Original Source Data Submitter Project

Questions and Answers Document for APD Data Submitters

Version 1.11 – November 2021

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Contents

The OSDS Project Team welcomes feedback and comments on this document, please contact us at:

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Original Source Data Submitter Project (OSDS) Questions and Answers

Version 1.10 – May 2021

1. Overview and Purpose of Document

The information presented in this document is current as of the date indicated on the cover page and reflect ongoing dialogue between the OSDS Project Team and All Payer Database (APD) Data Submitters during the development phase of the OSDS project. Questions in this document were sent to the Optum Service Now help desk were raised during informational sessions facilitated by the OSDS Project Team.

APD Data Submitters are urged to familiarize themselves with this document to be fully informed on the most recent communications from the OSDS Project Team.

This document will continue to be updated as questions are received and/or subsequently clarified during the development phase of the OSDS system. Every effort has been made to provide accurate and complete information. Edits, deletions, or changes to this document will be maintained as updated versions of this document are released.

The OSDS Project Team welcomes questions and feedback to: apd.osds@health.ny.gov.

The OSDS Help Desk is available at (877) 363-5630 or a ticket can be created through ServiceNow at https://optum.service-now.com/itss2 for assistance with technical questions.

2. General Information

General Question	Answer
How can I be included on email distribution lists for the OSDS project?	Email apd.osds@health.ny.gov to be added to the APD Data Submitter distribution list.
Is there a public website for the OSDS Project?	The New York State (NYS) Health Connector: https://nyshc.health.ny.gov/web/nyapd/apd-osds
What is the best way to stay connected and informed on updates for the OSDS Project?	The OSDS Project Team conducts a series of monthly information webinars which are published on the NYS Health Connector at https://nyshc.health.ny.gov/web/nyapd/apd-osds

General Question	Answer
When will OSDS Companion Guides be made available?	OSDS Companion Guides are now available on the NYS Health Connector under Guidance Manuals located at https://nyshc.health.ny.gov/web/nyapd/apd-osds-guidance-manuals
What is the added value of the OSDS system?	The OSDS system allows for the submission of off-exchange commercial data to support the required functions of the NYS All Payer Database.
What will be the OSDS' source of Medicaid enrollment data?	The primary source of Medicaid enrollment data will be the New York State of Health (NYSOH). The OSDS system will also receive Medicaid enrollment data from eMedNY.
Does NY have IRB approval to receive the Commercial Substance Use Data?	APD Data Submitters are required to comply with 10 NYCRR Part 350 data reporting standards. The NYS APD is currently approved by the Department of Health (DOH) IRB as a research system.
Will the OSDS system testing server be secure or unsecure?	The OSDS system server will be secure.
Will the Encounter Data Quality (EDQ) report card still be valid and will it be changed now that the CHP component is not part of the MEDS?	OHIP does not believe there will be any changes made to the EDQ report card. Please continue to reach out to OHIP with policy related questions.
The OSDS Project Team collects both administrative and technical contacts from APD Data Submitters. Will technical communications be sent to both the technical and the administrative contact?	All OSDS communications intended for an organization's primary technical contact will also be sent to the designated administrative contact.
How are questions and comments from OSDS Informational WebEx shared with APD Data Submitters?	Questions from OSDS Informational WebEx meetings are included in updated versions of this document, which is published on the NYS Health Connector.
My company will be submitting on behalf of data submitters. How are TPAs kept in the loop?	Anyone who is submitting data to the OSDS needs to provide a primary administrative and a primary technical contact from that organization. These contacts will be used to distribute information as well as to initiate OSDS Registration Process.
Our organization will not be submitting data to the OSDS directly. We utilize a TPA and PBM who submit on our behalf. Do we need to complete a DSA or EDI Registration Form?	Yes, even if an organization is not submitting data directly, they are required to complete the OSDS Registration Process. Information gathered during the process is used to confirm the connections between issuers and the vendors they utilize.

General Question	Answer
How can we access presentations given during OSDS training, informational webinars, or other sessions?	Training presentations are provided to participants in one of two ways: 1. Response file training presentations are attached to the meeting invitation or sent to participants via email. 2. The NYSDOH Informational Webinar presentations are added to the Information Library on the NYS Health Connector: https://nyshc.health.ny.gov/web/nyapd/information-library
How can we access the weekly known issue log and release notes?	Known issue log and release notes are sent to the outbox associated to the data submitters OSDS SFTP ECG connection. These documents are sent on a weekly basis.
How can we receive the weekly known issue log and release notes outside of the OSDS SFTP ECG connection?	DOH decided that the most efficient and expedient method of distributing updates was via the OSDS SFTP ECG connection.
Can the known issue log be updated to include a target date for resolution?	Issues are added to the known issue log as they are identified and collected. The known issue log enables data submitters to have visibility on the issues that are being remediated. Release notes identify when an issue is resolved. Known issues may be discussed during the weekly submitter forums. Submitters are encouraged to participate in these meetings and request updates.
What reference materials are available that document the implementation steps and address questions?	There are Implementation Guides for every subject area. As a reference source, you will want to start with the Implementation guides, as they provide detailed instructions and examples to help explain requirements. All Implementation guides can be purchased in x12 store, with exception of the NCPDP implementation guide, which can be purchased at NCPDP.org. In addition, we have created Companion Guides for each Implementation Guide. These are not meant to replace the implementation guides but rather to provide supplemental information. Companion guides can be found at the NYS Health Connector Site.

General Question	Answer
What is the projected date the OSDS will go live?	The OSDS opened for 834 submissions on August 3rd, 2020. The system is projected to open for commercial and Medicare LOB submission of encounters on November 9, 2020. No official date has been set for the transition from the EIS to the OSDS. We anticipate the LOB currently being submitted to the EIS to transition to the OSDS in early 2021. The implementation date will be based on a number of factors including the timeframe required to transfer EIS history files to the OSDS. DOH will continue to work with both the EIS and OSDS project teams to determine the implementation date and communicate updates through the informational webinars.
Is Social Security Number a required field on the file? We are trying to eliminate the use of Social Security Number as a member id due to concerns with privacy	Social Security Number is not required if you do not know it. If you do know it, it is expected.
We use HIPAA Suite to report EDI transactions. The 834 x318 is not supported by HIPAA Suite. What options are available to address this?	Submitters experiencing similar challenges are encouraged to email apd.osds@health.ny.gov to arrange a conference call to discuss potential options.
We receive our 834 enrollment file through Marketplace, via the current EIS system. Since there is no mention of these 834 files being replaced by the OSDS system, is it ok to assume that we will continue to receive these 834 files through Marketplace via the EIS system once OSDS goes live?	Anything that you received via the health exchange now you will continue to receive. If your lines of business are covered within the health exchange you will continue to receive your membership information via the same mechanism. You will change where you are submitting your data to be to the OSDS once we go live rather than the EIS.
Do issuers have the option to wait until 2021 to begin production submissions of Medicare and Commercial encounters when the full transition to OSDS will occur or are they required to build and maintain both the EIS and OSDS submission and response channels simultaneously?	DOH expects Commercial and Medicare data to be submitted when the OSDS opens in September 2020. Organizations that believe they cannot meet this timeline, should email the OSDS Team at apd.osds@health.ny.gov.
How do I obtain access to the APD OSDS Portal?	To access the APD OSDS Portal, please open a Help Desk ticket with Optum. Optum will provide the instructions to obtain access in the form of an attachment detailing the instructions for access to the APD OSDS Portal.

3. Data Submitter Information

Information in this section is supplemented by the OSDS STANDARD COMPANION GUIDE – Data Submitter Information

https://nyshc.health.ny.gov/documents/39436/108308/osds_standard_companion_guide_data_submitter_information.pdf

Data Submitter Question	Answer
Who will submit member and encounter data to the OSDS system?	All current Encounter Intake System (EIS) Data Submitters will submit encounter data to the OSDS system for their Medicaid (MMC), Child Health Plus (CHP), Essential Plan (EP) and Qualified Health Plan (QHP) members. All current EIS Data Submitters will be required to migrate to the OSDS system. Medicare Advantage and off-exchange commercial issuers will submit member and encounter data. The OSDS system includes all commercial lines for mandated reporting. Employee Retirement Income Act (ERISA) issuers may voluntarily report. Please see the APD Data Submitters letter for issuers in the informational library of the health connector for more information. SHOP/commercial encounters will be implemented in the OSDS system
How far back will APD Data Submitters need to submit data?	For off-exchange commercial data, when the OSDS system goes into production, calendar year 2018, 2019, and year to date 2020 enrollment and encounter data should be submitted. For all lines of business that are currently being reported to the EIS, issuers will migrate from the EIS to the OSDS system for submissions.
Claims data shall include medical, dental, and pharmacy. Do we need to also include vision claims?	Vision encounters should be submitted to the OSDS system.
How similar will the commercial submission files be to the existing QHP submission files?	Mostly identical, but further specifications are delivered in the OSDS Companion Guides and the Tier II Edit Disposition.
How will files be submitted to the OSDS system? Will there be changes between the EIS and the OSDS system?	The OSDS system will use its own Secure File Transfer Protocol (SFTP) connections. Connections will be established during the Electronic Data Interchange (EDI) registration process.
Would off-exchange include just HMO under Article 44 or would it also include EPO, PPO and large group claims under Article 42 as well?	Per APD regulations, the OSDS system will be collecting data on both articles referenced and would include large group data as well.
Will Workman's Compensation data be required in the commercial data submissions?	Workman’s compensation will not be collected in OSDS at this time.
What will the frequency of submissions be for the data? As you know, Medicaid submissions are daily.	The specific frequency for Medicaid programs is determined by the responsible DOH program. Medicaid issuers should continue to adhere to the encounter submission frequency required by the Medicaid Model Contract. Outside of any contractual requirements, the expectation is weekly with a minimum frequency of submission for each line of business is monthly.

