP/ADAP data exchange file. This file identifies all beneficiaries currently enrolled in a Medicare Part D plan.

7. Update the information for specific SPAP or ADAP within the HPMS module

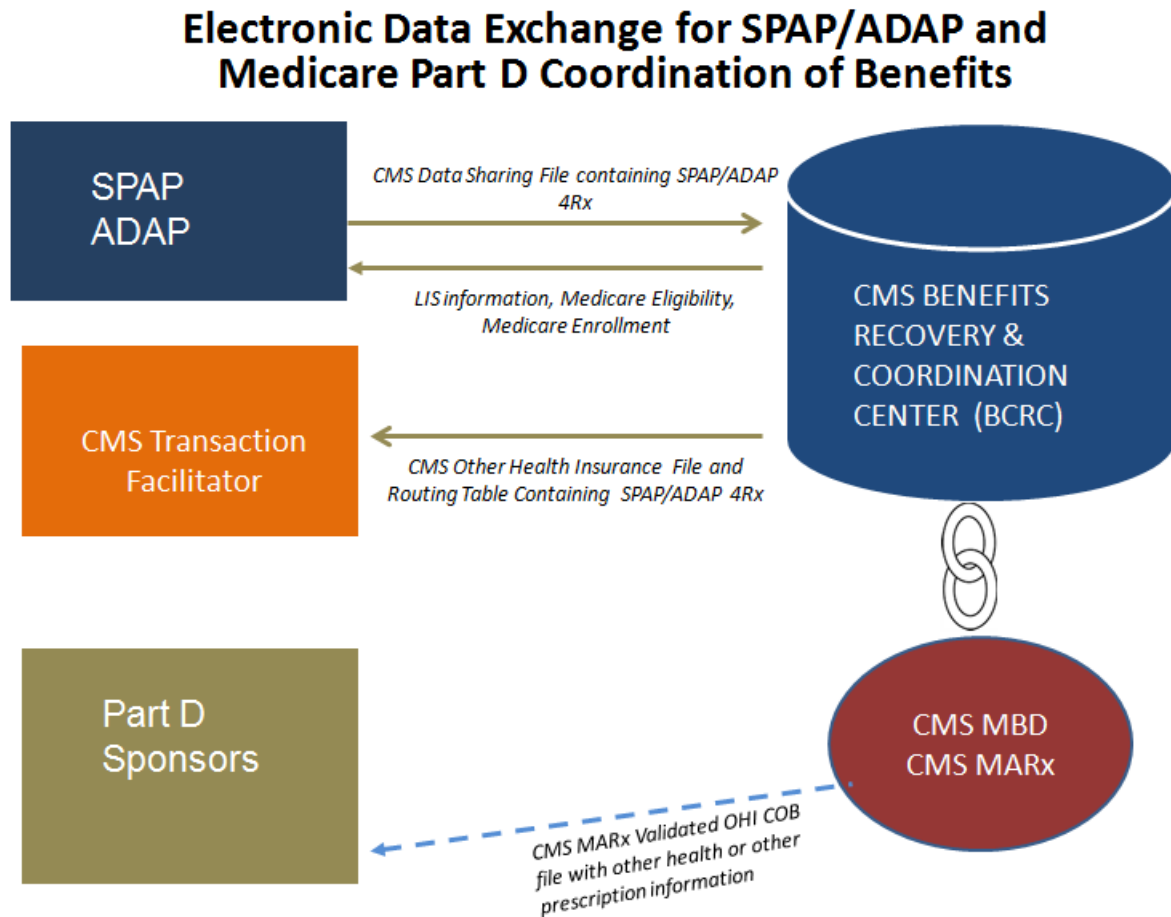
Periodically review the information that appears in the HPMS module for specific SPAP/ADAP.

The information in the HPMS module is an input to the NCPDP SPAP ADAP BIN(IIN)/PCN list which is available to the general public at <http://www.ncdp.org/Resources/SPAP-ADAP-BIN-PCN>.

5. ILLUSTRATED FLOW OF ELECTRONIC DATA EXCHANGE FOR SPAPS AND ADAPS

Eligibility data sharing is the first step in the coordination of benefits process. Sharing the eligibility data electronically allows the pharmacies to be aware of any SPAP or ADAP coverage. From this data exchange process, the pharmacy can bill any remaining portion of the patient responsibility after Medicare was billed to the SPAP or ADAP. Mail order, home infusion, and specialty pharmacies find this very beneficial when the beneficiary is not present at the time the claim is processed and cannot provide evidence of other secondary insurance.

CMS requires SPAPs and ADAPs to have a unique BIN(IIN)/PCN combination for TrOOP eligible members. This unique BIN(IIN)/PCN combination or the supplemental insurer type code on the CMS SPAP or ADAP data sharing file help identify TrOOP eligible dollars.



6. ILLUSTRATED FLOW OF REAL TIME CLAIM DATA EXCHANGE SPAP/ADAP PROCESS

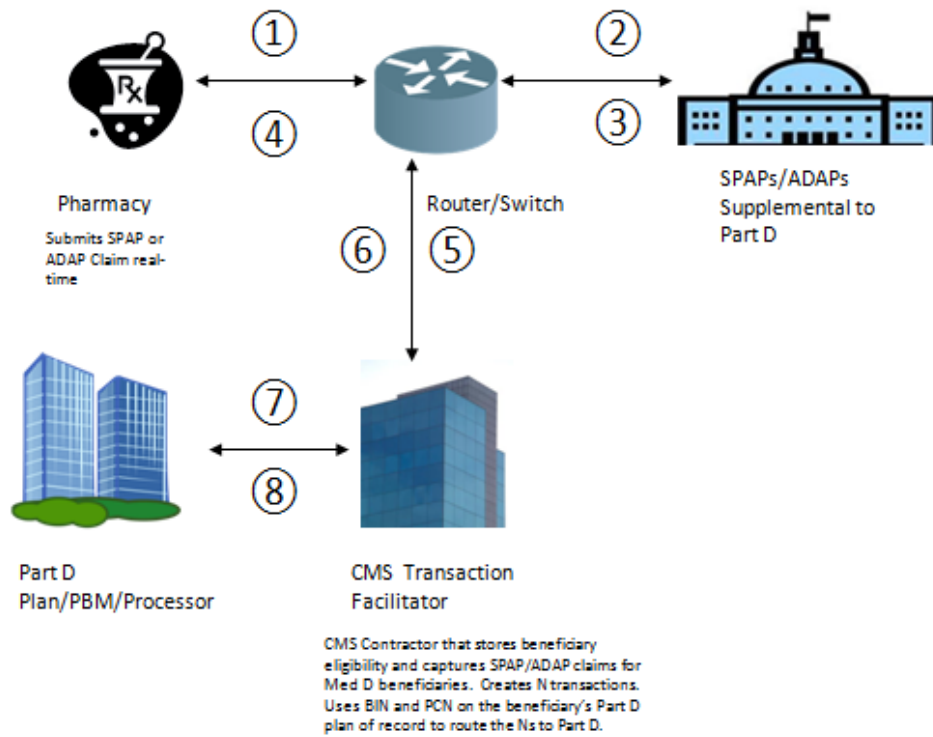
The illustrated supplemental flow starts after the Part D claim has been adjudicated by the Part D Processor.

1. The Pharmacy sends the Claim Transmission Request to the Switch/Service Intermediary.
2. The Switch/Service Intermediary sends the Claim Transmission Request to the SPAP/ADAP Supplemental to Part D.
3. The SPAP/ADAP Supplemental to Part D receives the Claim Transmission Request and sends a Claim Response to the Switch/Service Intermediary.
4. The Switch/Service Intermediary sends the Claim Response to the Pharmacy.
5. The Switch/Service Intermediary compiles and sends the Claim Request and Claim Response to the Part D Transaction Facilitator.
6. The Part D Transaction Facilitator responds to the Switch/Service Intermediary.
7. The Information Reporting (N transaction) is created and routed to the Part D plan of record on file with CMS for that beneficiary's date of service.
8. The Part D plan responds to the Information Reporting transaction with an acceptance or rejection.