Data Submitter Question	Answer
What will be the maximum number of lines that can be submitted on the outbound file? For Medicaid today, it is 12k lines.	A determination of maximum lines has not yet been made. The OSDS system has not identified a restriction based upon the number of lines submitted. The OSDS system has determined that a submitted file cannot exceed 50MB.
Is OSDS limited to commercial submitters?	No, the OSDS system will collect medical, dental and pharmacy encounter data from current EIS submitters in addition to off-exchange commercial and Medicare Advantage member roster and encounter data. ERISA plan reporting is voluntary.
If an issuer collects data from different systems (for example, a system for group off-exchange and a system for individual off-exchange), will this data need to be merged for reporting purposes or can two separate reporting files be made?	Separate reporting files can be submitted to the OSDS system.
Do you anticipate changes to the current 837 outbound file naming convention? Will CHP have a separate file name even though the current HIOS may be the same as mainstream Medicaid?	Yes, there will be changes to the current 837 outbound file naming convention. The CHP submission will require a different file name which will indicate the different line of business. Please refer to the OSDS Standard Companion Guide Data Submitter Information for more information.
Will insurers be required to be re-certified before submitting files to the OSDS system, even for the current data being collected (QHP, EP, MMC, and CHP)?	Yes.
For non HIOS based plans, would the combination of National Association of Insurance Commissioners (NAIC) plus Group ID plus Benefit plan be an example of what the OSDS system would accept for an off-exchange commercial plan identifier? I was just trying to interpret the requirement where we would take the NAIC and then come up with some unique combination of IDs to create something that would be a replacement for the 16-digit HIOS ID when it is not an ACA plan and it is not being sold on-exchange. It sounds like you're asking for it all to be numeric as opposed to alpha-numeric.	Each submitter will have their own business practices. The general guidelines are to conform to an Issuer, Product, and Plan level identifier which can be consistently reported for the members enrolled within it. It is up to submitters to establish an identifier that will be accepted by the OSDS system. The OSDS system will accept alpha-numeric plan identifiers. Please refer to the OSDS Standard Companion Guide Data Submitter Information for more information.
Can you confirm that in NY the HIOS ID will stay the same from year to year? HIOS numbers in other states can change.	If an organization does not change corporate structure, the HIOS should not change.

Data Submitter Question	Answer
If we are submitting information for multiple plans, should information for each plan be submitted in different files?	The requirement is to submit a file for each Line of Business (LOB) and issuer identifier. For QHP, EP, CHP and MMC LOB's, the OSDS system will accept those files separately by five-digit HIOS and LOB. When an Issuer has multiple HIOS IDs, the issuer should submit the HIOS ID that is used for the plans that are contained within the submission for that LOB. Off-exchange commercial non-ACA files must be submitted separately by NAIC or the assigned OSDS Submitter ID to the OSDS system, whichever is appropriate for that LOB.
Is the intention to create the NAIC group plan combo for State products too?	Having NAIC group and plan type combination would be for the non-ACA / non-State products. The ACA and State products should report the 14-digit HIOS if available.
If we can submit the 16-digit HIOS commercial plan ID, are we required to submit the NAIC?	If you have a commercial HIOS ID, please submit the 14-digit HIOS. The NAIC should be submitted if there is no HIOS ID.
Is the 16 digits requirement for Managed Long-Term Care (MLTC) and Fully Integrated Duals Advantage (FIDA) also or only other types of plans? Also, where can I find the different values that are populated in the various segments of the HIOS ID?	The preferred method is to report a 14-digit HIOS ID, however, NYSDOH will provide further guidance if this method cannot be met.
Is a data submitter registration required for OSDS system, like it is for EIS? Is it different than being a trading partner?	Yes, all data submitters will be required to register prior to submitting data to the OSDS system. The transactions for off-exchange commercial health plan data that will be submitted to the OSDS system are not included in the list of Health Insurance Portability and Accountability Act (HIPAA) -covered transactions at 45 CFR Part 162. As a result, the HIPAA transactions standards regulations do not govern the submission of off-exchange commercial data to the OSDS system, and data submitters will not execute a HIPAA Trading Partner Agreement with respect to the transmission of off-exchange commercial enrollment, encounter, and pharmacy information to the OSDS system. To establish the mutual obligations of data submitters and the Department with respect to OSDS transactions, data submitters will be required to sign an OSDS system Data Submitter Agreement upon registration. This Data Submitter Agreement will not replace or supplant any existing HIPAA Trading Partner Agreement(s) executed by an issuer with respect to eMedNY or NYSoH transactions; rather, the OSDS system Data Submitter Agreement will be in addition to such preexisting arrangements and will be specific to the OSDS system transactions. Issuers who submit data to eMedNY and/or NYSoH will continue to operate as HIPAA trading partners of those entities.

Data Submitter Question	Answer
Is a Health Insurance Oversight System (HIOS) ID number required for OSDS system? If so, how do I start the registration process?	No, a HIOS ID is not applicable to all lines of business. If a submitter already has a HIOS ID, it must be used when submitting data to the OSDS system that falls within the purview of the HIOS ID. Information on the registration process may be found in the OSDS Standard Companion Guide - Data Submitter Information.
Can you confirm if Self-Funded Administrative Services Only (ASO) products are considered commercial products and should be submitted to the OSDS? Our assumption is no but we want to verify.	Per the APD regulation at 10 NYCRR Section 350.1(k), self-insured health plans regulated by the Employee Retirement Income Security Act of 1974 (ERISA) are not required to submit data for inclusion in the APD. However, such self-insured health plans may elect to participate in APD data submission on a voluntary basis.
Is there a naming convention for the file name?	Please refer to the OSDS Standard Companion Guide - Data Submitter Information for detailed information on naming convention.
As a Third-Party Administrator will we need to submit a file for each issuer or one file with all issuers?	NYSDOH OSDS system expects to receive a file for each issuer.
How should we report large group and self-funded that don't have a HIOS ID number?	If it is an off-exchange cost share variance of an ACA product you should report the HIOS ID. All other non-ACA large-group/commercial products should be reported with the NAIC ID that corresponds to the product. In the event there is not a corresponding NAIC ID for the product being submitted, please use assigned OSDS Submitter ID followed by the plan and product ID.
What is considered "TPA relationship vs PBM"	For Third Party Administrator self-funded plans they would submit their information. PBMs serve a similar role as Third Party Administrators, but specifically for Pharmaceutical Benefits Management.
Can you please confirm which version number of the 837 specs will be used? Version 1.2?	The OSDS system will require X12 5010 specifications for X298 837P, X299 837I, and X300 837D.
What is the timeline to submit commercial dental production data?	Testing began mid-February 2020 and the OSDS System opened for production files for 834 submissions on August 3, 2020. The encounter data submissions for commercial and Medicare LOB began November 9, 2020. . The LOB currently being submitted to the EIS will transition to the OSDS in 2021.
Are there change logs available for the Companion Guides?	All OSDS Guidance Material contain change logs and version numbers. For the Tier II Edit Disposition, the change log can be found on the second tab of the excel spreadsheet. On all other Companion Guides, the Change Log appears on the last page of the document.

Data Submitter Question	Answer
When will details about the SFTP connection for testing and production will be shared for the OSDS project?	SFTP connection details will be shared during the EDI Registration process.
When reviewing the file name changes, will the QHP submission also need to be changed to include OSDS Submitted id?	All data submitters will receive an OSDS assigned Submitter Identifier and must use that identifier where applicable regardless of Line of Business. Please refer to section 3.1.4 of the OSDS Standard Companion Guide - Data Submitter Information located on the NYS Health Connector. The OSDS assigned Submitter Identifier will be provided with the EDI Registration Form.
Are there any consequences for not submitting 834-member roster files weekly?	New or changed member data not submitted on a timely basis may result in rejected encounters for those members. Rejected encounters may result in a submitter being out of compliance with reporting requirements.
Should HARP/MLTC be included within the Medicaid "M" files?	Yes, the HARP/MLTC would be considered a part of the Medicaid program.
If a data submitter is submitting paid claims information via NY EIS do, they need to register in order to start submitting to the OSDS system?	All APD data submitters need to sign a Data Submitter Agreement (DSA) and complete the EDI Registration Form to onboard to the OSDS System.
If we don't have to register or sign Data Submitter Agreement (DSA) again, can we submit APCD data using our existing HIOS ID for DDNY and DDIC data and another existing HIOS ID for DICNE data?	All data submitters are required to have a signed/approved DSA. The existing HIOS ID can be used in conjunction with the OSDS assigned Submitter Identifier which will be provided with the EDI Registration Form. The appropriate position for each element to be used can be found in the corresponding Implementation and Companion Guides.

Data Submitter Question	Answer
Currently when submitting in the EIS, our health plan does not zip files together if a file is split due to file size being greater than 50MB. Is this something we will now be expected to do for all file types in the OSDS system? What Naming Conventions should be used for the ZIP files?	If a file is greater than 50MB regardless of file type, the expectation is the file will be split and submitted in a .zip file. The .zip file naming convention for inbound files exchanged with the OSDS system is: (User ID).(Date Time).(zip) User ID OSDS assigned Submitter Identifier followed by the five-digit HIOS number or NAIC ID prefixed with" N" or the OSDS assigned Payer ID. (HIOS Example: Z1234512345, NAIC Example: Z12345N12345). Date Time 12-digit date and time stamp (24 hour time, in the format YYMMDDHHMMSS) File Extension as .zip HIOS EXAMPLE: Z1234512345.YYMMDDHHMMSS.zip NAIC EXAMPLE: Z12345N12345.YYMMDDHHMMSS.zip
Please clarify the 1/1/18 effective date. NYS OSDS is requiring that we submit claims from 1/1/18 to present. Is this only for the off exchange commercial data or do we need to include other LOBs? We assume this is for off exchange commercial since our Medicaid and EP data is already in EIS.	The January 1, 2018 date is for all Lines of Business that are not currently reported to the EIS.
Please advise how you plan to address connectivity issues?	Any issues with connectivity should be immediately reported to Optum Support Services at 877.363.5630 or submit a ticket at https://optum.service-now.com/itss2. If you do not receive a timely answer, please contact the OSDS Project team at apd.osds@health.ny.gov.
Are the terms in the OSDS Data Submitter Agreement (DSA) negotiable or do data submitters need to complete and return the OSDS DSA as it is?	The terms of the OSDS Data Submitter Agreement (DSA) are not subject to negotiation. The DSA must be completed and returned to the Department as-is and without alteration.
Our organization has a HIOS ID as well as 2 NAIC IDs. For our Large Commercial Population, we have non-ACA benefit plans that do not have the 16-digit HIOS ID. In this scenario, can we still use HIOS]PlanID]ProductID? That way, all our submissions (across all LOBs) will consistently point back to the submitted HIOS, regardless of the Benefit Plan structure.	Based on the scenario used "HIOS]PlanID]ProductID" would be correct.
If we have the same ISA13 for an 834 and 837 file, will the OSDS reject the file? What if the ISA13 is the same for a full replacement and a corrected file?	Every ISA, regardless of the file type, test/product status, etc. must have a number that is unique for the Submitter. If files are submitted without unique values, the file will be rejected.

Data Submitter Question	Answer
Can an organization sign up for more than one Optum ID to access the Help Desk?	Yes, the Optum ID is at an individual or user level basis. This ID associates the user of the helpdesk to Optum. If additional Optum IDs are needed, please send an email request to nys.osds@optum.com.
On the first page of the DSA, should we put an individual's name or the organization name on the line before "Data Submitter"? Does the contact on page 4 need to be the same as the person signing on page 5?	The organization name should be placed in the field on the first page as the agreement is between the organization and NYSDOH. The contact on page 4 should be one of the organization's primary contacts (either administrative or technical). This is often different than the individual signing on page 5 as this individual needs to be someone with the authority to bind the organization to its terms.
When does the EDI Registration Form need to be completed?	The EDI Registration form is a predecessor to establishing the SFTP connection and is sent after completion of a Data Submitter Agreement. This needs to be completed prior the organization being able to begin testing. The process can take up to 14 days. If you are having an issue completing a section of the form, please contact the helpdesk.
Please confirm if the 14-digit HIOS ID only applies to Commercial member reporting files (834) and encounter files (837, NCPDP). For all other LOB's encounters, we should submit the current 5-digit HIOS/Issuer ID.	For on-exchange commercial encounters, the NYSDOH will require submitters to send the 14-digit HIOS ID. Off-exchange commercial payers will not be required to submit a HIOS ID. Off-exchange payers are required to submit a composite of issuer plan product. (Please refer to the Companion Guides)
Do all submitter ID's begin with the letter "Z"?	All assigned submitter IDs begin with a "Z".
We understand that there is a 50MB file limit. However, will there be any transaction count limitations?	The OSDS system will not have a constraint related to the number of claims. As you stated the only constraint is 50MB file limit.
We have been assigned an OSDS Submitter Identifier with the EDI Registration Form. Should the Submitter Identifier be used in the 837 transaction or should the HIOS ID be used in the Submitter ID field? In addition, which ID should be used in Loop ID 1000A for the Submitted ID filed?	The Submitter Identifier is used to ensure the SFTP folders match the transaction submitter. If the Submitter Identifier is not valid for the SFTP inbox, the file will be rejected. The existing HIOS ID must be used in conjunction with the OSDS assigned Submitter Identifier which will be provided with the EDI Registration Form. The appropriate position for each element to be used can be found in the Data Submitter Information Companion Guides Section 3.1.4 located on page 11. User ID OSDS assigned Submitter Identifier followed by the five-digit HIOS number or NAIC ID prefixed with" N" or the OSDS assigned Payer ID. HIOS Example: Z1234512345 NAIC Example: Z12345N12345

Data Submitter Question	Answer
The Plan ID and Product ID information in the EDI Registration form, how it will be used by OSDS? Will It be matched against the Plan ID information provided in Loop 2750 Ref 02? What happens if we start offering a new plan in NY and that is included in our reporting, which was not available to us during the EDI Registration process. Will those member records be rejected?	The Plan Information tab of the EDI Registration form is intended to capture plan information to allow validation of Loop 2750 of the 834 file. When that member gets recorded within the 834 file, this will carry forward for what the 837 file will be validated against. This will all be linked together. To report changes to the information in this tab, the EDI Registration form has a question asking, "is this a new registration or an update to an existing?" This would be checked for update and a new version can be submitted. If you have a plan that you stop offering, there is a begin and end date to note when the plan was available. If a new plan becomes enrolled, it would be documented within this tab. If this is not completed, the Submitter's 834 file would be rejected.
We have more than 10,000 different Plan IDs and Product IDs associated with the plans we sell in NY. How can we report all of this information correctly on the EDI Registration form?	The EDI Registration Form has a separate tab as a spreadsheet, as some plans have thousands or records to report. We will input this spreadsheet when it is received. We are taking the information provided in the columns of this spreadsheet, interpreting what was provided and sending an email back to the Submitter to validate what is to be loaded is accurate. It will take about a week to load this new plan and product into the OSDS system.
How can we make a request for an additional individual within our organization to obtain an Optum ID? Is the ID associated with a company vs an individual?	You are able to work with the Optum Help Desk 877.363.5630 or submit a ticket at https://optum.service-now.com/itss2 to request an Optum ID for another individual. We will verify the request is for a submitting organization or issuer related to the OSDS before establishing the ID. This is an individual Optum ID associated with your Help Desk account as opposed to the Optum assigned submitter identifier provided on the EDI Registration form.
What HIOS ID should plans use on their current APD submissions (i.e.; Medicaid, EP, CHP and Commercial on-exchange) when they move to the OSDS? Our understanding was to use the current 5-digit HIOS ID.	The preferred method is to report a 14-digit HIOS ID, however NYSDOH will provide further guidance if this method cannot be met.
For TPA's submitting on the plan's behalf, will they be using their assigned OSDS Submitter ID or the plan's assigned Submitter ID?	When the TPA submits on behalf of the plans, they will use their assigned OSDS Submitter ID and use the plan's information.
When the OSDS system is goes live, does that mean issuers should begin submitting production files that day?	NYSDOH OSDS expects to receive production files on go live date. If a submitter feels they will not be ready on go live date, we encourage submitters to reach out to the OSDS Project Team for assistance.

Data Submitter Question	Answer
Can you please let us know when we can expect receive the Response File Training presentations via email?	All training slide presentations have been sent to participants. Please reach out to Optum through the help desk if you have not received these presentations.
Can you clarify when we are to use our NAIC number and when to use OSDS assigned submitter identifier? Do we continue to use our HIOS ID for Medicaid files?	The Submitter should continue to use the HIOS ID for Medicaid files. In Loop 2330B, the 14-digit HIOS ID would be provided. Anything the Submitter is currently doing within the EIS, on the exchange, you will continue to use your HIOS ID. For ACA plans outside of what is on the exchange and for SHOP, the HIOS ID would also be used. For commercial plans that are not subject to a HIOS ID, that is when the NAIC would be used. If your Medicare Advantage is incorporated into NAIC, then this would be used. If there are programs or self-funded that do not fall under the HIOS ID or NAIC, an Optum assigned Payer ID will be provided.
The HIOS ID we have is 5 digits. Where do we find the 14 digit one?	This is dependent on what type of data submitter you are. If you are operating in the Medicaid Managed Care program, and your members are currently enrolled on the health exchange, on the 834 that is provided to each data submitter or issuer, every member has an assigned 14 HIOS ID on that file. You would find it of the 834 file provided to you by the NYS Health Exchange. For programs such as Managed Long Term Care (MLTC), MAP and for programs where members are not enrolled solely through the NYS Health Exchange (and continue to be enrolled through the WMS), the 14 digit HIOS ID will not be provided. DOH is working with the OHIP program to define a process to provide this to the data submitter community.
How often should we submit files? Can we submit monthly or do you expect weekly submissions? If we submit files on a schedule other than weekly, will they be rejected?	Unless otherwise specified by a contractual requirement, we recommend that submitters use the following submission frequencies: • 837: Weekly (recommended but not mandatory), full file • 834: Weekly (recommended but not mandatory), full file Acceptable submission frequencies (files will not be rejected) are as follows: • Daily • Weekly • Biweekly • Monthly

Data Submitter Question	Answer
Should we delete files from the SFTP after we pick them up?	The ECG process does not provide submitters with delete permissions to the Outbox folders. ECG will automatically delete files from the Outbox folder as soon as it receives a status update that a file was downloaded. The next time you log in, or if you navigate out of the folder, refresh and go back into the folder. You will see that the files are gone.
Will the OSDS system use the nationwide APCD council's common claims file format?	The OSDS and EIS legacy system use the x12 and NCPDP file formats as described in the companion guides.
Should we add a TPA contact to the EDI Registration Form if the TPA will not be submitting data to the OSDS system?	If your TPA is submitting to EIS but not to OSDS, they do not need to be included in the EDI Registration Form.
We are setting up our SFTP connection. The IP addresses in the emails (both outbound and inbound file exchange) are listed as production. Are we missing an attachment, or do we use these IP addresses for both production and UAT?	Submitters will use the same IP address for both the UAT and production ECG connection servers. There are separate folders for UAT and production in your mailbox; the production folder name starts with the letter **Z**.