Note: If the SPAP/ADAP BIN(IIN)/PCN for your program does not match the NCPDP SPAP/ADAP BIN(IIN)/PCN list and that same BIN(IIN)/PCN is not present on your cardholder's other health insurance (OHI) on file with CMS, no N transaction will be generated. As a result, nothing will be routed to the Part D plan and the SPAP/ADAP dollars paid towards the claim will not be electronically counted towards TrOOP.

Note: If your Pharmacy does not use a Switch/Service Intermediary, refer to <http://medifacd.relayhealth.com/nx/supplemental-payers/nx-batch-transactions>

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Note: The term BIN has been replaced with IIN.

7. SPAP/ADAP DATA EXCHANGE IMPACTS

BENEFICIARY IMPACTS

SPAP and ADAP Participating in Data Exchange:

- Allows SPAP/ADAP coordination of benefits to occur electronically without beneficiary involvement.
 - The pharmacist is made aware of the beneficiary's supplemental coverage electronically. Any remaining out-of-pocket expenses can be routed electronically to the supplemental payer (SPAP or ADAP).
 - The electronic coordination of benefits can be very beneficial for mail-order and specialty pharmacy fills where the beneficiary is not present to assist in the coordination of benefits.
 - With the SPAP/ADAP eligibility being present with a Part D Sponsor at the time a claim is processed, supplemental payer dollars count towards TrOOP which allows the beneficiary to move through the Part D phases as designed.
 - Beneficiary benefits are fully maximized when using electronic coordination of benefits.
 - Beneficiary financial liabilities will be reduced.

SPAP and ADAP Not Participating in Data Exchange:

- Does not allow SPAP/ADAP coordination of benefits to occur electronically without beneficiary involvement.
 - If the data sharing file is not sent, the pharmacist is not made aware of the beneficiary's supplemental coverage electronically. Often, the beneficiary does not have full details of their existing coverage. This causes a disruption of care when the beneficiary cannot afford the medication. The beneficiary may leave the pharmacy without their prescription, which may lead to an interruption of coverage/care.
 - If no data sharing occurs, a negative financial impact to the beneficiary's mail-order and specialty pharmacy fills may occur.
 - Beneficiaries may not experience the benefit of a qualified payer. SPAP/ADAP claims dollars may not count toward TrOOP expenses.

SPAP/ADAP IMPACTS

SPAP and ADAP Participating in Data Exchange:

- SPAPs and ADAPs may be financially refunded as a result of participating in the data exchange as a result of claim adjustments.
- SPAPs and ADAPs receive low income subsidy data and Part D eligibility and enrollment information on the CMS response file.
- Enables the Part D Transaction Facilitator to match the OHI with the claims data to locate the Part D plan of record. This allows the N transaction to be routed to the Part D Sponsors for TrOOP application.
- SPAPs and ADAPS would have the capability to use the Part D Transaction Facilitator supplemental payer reports which allows visibility to N transaction acceptance rates.

SPAP and ADAP Not Participating in Data Exchange:

- Part D Sponsors may not be able to refund SPAPs/ADAPs as a result of claim adjustments because the information is not available.

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- Pharmacies will not have other coverage information on file to perform coordination of benefits. This could lead to disruption of care, no access to medication and member dissatisfaction.

8. ANNUAL AND ONGOING RESPONSIBILITIES OF THE SPAP/ADAP PROGRAMS AND THEIR PROCESSORS

1. Data Use Agreement with CMS

Current/active SPAP/ADAP contacts will receive an email message from CMS via the HPMS system to log in and submit coverage details for their program, as well as an attestation that the program information submitted aligns with all applicable Medicare guidance and regulations. CMS typically requests this information be submitted no later than August 4th of each year to permit time for reviews, coordination of benefits with Part D Plans and for clarification of any additional information as needed.

States with programs registered in the HPMS module can go in at any point during the year to make updates to staff contact information, as well as to update BIN(IIN)/PCN processing information if there is a mid-year change.

2. Continue to Send Electronic Eligibility Data to CMS

Data is exchanged between the SPAP/ADAP and CMS monthly.