How can we distinguish between the file sent to NYS and the Acknowledgement (ACK) file received from NYS?	The submitted file has the Interchange Control Number that is used to distinguish between the submitted file and the received response files. Please refer to the naming convention outlined in the Data Submitter Companion Guide. For example:
	• Inbound files are prefixed with TR.
	• Outbound files from the OSDS system will have the following prefixes:
	  ○ RJ - Reject files
	  ○ IA - TA1 or RxFA
	  ○ FA - 999 or RxTA
	  ○ HN - 277DRA, RxCA, and 834RL

How often should submitters update plan information tab of the EDI Registration Form as new products are added and other products are terminated?	Submitters are encouraged to update this document as changes are made to ensure that the information is accurate and up-to-date. It is important to note that records will be rejected if these updates are not made. Submitters should use the Plan Information tab in their EDI Registration form to add and terminate products: • For new products, enter the date the plan was available in the Date Plan Became Available column. • For terminated products, enter the end date in the Date Plan No Longer Offered column. Submitters should submit updated EDI Registration forms to the helpdesk with a summary of what was updated.

Data Submitter Question	Answer
Is the 14-digit HIOS ID for Medicaid plans based on counties?	Yes.
Will a 16-digit HIOS IDs be rejected?	Yes, submitters will need to modify their code by to accommodate a 14-digit HIOS. 14-digit HIOS IDs are required for all LOBs that have a HIOS. This excludes Medicare Advantage because MA does not have a HIOS.
Is the OSDS system accepting denied claims (referred to as Admin Denied in EIS) for commercial and Medicare LOBs?	Yes, the OSDS system will accept these claims.
How will the process work to send all the historical data that is required to be submitted to the OSDS system when the system opens? How will data be synchronized?	As we near the transition more information will be shared via the weekly forum and trainings. In short, submitters will need to send data sequentially as it occurs, so 2018, 2019, and then current data. Member transactions must be approved prior to submitting claims for them.
Is the .DAT file extension case sensitive?	No, but it is highly recommended (not required) that you use capital letters.
Should files be PGP protected?	Optum does not require files to be sent to ECG with PGP encryption. Optum requires that they are sent via SFTP and not FTP.
How are duplicates claims handled? If we submit a claim to OSDS a second time, with the same date of service and unique keys, will it be duplicated?	When a claim is received in the OSDS system, that is a duplicate of a claim that was received previously in either the OSDS or the EIS system, it will be rejected as a duplicate in the system.
How are adjustments and voids handled?	When a claim is received in the OSDS System that is intended to adjust or void a previous claim, the adjustment or void will replace that claim as intended for claims where the original was submitted in either the EIS or OSDS.
What is the OSDS expecting as the plan identifier for Medicare?	For Medicare Advantage, the Medicare Advantage Composite would consist of up to 3 components (Issuer, Plan and Product). The components are separated by the right square bracket "]" and limited to 50 characters. Example: NAIC = N12345 CMS assigned Plan Contract Number i.e. (H3388) This typically starts with the value of "H" CMS Plan Benefit Package (PBP) assigned by CMS i.e. (001) This may be left blank but is preferred. This would be reported in the 2330B in the 837 and 2750 in the 834 as: N12345]H3388]001

Data Submitter Question	Answer
How does a plan determine which HIOS to use for Medicaid Managed Care (MMC) homeless members?	Homeless members are attributed to a particular fiscal county within NYS. That county code would be used to map the 14-digit HIOS.
Do the history files need to be submitted in weekly increments?	No, the history file submission process will vary by submitter depending on their internal system capabilities. There are a variety of ways to structure the files as long as the file size limit is not exceeded. Plans should assure that the file submissions are sequenced to align with the member adjustments and voids.
We are submitting both individual and group coverages but one area will be ready to begin production submissions ahead of the other. Can we submit history for one coverage group and start the weekly file process before submitting coverage of the other area?	Yes, you can submit history and then weekly membership and the encounters for one offering while still working on the membership files for the other area. The member record must be accepted before the encounter can be processed for that member.
Our organization would like to verify what commercial and Medicare product information (plan information tab from the EDI Registration Form) has been loaded to the system before making production submissions, how do we do this?	Open a help desk ticket and this information can be provided.
We were just certified for production for the 834 transaction. I assume that our latest Plan/Product information available in production is the same as OSDS test setup? We are preparing to send our production and wanted to confirm.	Once request for certification is approved, the current plan information is migrated and available to the production environment.
For encounter submission, if we have problems mapping the member to a HIOS ID, can we use 5-digit plan HIOS ID as default value?	For commercial and Medicare members the expectation is a full 14-digit HIOS or issuer/plan/product identifier as reported on your EDI Registration form. Encounters for commercial and Medicare will be validated against the 834 and cannot have an abbreviated id. Please refer to the companion guides for more information. For all other LOB, validation for encounters is done with a hard edit on the 5-digit HIOS ID, if you only report the 5 instead of the full 14 you will receive a soft edit.
Is a timeline extension request, considered a 'non-compliance' issue? My management team is getting nervous that we will be faced with some form of penalty, as we will not be able to hit original timeline extension dates requested.	Ideally, NYSDOH expects dates provided in timeline extensions to be realistic dates and multiple requests for extensions may result in non-compliance. However, exceptions to this can be made depending on circumstances. The OSDS Project Team should be alerted as soon as possible when it's determined original timeline extension dates won't be met. OSDS Project Team can be reached at: **apd.osds@health.ny.gov**

Data Submitter Question	Answer
For encounter submission, if we have problem mapping the member to a HIOS ID, can we use 5-digit plan HIOS ID as default value?	For commercial and Medicare members the expectation is a full 14-digit HIOS or issuer/plan/product identifier as reported on your EDI Registration form. Encounters for commercial and Medicare will be validated against the 834 and cannot have an abbreviated id. Please refer to the companion guides for more information. For all other LOB, validation for encounters is done with a hard edit on the 5-digit HIOS ID, if you only report the 5 instead of the full 14 you will receive a soft edit.

4. Migration from Current Encounter Intake Submitters

Information in for current EIS data submitters that will migrate to the OSDS system for encounter data reporting.

EIS Migration Question	Answer
Should we anticipate new file specifications for the off-exchange commercial or will it remain relatively the same as to what QHP uses?	Commercial encounters will be collected using the same encounter format currently used for the QHPs on the EIS. The commercial enrollment roster will be collected in the 834 X318 Plan Membership Reporting format. As this is new, it will require APD Data Submitters to purchase the necessary Implementation Guide.
If an issuer only participates On-Exchange and are a dental issuer only, do we need to be aware of the OSDS system requirements?	Yes, as a current EIS data submitter, the data submitter will be required to transition to the OSDS system.
Will the data edits be the same as the current edits in place for the Medicaid Encounter Submissions or will they be different?	For the most part, the OSDS system edits will remain the same. Any changes to business logic would be to address any edit limitations that currently exist in the EIS.
Will Managed Long Term Care (MLTC) encounters remain in the EIS? Are Programs of All-Inclusive Care for the Elderly (PACE) plans part of the transition?	All MLTC data submitters currently submitting to the EIS will be required to transition to the OSDS system.
Can we validate our data migrations from the EIS to the OSDS system platforms and have visibility to the encounter data either via the EIS or new OSDS platforms?	All transactions submitted to the EIS will be processed and responded to through the EIS. All transactions submitted to the OSDS system will be processed and responded to through the OSDS system.

EIS Migration Question	Answer
We currently submit CHP encounters for members who subscribed with the plan (not on the exchange) prior to 8/1/2018. Will we be able to continue to be able to submit these to EIS prior to cutover to the OSDS system? Will we be able to submit them to the OSDS system for any service date?	Current EIS data submitters will continue to submit to EIS prior to the OSDS system becoming operational. The OSDS system will be able to accept for any service date on or after January 1, 2014.
The EIS and the OSDS system will not be run in parallel. Will the State be providing more detail on date of service submission?	The transition to the OSDS system is not based upon date of service, it is based on date of submission.
Can plans begin to make changes now to send Medicaid and CHP encounters on separate files using the sample HIOS ID under the EIS?	Yes.
It looks like we will use the same Post Adjudicated Claims Data Reporting (PACDR) format (for us, the dental X300), thus is it correct that the files we submit will be substantially the same in format to what we currently submit?	Yes.
Can we tie a single Member ID to a person, regardless of plan affiliation or enrollment span? For example, we have members that may move between EP, Medicaid, and CHP and have different member IDs based on enrollment spans because of those switches. This has a large impact on rejections.	The submitter should submit the unique identifier within the issuer product and plan combination to tie the member coverage to the claims and encounters that come in for that individual. If the member record does not match the encounter record, the encounter will trigger an edit.
Will the same level of information in EIS CG be covered in the OSDS system?	Yes. The details covered in the EIS CG will be covered in the OSDS system data submitter CG
Does the OSDS Standard Companion Guide - Data Submitter Information break out processes for current EIS submitters vs. new OSDS submitters?	The OSDS Companion Guide is designed for all data submitters, regardless of prior submission to the EIS. Specific information for data submitters migrating from the EIS to the OSDS can be found in the Information Library on the NYS Health Connector.
Does the NY EIS receive APCD “commercial dental data”?	The NY EIS does not accept commercial data.
How and where will the Medicaid encounter data be routed from the OSDS to support important Medicaid program functions such as Stop Loss, Risk Rate Development, VBP, Kick Payments, etc.?	OSDS encounter data will be sent to the Medicaid Data Warehouse (MDW) for the Medicaid, Essential Plan and Child Health Plus populations, like what is being sent today by the current EIS contractor.
Is there a summary available for the changes between the EIS 837 and NCPDP companion guides and the OSDS 837 and NCPDP companion guides?	The following documents in the information library on the health connector may be of some assistance to you: EIS to OSDS Migration Release Notes Tier 2 Edit Change Log EIS to OSDS