The 4Rx data on ID cards and the point-of-sale edits for 4Rx data must be the same as what is sent to CMS. For SPAP/ADAP payments to be applied correctly, the 4Rx data must match the 4Rx eligibility data sent to CMS.

3. SPAP/ADAP supplemental claims payments must be routed to the Part D Transaction Facilitator for SPAP/ADAP dollars to count towards TrOOP.

Two options will allow this to happen:

- Using an online processor to electronically process claims at the point-of-sale will allow claims to route automatically to the Part D Transaction Facilitator.
- Sending a batch file of supplemental claims payments to the Part D Transaction Facilitator and performing the other steps of coordination of benefits will help allow SPAP/ADAP dollars to count towards TrOOP.

<http://medifacd.relayhealth.com/>

and

<http://medifacd.relayhealth.com/nx/supplemental-payers/nx-batch-transactions>

4. Ensure pharmacy edits are locked down (only applies to real-time)

Require pharmacies to submit the correct 4Rx data elements on all claims submissions for your SPAP or ADAP. The information should be the same as your Cardholder ID cards and should be in alignment with the 4Rx data sent on the Data Sharing File.

Reject claims for missing/invalid

- BIN(IIN)
- PCN
- RXGRP
- Cardholder ID

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To ensure your payments assist the beneficiaries, reject claims where Medicare Part D should be the primary payer for beneficiaries. The identification of Part D enrollment can be obtained by using the SPAP/ADAP eligibility response file from the CMS COB Contractor. Using information from this file requires pharmacy claims to be billed to the primary payer.

5. Review and/or update the information for specific SPAP or ADAP in the HPMS module

Periodically review your SPAP or ADAP information that appears within the HPMS module.

The information in the HPMS module is an input to the NCPDP SPAP ADAP BIN(IIN)/PCN list which is available to the general public at <http://www.ncdp.org/Resources/SPAP-ADAP-BIN-PCN>.

9. RECOMMENDED STEPS WHEN CHANGING BIN(IIN) AND/OR PCN AND/OR PROCESSOR

NCPDP RECOMMENDATION FOR SPAPs/ADAPs when changing processor, adding processor, or changing BIN(IIN)and/or BIN(IIN)/PCN:

- Notify prescription drug industry at least 60 days in advance of upcoming changes by:
 - Updating the CMS HPMS module which will provide notification to
 - CMS
 - NCPDP
 - Part D Transaction Facilitator
 - Notifying the Switch/Service Intermediary entities
 - Publishing and distributing updated Payer Sheet with updated information and effective date to notify pharmacies

To ensure Medicare Part D beneficiaries' TrOOP is accrued properly, it is recommended the former BIN(IIN)/PCN be used for any adjustments for dates of service prior to the new BIN(IIN)/PCN or processor. To accomplish this, it is recommended there is communication and sharing of data between the old and new processor.

Scenario 1 Former Processor A processes historical claim (runout) data

The Former Processor A is processing historical claim (runout) data. The New Processor B will process all new claims for dates of service 1/1/2015 and forward will use the new BIN(IIN)/PCN.

Using January 1, 2015 (1/1/2015) as the example effective date, follow the steps listed below.

1. Description:
 - a. Former Processor A processes claims through 12/31/2018 under their own unique BIN(IIN) and PCN.
 - b. New Processor B processes claims with date of fill of 01/01/2019 and forward under their own unique BIN(IIN) and PCN.
2. 4Rx changes
 - a. Communicate or report information to CMS:
 - i. Report new BIN(IIN)/PCN information to CMS via the HPMS module.
 - b. SPAP/ADAP OHI should be relayed to CMS to reflect BIN(IIN)/PCN change with new effective date of 01/01/2019 and to reflect the termination date of 12/31/2018 for the old BIN(IIN)/PCN.
 - c. SPAP/ADAP current eligibility and all history must be sent to CMS for a period of 36 months due to COB requirements.
3. Switch/Service Intermediary entities notification
 - a. If BIN(IIN) with New Processor B is a new BIN(IIN) for that processor – New Processor B must notify Switch/Service Intermediary entities to add BIN(IIN).