EIS Migration Question	Answer
Is it OSDS' position that in the case of a full claim denial due to a single line duplicate denial the remaining lines are not to be submitted into the system? It is our understanding that the rule will apply to the OSDS as it did in the EIS.	We would expect the same rules that are currently used for the EIS system. The rules are general because each payers claims system is different. We want all accepted claims within the issuer's system. We also want administratively denied claims (for reasons such as covered under capitated arrangement, global bills, required prior authorization, etc.) but it is impossible for NYSDOH to develop unique rules for each claims system.
When will EIS history be available in OSDS? Will it be there at go live?	History data is now available, please refer to the release notes for more information. When the system goes live there will be a cut over period to allow for loading of the most recent EIS history.
During the transition from the EIS to the OSDS, does DOH anticipate that there will be a blackout period (i.e., a period of time when claims will not be submitted)?	DOH is working with the EIS and OSDS teams to determine the duration of a potential "blackout period". The Data Submitters may submit files to the OSDS during the blackout period, but the OSDS will not process any file until the production date.
Will NYS Plans continue to submit data to the EIS even though the OSDS is opening for other LOB?	Yes. NYS Plans will continue to submit data to EIS. DOH will notify NYS Plans of the specific dates and activities for the transition from the EIS to the OSDS.
Are issuers expected to submit historical encounters once OSDS goes live? Are historical encounter submissions expected for MLTC plan as well? Is DOH expecting FIDA encounters to be included to historical submissions?	For Commercial and Medicare Advantage, the answer is yes, the begin dates expected is all encounters from 1/1/2018 forward. The same is true for member eligibility and the 834's. You have already made the Medicaid side of those submissions. The Medicare side of the submissions would be expected to be sent in.
The Office of Health Insurance Programs (OHIP) and OQPS have agreed to delay the transition from the Encounter Intake System (EIS) to the Original Source Data Submitter (OSDS) system from September 2020 to Early 2021. Does this date change mean that we should submit Commercial and Medicare to the OSDS and CHP, Medicaid, QHP, and EP to the EIS at the same time?	Yes. Encounter files for all lines of business currently being submitted to the EIS should continue to be submitted to the EIS until further notice on a transition date. Commercial and Medicare data should be submitted to the OSDS beginning in August for enrollment data and for encounter data once those transactions open.
We are using the same process to submit 837 transactions for all LOBs. The change in the EIS transition to the OSDS will necessitate that we maintain two different process to submit 837 transactions to EIS and OSDS. Will the EIS rules remain the same?	Yes. The EIS will not change its rules.

5. X12 834 X318 Plan Member Reporting

Information in this section is supplemented by OSDS STANDARD COMPANION GUIDE - X12 834 X318 Plan Member Reporting

https://nyshc.health.ny.gov/documents/39436/108308/osds_834_companion_guide.pdf

834 X318 Plan Member Question	Answer
Are the 834 X318 requirements only for off-exchange submitters?	Yes, the 834 X318 requirements are for off-exchange commercial submitters.
Can you please provide more information on the 834 X318 transaction and who will be required to submit this? Is this required for all issuers?	All off-exchange commercial APD Data Submitters will be required to submit an X12 834 X318 Plan Member Reporting transaction.
Are the subscriber and member identification numbers generated by the APD Data Submitter?	Yes.
Would the commercial submissions include the members who reside in NY and Policies purchased through one of the Licensed Companies in NY?	Commercial submissions would include members who hold a policy from a health care payer as defined by NYSDOH regulation at 10 NYCRR Section 350.1. Enrollment and encounter data related to members covered by an insurance policy offered in NYS under a NYS licensed insurer must be submitted to the OSDS system regardless of member residency.
Will the State require a full replacement of membership each month or just enrollment changes? Is it anticipated that the file will be weekly, monthly or daily?	Once a terminated or cancelled member has been successfully transmitted, subsequent transmissions for that member coverage do not need to be sent. A full replace would be a full replacement of all the active or changed coverage segments that have occurred.
Will X12 834 X318 files expected be sent to the same location X837 encounter files are submitted. How will 834 X318 files be used, will there be penalties associated to file rejections and acceptance/rejection rates?	Yes, the 834 X318 and 837 files will be sent to the same SFTP location. The 834 X318 files will be used to validate member information received in the encounter files and to support master data management in the APD. Data compliance standards will be specified per regulation.
For the premiums that are being requested, will you be looking for a premium per member or if it is a family premium are you looking for only the premium on the subscriber? Also, monthly or by year?	Guidance on reporting premiums is provided in the OSDS 834 X318 Plan Member Companion Guide within Loop 2300 AMT02.
For the commercial off-exchange data, is there a more specific definition as to what plans/members the APD is looking for, or are you looking for all commercial plans/members in our system? If the latter, this would be quite substantial – in effect you would be collecting data on every member in our system – is this what the APD is looking for?	The APD will collect data on any covered person who has health insurance issued by a third-party health care payer, as defined in the APD regulation. The only limitation on data to be collected is in relation to ERISA plans, which per 10 NYCRR § 350.1(k) are not required to submit data to the APD but may instead elect to participate in APD data collection on a voluntary basis.

834 X318 Plan Member Question	Answer
If we submit two 834 X318 files in one day and it contains the same member, would the 2nd file overwrite the enrollment information from the 1st file if the spans overlap? Does the 837 transaction have to be submitted on the same day as the 834?	Regarding the 834 transactions, if a data submitter is submitting the same Plan, Submitter, and Member the latter record would supersede the earlier record. The 834 does need to be submitted first, but 837 transaction does not need to be submitted the same day.
Can one 834 X318 file contain members from multiple commercial plans?	It is preferred the 834 x318 files be unique members by issuer, product and plan combination. However, the OSDS system will accept files split by transaction type and line of business per submitter/issuer.
What will happen if two plans by some chance submit the same member ID on the 834 X318?	The unique member ID and the coverage dates provided in the 834 X318 will allow the encounter data to be validated.
What if a member has more than one ID with a payer? Would that fail the unique constraint? A member is under more than one coverage. For example, someone has coverage as a subscriber on one policy and as a dependent on another policy. They would have two different member IDs. Would there be a problem accepting these because they would appear twice on the 834 X318?	It will not fail a unique constraint. The OSDS system requires uniqueness within issuer, product, plan, and subscriber. The example provided is two different subscribers with two different IDs so there would be no problem accepting them.
For the Member ID, can it be Payer Specific ID? For QHP submissions there is a specific requirement to submit the Health Insurance eXchange (HIX) ID.	The submitter should report the member ID that has been assigned to the commercial plan enrollee. If the member has a HIX ID and has QHP coverage, the submitter should submit the HIX ID. For off-exchange commercial submissions, the member ID reported on the 834 X318 transaction must match the member ID on the incoming encounter otherwise the record will trigger an edit.
If a member dis-enrolls and re-enrolls, does a submitter need to use the same ID number?	If the member re-enrolls in the same issuer, product, plan combination then using the same ID is the preferred approach.
Will you accept de-identified members with protected diagnosis codes?	Member ID should be submitted and should not be submitted in an encrypted or de-identified format because the record will be rejected. The OSDS system and the APD have rigorous privacy and security procedures in place to protect patient data.
Has a standard syntax/structure for member/subscriber ID been established for commercial member data? If so, could you please share that syntax?	There is no OSDS specific syntax for Member/Subscriber Identifiers. The format for these must follow the Implementation Guide standard.
Is the 834 X318 a bi-directional process?	The 834 X318 is not a bi-directional process. The 834 X318 process is only for off-exchange commercial submitters to report member roster information to the OSDS system.

834 X318 Plan Member Question	Answer
I believe the requirement for the 834 X318 is to send a weekly (full) file to APD. Can you confirm, or do we only need to re-submit records that error out, after an initial file load? Do we also need to send change files?	A full file replacement is required with a recommended frequency of weekly. Records that error out may be resubmitted in a separate submission before the next full file replacement. Direction is included in the 834 X318 Companion Guide.
If an 834 X318 member roster record gets rejected, would all encounters associated with this member subsequently be rejected due to lack of eligibility?	The encounter would be rejected if the system does not have the 834 X318 member ID and a coverage span covering that service date of the encounter.
Referring to a member who was enrolled in multiple plans over the course of the historical reporting period. For example, how would we report one record for “Plan X” in 2018 and another record for “Plan Y” in 2019?	Historical reporting may contain an individual who may have been in multiple plans. The unique member ID and the coverage dates provided for the issuer/product/plan in the 834 X318 will allow the encounter data to be validated.
Will a medical encounter date of service be checked against effective/term dates of the member on the roster, or is it truly just if the member ID is present verses not? This drives my question about submitting two separate eligibility spans for one member on one file, which one was accepted/rejected?	The encounter date of service will be checked against the member’s coverage span. Submission to the OSDS system will need to conform to the 834 X318 requirements.
Besides the first full file to go back to 2018 what is the expected timeframe to be covered for each full weekly file?	The expectation is that it would be a 24 month full membership submitted weekly.
Do we have to report a term/cancel transaction as well or just the active membership?	Once a terminated or cancelled member has been successfully transmitted, subsequent transmissions for that member coverage do not need to be sent. A full replace would be a full replacement of all the active or changed coverage segments that have occurred.
We would prefer to submit members individually and not tie to families.	The OSDS system will not tie members to families.
In the 834 X318 Companion Guide, what is the definition of “At Risk”?	The definition the OSDS system is using is contained within Section 1.5 of the Implementation Guide. More information can also be found in Section 1.4.2.
Should the Reporting Category Loop 2750, Segment Reporting Category Date, Data Element DTP03 be January 2018?	Yes, as it stands 24 months prior to onset
If a Third-Party Administrator does not obtain premium information. Will the transaction be rejected?	The Premium Information in loop 2300 is required (X318 Hard Edit 00432), but if no premium information is present, then a 0 dollar amount can be submitted in AMT02 in combination with AMT01=ZZ

834 X318 Plan Member Question	Answer
Will the transaction be rejected if the information in Loop 2100A – Member Name, Segment - Member Demographics, Data Element DMG05 – Composite Race or Ethnicity information is not present?	This information should be reported to the OSDS system or the member record will not be processed. However, you can report a 7 (Not provided) if the information was not given, or an 8 (Not Applicable) if it was not asked for by the issuer.
Are ASO and Federal employees included in member reporting?	Information on the ASO population can be submitted to the OSDS but is not required. We do require submission of information for federal employees, like all other employees that fall under the same parameters as the rest of the OSDS population being reported.
In Loop 2100A – Member Name, Segment N4 – Member City, State, Zip Code, Data Element NM109 – ID Code, what should be reported when it is not the subscriber, since Loop 2750 REF02 does not reference a member at all?	The internal issuer Member Id for that individual.
In Loop 2100A – Member Name, Segment NM1 – Member Name, Data Element N406 – Location Identifier, when the member is not in New York State should the field not be provided?	There should be a valid value in the field for county/parish within New York State and outside New York State
When a member has multiple products that they are covered under, is there an expectation that there would be repeating Loops?	If there is a different product plan combination for the issuer, they would be in separate files. If the product and plan combination is the same but they have multiple benefits, the OSDS system expects to receive repeating Loops. If the products are treated separately it is expected to see them as separate records. One file with separate records.
Can we submit different files by LOB?	Yes, different LOBS have to be submitted as separate files.
What needs to be submitted for self-funded when the premium information isn't collected?	There is a default value of "ZZ" which should be used if the information is not collected.
Could you please provide examples of the Maintenance Type codes for both the 2000 and 2300 Loop? Also, we would like to see examples of several breaks in coverage, Full retro-termination, Future dated enrollments.	The OSDS Project Team has developed commercial member scenarios. The Member Scenarios can be located within the NYS Health Connector Information Library under Transactions Examples.
Can you submit unlimited change to a previous file?	Yes.
Should there be two files submitted for "changes" and "no changes"?	The OSDS system would expect to receive only one file weekly with both changes and no changes. When correcting fixes to your weekly file, a correction file should be sent prior to the next week's full file.

834 X318 Plan Member Question	Answer
Can future enrollment dates be submitted?	You can submit future enrollment dates.
If we know that some of the conditional elements will always be default can we skip it, or does it need to be entered (i.e.; Social Security Number)?	Unless it is otherwise specified you are not expected to send in default values in conditional fields
Are end dates always sent or only sent when there is a termination?	There is no requirement to include an end date if one does not exist. If a data submitter has an end date It can be included.
In the X12 note in the TR3, do subscribers have to be sent before dependents in the 834 X318? Will the OSDS system require that subscriber and all dependents for that subscription must be on the same file since OSDS might not process the 834 X318 files (when broken into multiple files) in the order they were created by the issuer?	No, subscribers do not have to be sent before dependents in an 834 X318 file. All dependents for a subscriber do not have to be on the same 834 X318 files.
If during the period being reported in the 834 X318 a subscriber had 2 or more different coverages, either overlapping or non-overlapping, would APD accept these different coverages being sent as separate HD Loops under one INS, or would they have to be sent as separate INS Loops?	Yes, the OSDS system will accept these different coverages as being separate HD Loops under one INS, they do not have to be sent as separate INS Loops.
If coverage is cancelled (had no days of coverage) how many files does this need to be sent on?	If coverage was initially sent and accepted to the OSDS system, the corresponding cancellation would need to be sent once.
Should future coverage be sent as part of the 2-year window, or would the 2 years be only the date it was sent and 2 years previously? How strict will the 2-year window be enforced?	Per the 834 X318 Companion Guide, future dates will be accepted. In the case of a cancellation or delete record, the Benefit Begin date must equal the previously submitted Benefit Begin date.
Will the initial catch-up files have to be accepted before weekly submissions commence?	A data submitter's initial file will need to be accepted before submitting weekly files.
If you have an "n" entry for every time that the person had coverage. For a certain portion of population, they happened to work in different restaurants, McDonalds, Tim Horton's, Burger king if they are 2 months in each place there will be 3 entries to be sent on the initial file until they rolled off their 3 coverages will be sent every week. File will grow from initial submission in May next year until April 21.	For terminations where the OSDS system did not received a member record, the OSDS system does not need to receive that information. If the OSDS system receives a future dated member record, which is then cancelled before being activated, the cancellation would need to be sent to the OSDS system.
If there is a member signing up at a future date, and it is submitted, but it is cancelled before the start date. How many times do I need to send it?	If the Submitter has already sent an "add" for future coverage, a cancel would then need to be sent. If this is specifically about the initial file submission, it would not need to be sent at all since the member never had coverage. If the member signs up and cancels before the "add" is sent, the Submitter will not need to send anything.

834 X318 Plan Member Question	Answer
Can you have two HD Loops within one INS?	Yes, you can have more than one, the Loop repeat is 99.
The OSDS system is asking for a full rolling 2 years of enrollment, instead of just current enrollment and changes to older non-current enrollment within the 2-year window. Is this correct?	Two year look back would have the same rules as the previous submissions, the only difference would be that coverages terminated prior to 2 years minus the submission date need not be included. All weekly files are expected to have terminated coverage that falls within the time frame request.
In our experience, we do not typically receive LUI information on the 834 X318 s we receive, so it would only be in our systems when supplied by the member.	The OSDS system expects data submitters to report anything they receive and store.
Please provide samples of rolling data submission change.	The OSDS Project Team has developed commercial member scenarios. The Member Scenarios can be located within the NYS Health Connector Information Library under Transactions Examples.
Deductible Amount. So, you are expecting D2 even if the amount is zero? What do you mean by Deductible?	The OSDS system expects the yearly Deductible Amount. Zeros are acceptable in the Amount field. Please refer to the 834 X318 Companion Guide for instructions on how to populate deductible amount.
Should subsequent 834 X318 files, after the initial submission contain a "full" file of every Off-Exchange Member or just the changes since the last submission?	Every 834 X318 submission of Full file Replace changes should be reported using the appropriate codes, and within submission cycle. A full replacement consists of all the active or changed coverage segments that have occurred.
At what point would a cancelled/termed member no longer be sent on the full replacement file? After being sent once as cancelled/termed or for the rest of that plan year/calendar year?	After being sent once unless the information in the active portion of the termination changes for the reporting period.
In the 834 X318 OSDS Companion Guides how do we understand situational vs. required when looking at the information? Should we assume that where it says “expects to receive” if there is a default value it is used; and if it says “expects to receive” but there is no default value it should be considered situational?	If there is “when available in the Information Source System” that implies it is a situational element and will not cause the record/file to reject.

834 X318 Plan Member Question	Answer
Can the OSDS Project Team publish a sample 834 record and some enrollment scenarios to help validate the 834s?	The OSDS Project Team has developed samples to assist data submitters in understanding situational submissions and what would be expected in the different segments. The Member Scenarios can be located within the NYS Health Connector Information Library under Transactions Examples. Informational WebEx session slide decks, which are available on the NYS Health Connector, include 8 scenarios relative to retrospective termination and retrospective extensions of coverage. If there are other examples data submitters are looking for, please let the OSDS Project Team know: APD.OSDS@health.ny.gov.
In the Companion Guide the Receiver name in the ISA segment as NYSDOH-APD and some places it is NYSDOH APD, which one of these is the accurate Receiver Name?	Data submitters should use the "NYSDOH-APD" with the hyphen. This change will be reflected in Version 1.1 of the Companion Guide.
Is the 834RL an EDI format or a flat file format?	The 834RL is a pipe delimited flat file format. More information can be found in the 834 Companion Guide.
The APD is requesting that we populate Loop 2000, Field INS03 (Maintenance Type Code) with '021' Addition for ALL records. Again, this was in the context of the Initial File Only. Can you confirm that I have captured this requirement correctly? If yes, then what Maintenance Reason Code is APD looking for in Loop 2000, Field INS04? The implementation guide states that this field is required if the INS03 is '001', '021' or '024'. Should we use 'XN' for notification only?	In Loop 2000, Field INS03 for the initial file, the requirement is code "21" (Addition) for all records that have any active coverage in 2018 through September 2020. Example of Coverages that all need to be sent: • November 11, 2017 – March 1, 2018 • January 1, 2018 - June 30, 2018 • March 15, 2018 with no end date INS04, should be sent as "20" (Active) on the Initial file. Additional example of coverage segments to be submitted are available on our website. https://nyshc.health.ny.gov/web/nyapd/apd-osds
Loop 2320: If there is NO other insurance carrier, is OSDS still expecting this Loop to be sent with COB01 = P (Primary) and COB03 = 6 (No Coordination of Benefits) Or should we only populate this Loop when there is an actual COB arrangement with another insurance carrier? If there is another insurance carrier, does OSDS expect 2 iterations of this Loop. One for the Primary (e.g. ABC Health) and one for the Secondary (e.g. XYZ Health).	NYSDOH is expecting to receive information in Loop 2320 when there are additional payers. If there is another insurance carrier, OSDS prefers for submissions to submit as one member record with 2 iterations of Loop 2320 to identify multiple payers.