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- b. If BIN(IIN) is an existing BIN(IIN) for the New Processor B, then no action related to Switch/Service Intermediary entities is necessary.
4. Changes for Part D Transaction Facilitator
 - a. If BIN(IIN) with New Processor B is a new BIN(IIN) for that processor – SPAP/ADAP must notify the Part D Transaction Facilitator to add BIN(IIN) at TBTSupport@relayhealth.com.
 - b. If BIN(IIN) is an existing BIN(IIN) for the New Processor B, no action related to the Part D Transaction Facilitator is necessary.
5. Changes for Pharmacy
 - a. The Former Processor A should update the payer sheet for the SPAP/ADAP to indicate it is valid only for dates of service through 2018.
 - b. The New Processor B should create a payer sheet that communicates:
 - i. The new BIN(IIN)/PCN is effective for dates of service for 2019.
 - c. All claims/reversals for dates of service prior to 2019 should be submitted to the old BIN(IIN)/PCN.
 - d. In addition to the payer sheet, it is recommended the Former and New Processor should consider additional, alternative communication (email, fax) to pharmacy.
 - e. The New Processor B should consider claims/reversals testing by Pharmacy.
6. Timing

If this is a new BIN(IIN) for New Processor B –allow 30-60 days prior to the effective date for the Switch/Service Intermediary entities and Part D Transaction Facilitator to update their routing tables.

Scenario 2 New Processor B will process historical claim (runout) data

The Former Processor A is not processing historical claim (runout) data. The New Processor B will process prior year historical data with the old BIN(IIN)/PCN (i.e. where the BIN(IIN)/PCN belongs to the plan and/or the former BIN(IIN)/PCN will not be used by any entity for future claims) and all new claims for dates of service 1/1/2019 and forward will use the new BIN(IIN)/PCN.

The SPAP or ADAP must ensure all historical information from the Former Processor A is transferred and imported into the New Processor B system (e.g. eligibility, benefit set up and design, prior authorization, claims history, formulary, information reporting, etc.) The intent is for the New Processor B to process in the same manner as the Former Processor A. The change in processor should be transparent.

Using January 1, 2019 (1/1/2019) as the example effective date, follow the steps listed below.

1. Description:
 - a. New Processor B processes claims through 12/31/2018 under Processor A's unique BIN(IIN) and PCN.
 - b. New Processor B processes claims with date of fill of 01/01/2019 and forward under their own unique BIN(IIN) and PCN.
2. 4Rx changes
 - a. Communicate or report information to CMS:
 - i. Report new BIN(IIN)/PCN information to CMS via the HPMS module.
 - b. SPAP/ADAP OHI should be relayed to CMS to reflect BIN(IIN)/PCN change with new effective date of 01/01/2019 and to reflect the termination date of 12/31/2018 for the old BIN(IIN)/PCN.

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- c. SPAP/ADAP current eligibility and all history must be sent to CMS for a period of 36 months due to COB requirements.
3. Switch/Service Intermediary entities notification
 - a. If BIN(IIN) with New Processor B is a new BIN(IIN) for that processor – New Processor B must notify Switch/Service Intermediary entities to add BIN(IIN).
 - b. If BIN(IIN) is an existing BIN(IIN) for the New Processor B, then no action related to Switch/Service Intermediary entities is necessary.
4. Changes for Part D Transaction Facilitator
 - a. If BIN(IIN) with New Processor B is a new BIN(IIN) for that processor – SPAP/ADAP must notify the Part D Transaction Facilitator to add BIN(IIN) at TBTsupport@relayhealth.com.
 - b. If BIN(IIN) is an existing BIN(IIN) for the New Processor B, no action related to the Part D Transaction Facilitator is necessary.
5. Changes for Pharmacy
 - a. The New Processor B should create a payer sheet that communicates the 4Rx data to be billed including dates of services and the prior year rules for reversals and claims.
 - b. Note: Need to clearly indicate the runout period for prior year so Pharmacy can update beneficiary's profiles appropriately.
6. Timing
 - a. The old BIN(IIN)/PCN has moved to the New Processor B as of 01/01/2019 – allow 30 days prior to the effective date in order for the Switch/Service Intermediary entities and Part D Transaction Facilitator to update their routing tables. This assumes the Former Processor A was processing electronic transactions.
 - b. If new BIN(IIN)/PCN for 2019 is a new BIN(IIN) for that processor – allow 30-60 days prior to the effective date in order for the Switch/Service Intermediary entities and Part D Transaction Facilitator to update their routing tables.

10. FREQUENTLY ASKED QUESTIONS

10.1 WHAT ARE 4RX CHANGES?

Background: Four common data elements are used throughout the pharmacy industry to identify a beneficiary and to electronically submit claims. The same data elements can usually be found on the cardholder's identification card. These are referred to as 4Rx Data Elements. The four required fields are essential for the routing of information used in the adjudication of prescription drug claims. The four fields allow the claim transaction to be sent to the correct prescription drug claims processor which allows cost sharing to be returned real-time to the pharmacy.

This data allows payment on behalf of the beneficiary to be counted toward TrOOP. Incorrect 4Rx data can result in negative financial impacts to the beneficiary and the State program.

Any changes to these data elements would result in the SPAPs/ADAPs/Processor having to make certain updates as referenced in Section "[Recommended Steps When Changing BIN\(IIN\) and/or PCN and/or Processor](#)".

1. RxBIN(IIN): This is the Bank Identification Number (Insurance Industry Number)
2. RxPCN: This is the Processor Control Number
3. RxGrp: This is the RxGroup ID; this is NOT for the Employer Group ID used for medical claims. This field is optional but must be consistent between the OHI and the claims.
4. RxID: This is the cardholder identification number for the SPAP or ADAP.

For SPAPs and ADAPs to have electronic Coordination of Benefits occurring with Part D sponsors, CMS requires the 4Rx data on the claim to match the data on the Eligibility File. Therefore SPAPs/ADAPs must time line any changes in the data elements on the CMS Data Sharing File. SPAPs/ADAPs can experience a negative financial impact by not properly time-lining eligibility data to CMS. This may also result in beneficiaries experiencing negative financial impacts by not moving through the Part D stages appropriately.

Examples:

- Change in Processor with a new BIN(IIN)/PCN combination: SPAP changes processors on 8/1/14 and neglects to send the OHI to CMS with the new BIN(IIN)/PCN combination. SPAP processes claims on and after 8/1/14 with the new BIN(IIN)/PCN combination and neglects to update the SPAP/ADAP BIN(IIN)/PCN list. This situation would cause non-matched OHI for the N Transactions and limit the ability to receive financial refunds from Part-D sponsors for adjusted claims.
- Change in Processor without a new BIN(IIN)/PCN combination
- Change in Beneficiary Identification Number
- Change in/Add/Delete RxGrp
 - The 4Rx data elements on the OHI in the Data Sharing File need to be the same as the data elements required to process a claim. Processors should configure their adjudication logic to require the exact data elements and reject claims for M/I (missing or invalid) information where necessary.

Refer to *Overview of COB processes white paper* at <http://ncdpd.org/Resources/Medicare-Part-D> for 4Rx requirements.

11. APPENDIX A. HISTORY OF REFERENCE GUIDE CHANGES

11.1 VERSION 2.0

- Removed outdated website links and added links for the HPMS module to the Resources section.
- Added AIDS Drug Assistance Program (ADAP), HPMS SPAP ADAP Attestation, and State Pharmaceutical Assistance Program (SPAP) to the Acronyms and Definitions section.
- Modified the following sections to update any references to manual processes which have been replaced with the automated process through the HPMS module:
 - CMS Requirements for Coordination of Benefits
 - Essential Steps for Successful Electronic Coordination of Benefits
 - Annual and Ongoing Responsibilities of the SPAP/ADAP programs and their processors
 - Recommended Steps when changing BIN(IIN) and/or PCN and/or Processor
- Removed Appendix with Advanced Notice since the paper form is no longer used.
- Changed CMS Transaction Facilitator and Transaction Facilitator to Med D Transaction Facilitator throughout the paper.
- Updated the dates used in the scenarios in Section 9.
- Added Insurance Industry Number (IIN) acronym wherever BIN is referenced.