834 X318 Plan Member Question	Answer
In the 834X318 Transaction Information Companion Guide, it states that the "The deductible amount expected is the Annual Deductible Per Individual for the defined coverage". When populating Loop 2300 AMT02 (Monetary Amount). In scenarios likes high-deductible health plans (HDHPs), the deductible is aggregated across the Family versus embedded deductibles used in non-HDHP health insurance.	OSDS would expect the family level amounts to be submitted on the subscriber's record (i.e. family level premium, family level deductible maximums). Per the OSDS Standard Companion Guide -X12 834 Plan Member Reporting, each of the members would then be submitted with 0$ for those corresponding values.
What should be sent in Loop 2750 N102? The guide states that "NY expects to receive "Issuer/Product/Plan id" What are the specific expected values for this field?	NYSDOH expects to receive the 2750 N1 segment exactly as follows: N1*IAE*Issuer_Plan_Product_id~
Loop 2750 Field REF02 (Member Reporting Category Reference ID): Can the field include spaces, as long as the total length does not exceed 50 characters? Example: 18029]18439]FlexFit Platinum POS or should we format as: 18029]18439]FlexFitPlatinumPOS and remove all spaces.	The OSDS system will allow for spaces in the field as long as the total length doesn't exceed 50 characters.
Can you please let us know if there is a Companion Guide or PACDR for the 834 Response files? We cannot seem to find any actual file format or layout. Please let us know where we can obtain information on the following: 1) 834RJ – File rejection file 2) 834RL – Detail rejection file	The OSDS will produce proprietary file (834RJ) and record level (834RL) responses. The 834RJ guidance is available in the OSDS Standard Companion Guide – Data Submitter Information. The 834RL guidance is located in the OSDS Standard Companion Guide- X12 834 Plan Member Reporting Companion Guide under Appendix A.
Do you have a sample of how you would like an 834 to appear?	There are sample files available on the New York State Health Connector.
Can a plan create the 834 file with a single ST-SE and multiple INS per each member, is this acceptable for NY state?	Per the Implementation Guide you can have an infinite amount of Loop 2000 which includes the INS data segment.
When submitting an ADD for new born, with NO change to the Subscriber's existing Coverage Tier, Benefit Plan or Premium Amounts, etc. • Is OSDS looking for the Subscriber record to have a '001' Change code populated in Loop 2000, Segment INS, Field INS03 (Maintenance Type Code) and the corresponding '02' for BIRTH in Field INS04 (to show a change to the 'subscription'). • OR - Do we only Populate the New Born Member record with '021' ADD and '02' Birth and send over the Subscriber record with '030' for no change.	Populate the New Born Member record with '021' ADD and '02' Birth and send over the Subscriber record with '030' for no change.

834 X318 Plan Member Question	Answer
Loop 2300 segment HD01 MAINT_TYPE_CD: Our first full file will always be 021 (regardless of if member is active or termed), all other files depending on status. Is there a difference between this maintenance code and the maintenance code in Loop 2000, INS03?	Your understanding of code "021" is correct, the first full file must contain all member who were/are active since January 1, 2018. Loop 2000 INS03 is on the Member Level where you would report if a member status has changed. Loop 2300 HD01 Maint_Type_CD is on the Benefit Coverage level, where you would report if the benefit for that member has changed.
Regarding Loop 2300 segment DTP03: The Companion Guide states: "Future dates will be accepted. In the case of a cancellation or delete record, the Benefit Begin date (DTP03) must equal the previously submitted Benefit Begin date". We understand this to mean that the any dates submitted for the member with a future effective date (DTP03) must be the same on all subsequent files. In addition, the cancellation/termination date cannot be less than the beginning date. Is this accurate?	When reporting a cancellation or deletion the benefit begin date must be the same as the one previously submitted. When reporting a termination, the benefit end date must be the official termination date.
Regarding Loop 2000 INS05 BENE_STAT_CODE: For termed members should they be sent with value "A"? As we will be sending members from 1/1/2018, we may have members that have been termed. In this situation, for the first file to NYS, should we send "A" for Loop 2000 INS05 Benefit Status Code? Then, on the subsequent file to NYS, we what value should be in this field for these members? Or, should we not send these members on subsequent files to NYS? Additionally, we understand that termed members should only be sent once to NYS. If a member was sent on prior week's file with term date 2/1/19 and on the current week's file, the member's term date has changed to 1/15/19, should we resend this termed member to NYS with the updated termination date.	Loop 2000 INS05 will always be "A" unless one of the other options apply. If there are changes to a termed member record the update should be reported to the OSDS.
How should we structure transactions (ST/SE) in the 834? Is OSDS expecting a single ST/SE transaction or multiple in an 834 file? Should we group together households?	The 834 allows for it to be grouped together however, NYSDOH prefers for it to be a single transaction.
Which X12 Implementation Guide should we be utilizing, '5010 | 834 Plan Member Reporting' or '5010 | 834 Benefit Enrollment and Maintenance'?	You should be using the Implementation Guide '5010 X318 Plan Member Reporting.'
On the 834, do terms have to be sent on the weekly full replacement file, or is there a term by omission process?	The OSDS does not have a term by omission process, and as such terms need to be sent as they occur.

834 X318 Plan Member Question	Answer
Is the Issuer/plan/product identifier required to be at the file level? Or can the file contain multiple trios?	There is an issuer/plan/product identifier IN each submitted transaction. There is no requirement to split the files by issuer/plan/product. The requirement is submitters split their files by (Submitter ID + Issuer ID), Transaction Type and LOB. The Data Submitter Companion Guide outline this requirement.
We are currently in development of the 834 X318 EDI file, in regard to loop 2100A, segment PER – Member Communications Numbers. On page 64 of the X12 Implementation Guide you can see segment PER03 contains the communication number qualifiers for the first communication number you can include on this segment. We noticed the only valid values for PER03 are EM (Electronic Mail), OT (Other Residential Telephone Number) and WP (Work Phone Number). The following communication number can have additional qualifiers such as TE – Telephone number. In addition, on page 63, the example X12 provides has HP as a qualifier, which doesn't appear to be a valid value. If we only have a home phone number for a member, what qualifier does OSDS expect issuers to use on PER03? If we happen to have all communication values for a member (email, home phone, work phone, phone extension, alternate phone, etc.) we can only provide up to 3 of these on the 834. Can OSDS provide a hierarchy of which values OSDS would like to see so we know how to prioritize communication numbers?	There is a publishing error for the example provided "HP" is not a valid qualifier. The only valid qualifiers for the PER03 are EM, OT and WP. If you do not have and EM- Email or WP- Work Number to provide in PER03, please submit the home phone with the OT qualifier even though the guidance within the Implementation Guide state to use when reporting a TTY communication number. If you have many communication values for the member, the OSDS team has determine the reporting hierarchy to be the following: WP - Work phone TE - Home phone AP - Alternate Telephone EM- Email EX - Telephone Extension
How does the OSDS system maintain the membership records? If a submitter is sending membership records every week, is the prior week's membership record replaced with the latest file? How do we submit corrections if we submitted a record with errors?	The membership record files will be incrementally loaded and are not replaced by the new files. If there is a need for resubmission to correct errors, the correction can be submitted in the next weekly file or in an ad-hoc file.
For the initial file to load member data, what if a member has lapses in coverage from 2018 until present (i.e.; enrolled from 1/1/2018 to 10/31/2018 then re-enrolled for 6/1/2019 to current)? Assuming all coverage spans are under the same line of business, would plans be expected to submit all coverage spans or just the latest one?	All coverage spans should be submitted to the OSDS.

834 X318 Plan Member Question	Answer
In the Companion Guide under Loop 2750 field REF02, the comment states 'the Issuer ID must match the identifier provided in Loop ID1000C Field N104'. The X12 Implementation Guide states that Loop 1000C is only required when the information source is different from the submitter. Based on this Situational Rule, we will NOT be populating Loop 1000C (as we are both the information source and submitter). The language in the Companion Guide implies that this is a required field and not situational, please confirm.	The Submitter ID will always be the OSDS Submitter ID, therefore Loop 1000C will need to be populated and will be use the 2750 REF02 Loop.
If the member has a lapse in coverage, then we can separate each enrollment on a different file. Would this mean we can include the benefit end date on an "ADD" transaction (i.e.; 1/1/2018 to 12/31/2018) instead of sending a separate "TERM" transaction with the 12/31/2018 end date?	If the add is submitted with an end date, that end date is populated in the record and a separate term record is not required. However, if the coverage extends past that term date, either a change record with the updated end date, or an add record with the new coverage dates is required. Without one of them, the coverage in the process is closed as of the original term date provided.
Some of our plans have both an In-Network Deductible and an Out-of-Network Deductible that track independently and can have different values. In that scenario, which value should we report for 2300 AMT01="D2"?	We would expect to receive the In-Network deductible for the member. If there is a difference between the individual member deductible and the family deductible, please report the family deductible.
There is very little reference in the current 834 Companion Guide about correction file requirements. We are looking to better understand what corrections should be included, should control numbers change or remain the same, and should it contain only the corrected transactions or all members. Will there be a Companion Guide published outlining the correction file requirements?	At this time there is no plan on publishing a corrections file Companion Guide. The corrections should be sent for the rejected records. All control numbers should be unique with every submission therefore they would need to change. Only the corrected transactions would need to be resubmitted.
Would it be possible to obtain sample files of the different 834 responses? • RJ • TA1 • 999 • 834 Record Level Response	At this time, we will not be providing "sample" response files for the 834. The Data Submitter Companion Guide can be utilized for more information on the RJ. Guidance for the 834RL is located in the X12 834 Plan Member Reporting Companion Guide under Appendix A.
Within the Data Submitter Companion Guide, should the 834 file follow Section 3.1.4- Inbound File Naming Convention list on page 11 and 12?	This will be corrected in v1.3 of the Data Submitter Companion Guide. We are following the same naming convention for all inbound files. The 834 file inbound examples are missing the program suffix.

834 X318 Plan Member Question	Answer
Within the 834 file Loop 2750.REF02, for the 14-digit HIOS ID on the INS member level, if a member's HIOS ID changes should this be reported? If the member's HIOS ID changes within the same span, how should this be reported?	A change in the plan identification can fall into two categories: 1. The change applies to the entire coverage period and is a correction. In this case, a change record is expected with the new value. 2. The plan identifier changed for the member replacing the plan as of a different effective date than the previously reported coverage. In this case, a termination for the existing plan is expected and an add record for the new plan identification and related effective date should be sent.
Will the OSDS system accept enrollment reporting in ASCII text file format (e.g. similar to the All Payer Claims Database eligibility text file format) instead of X12 834 Plan Member Reporting format?	We will only accept the 5010 X12 834 Plan Member Reporting format.
We understand the 834X318 is to submit membership information to the OSDS system if we had an off exchange commercial membership, but we do not. We do however have a Medicare Advantage Plan in 2020 (and a FIDA plan that went away in 2019). Are we required to submit to the OSDS system the 834 X318 for the 2020 Medicare Advantage membership?	Yes, the Medicare Advantage Plan needs to be submitted.
We would like to clarify about what is required for Plan information tab of the EDI Registration form. The Plan Information tab is a prerequisite to processing 834 Member files correctly. Should we include our Medicare Advantage plan as well?	The plan information tab should be updated to include Medicare Advantage. Submitters should send 834 member file for all commercial off-exchange and Medicare Advantage/part C.
For Loop 2000, DTP-Member Level Plan Suspension Dates, is this segment required and if so what date (s) are expected to be sent? The TR3 says required when the member has been suspended from plan participation. Is this the same as a term?	This segment is not required. If you suspend the member's coverage and provide it the OSDS system, it will be accepted.
For Loop 2300, Maintenance Effective Date, what is NYS expecting to receive for a date in this segment?	We would expect to receive the date benefit change.
For Loop 2300, if we have an active employee today and we send them over with active coverage on the file and now that employee terminated employment are you expecting to receive and employment termination date or are you expecting to receive just a coverage end date?	We need the coverage end date in Loop 2300. If you have the employee termination date you can send that in addition, but this is not a requirement.

834 X318 Plan Member Question	Answer
Until we get to a weekly file, what type of data are you expecting on the 2018? Are you looking for an employee to remain active throughout that entire year or are you looking for employees that may have lost coverage within that year? Do we send one file for 2018, one file for 2019 and one file for 2020 until we are ready to send a weekly file?	If you have a member that had coverage for a portion of the time period, we are looking to receive that information and any encounters that go along with that. It is preferred that you send that all in one file as long as you are meeting the file size limitation of 50MB.
When the OSDS opens and we are sending history from 2018 to current, if a person had coverage from January 1st to May and it terminated coverage, are we sending that person as a term or add?	If the add is submitted with an end date, that end date is populated in the record and a separate term record is not required. You can also send it as a term, and we will process accordingly.
For Medicare Part C Submission in 834 file Loop 2100A NM109, should we use the plan assigned member ID not MBI ID? We assume this is the ID needed to be used in 837/NCPDP file as Primary Patient Identifier so claims data is matched with membership data. Does the OSDS want the MBI Id elsewhere so matching can be done to CMS records? Can you please confirm?	Yes, that is correct. In Loop 2100A NM109 for the 834, the plan assigned member ID should be used and not the MBI ID. This plan assigned ID will be used in 837/NCPDP file as Primary Patient Identifier. Then the MBI should be listed on the 834 as a secondary identifier so that the APD will be able to use this as part of the master data management process for patient indexing. Please refer to the 834 Companion Guide for additional information.
Is it possible for a member to be partially accepted? More specifically, can some 2300 benefit coverage loops be accepted while others are rejected for the same member?	No, there is no partial acceptance.
What maintenance type code should be used for the initial membership file? This question and answer document states 021 (Addition), but the companion guide instructs submitters to use 030 (Audit or Compare).	Optum expects that files will be sent with maintenance type code 21 (Addition) for the initial run. However, if submitters use maintenance type code 030 (Audit or Compare), it will be treated the same.
Is the 1000C Loop required or optional for an 834 X12 file?	The 1000C Loop is required: • The 1000A Loop is the submitter ID. The 1000C Loop is the issuer ID and will always be different because it contains the HIOS or NAIC ID.
Can we combine Dental and Vision 834 files, or should we submit them separately?	If the Member ID is the same for Dental and Vision 834 you can submit separately or combined, since it would start with the INS loop that establishes the member and will have the multiple coverage information from Loop 2300 under the HD segment.
What ID should I put in GS02?	GS02 is the filed issuer ID and should be populated with the HIOS_ID, NAIC_ID, or OSDS_SUBMTR_ID.
What ISA06 value should be sent with the 834 file?	The ISA06 should be populated with the submitter ID that starts with the letter Z.

834 X318 Plan Member Question	Answer
How are Membership files loaded to the OSDS system after the initial load? Please clarify whether or not terms can be sent only once.	Once we are in full production, the expectation is that a full roster file will be submitted weekly. The maintenance type codes should indicate Addition, Change, Term, Reinstate, and Audit for each record. The OSDS system will use these values to determine the action that needs to happen for the record. Terms must be sent at least once. There will be opportunities for the submitter to send corrected records throughout the week that will result in a record update (Update, Add, Term, Reinstate).
What do you expect in a file when a member has different 14-digit HIOS IDs that are effective for different date ranges? For example, one HIOS ID is effective from 1/1/2020 – 1/31/2020 and a second HIOS ID is effective from 2/1/2020 – present.	For on-exchange, use the 14-digit HIOS ID for the service day specific period. For off-exchange, 834 records for the previous month, and different 834 records with new plan information, current month and encounters should be sent accordingly.
Which is correct: the 834RL file in the OSDS 834 Companion Guide the 834RL file we are receiving from the off-exchange testing? When we compare the two, there are major differences.	The major difference is that the 834RL files you are receiving from testing have three columns inserted: • A column for the Interchange Control Identifier ISA13 that ties back to the EDI Registration form. • A column for a member-level identifier that will have a value if you selected the member supplemental ref with a qualifier of 6O. • A column for the control identifier within the 2300 in the HD level. Optum included this information in the 834 Companion Guide.
If the DMG05-01equals 7 (Not Provided) or 8 (Not Applicable) on the 834, do we need to populate DMG05-02 and DMG05-03? Is this acceptable for the DMG segment: DMG*D8*19990102*M*R*7~	You will populate either the 05-01, or both 05-02 and 05-03 fields The DMG segment included in the question contains a syntax error and would fail at 999.
What values should be submitted in the GS02 and GS03 fields?	The GS02 value for all will be the issuer ID only, e.g., if HOIS = 65005, if NAIC = N65005. The GS03 should be NYSDOH-APD.
How often does the OSDS system process complete, replace, or add 834s?	Historical data will be stored as part of the APD as this data is needed to handle encounters that come in for older dates of service. There is currently no established end date.
Will the existing Medicaid 834 (not the X318) the state sends to submitters change in relation to submitter IDs?	No.

834 X318 Plan Member Question	Answer
How should we submit premium amounts for members whose premium amounts have changed by year?	If the premium amounts have changed by year, we would expect multiple records for each year, to capture the change. If the premium amounts have not changed, then you do not need to submit multiple records.
For loop 2000 and loop 2300 Maintenance Type Code, if we do not have a way of knowing what has changed from the last file to the current file, can we use a value of 030?	If you have reported that member previously as an add and you are not sure if the status has changed, then yes you can use 030 if you need to. If it is a termination or cancel there should be a specific designation of that.
Should all NY state address have FIPS county code going forward?	All New York State addresses must have the 5-digit FIPS or if it is a restrictive address then you need to use ZZ. But one of the two is required if it is a New York address.
When will certification to production for 834 begin?	Certification for production began on 7/10 for the 834 transaction.
We have a number of members that are enrolled in an EPO or PPO product and these members are not required to select a PCP. Therefore, we would not have an assigned NPI (PCP) for these members if they chose not to select a PCP. How should we handle this on the 834 submission as the NPI is a required data element?	The PCP provider cannot be reported when an identifier for that provider is not known. When there is not an identifier available for that PCP suppress the Loop 2310 information from the member's record in the 834.
Many of our tier 2 errors are 412 and 413 which are occurring because we do not have addresses listed. Can you confirm what is this information used for and for the sake of transmitting to you should we populate with a group level address to avoid the errors?	A member address is required, the expectation is to receive a whole address – inclusive of County code, if the address is a New York State address. As this information is utilized in the APD, an employer group address should not be used. If there are issues, please open a help desk ticket – and this will be reviewed on a case by case basis.
When does the NYSDOH expect the history production submissions of member data to be completed?	Unless your organization has an approved extension, we expected this activity to be completed by November 2nd, 2020.
On our eligibility files we do not require an address, gender, or DOB. Although we do get most, we will have several fields that we do not have completed for these. A related issue to this is that the file also requires us to send a county code which we can only determine once we have a full address, so that field would also be affected for the addresses that we do not have.	These are required fields. The expectation is to include the member address, and it must be a whole address – inclusive of County code, if it is a NYS address. If there are issues, please open a help desk ticket.

6. Medicare Reporting

Information in this section will provide guidance to OSDS Data Submitters on submission of Medicare data.

Medicare Reporting	Answer
Will Medicare Part C data be provided by APD Data Submitters or from CMS?	The expectation is that Medicare Part C encounters will be included as APD Data submitted to the OSDS system.
Who is responsible for submitting Medicare Part C Data?	Medicare Part C data will be a Line of Business submitted to the OSDS system by an APD data submitter.
What file type or file format is expected for Medicare Part C submissions.	Medicare Part C submissions will conform to the file formats and standards as all other Lines of Business.
Will the transition from EIS to OSDS be applicable to Commercial Medicare lines of business?	The Commercial Medicare lines of business are not collected in the EIS.
Will Medicare, Medicare Supplemental and Part D be required in the commercial data submissions?	Yes, anything a Submitter is the payor for or covering the member for should be included in submissions.
Is there a separate timeline for Medicare data to be submitted to the OSDS?	Medicare submissions would be on the same timeline, and it will be in the same file format as what is already being supplied by submitters to the OSDS. If there is a concern about timeline, please reach out to coordinate an individual meeting.

Medicare Reporting	Answer
Can you clarify the regulations around Medicare data being submitted to OSDS/APD?	Public Health Law, Sections 206(18-a)(d) and 2816 authorizes the collection of covered person and claims data relating to individuals covered under Medicare and/or Medicare Supplemental plans from all entities that meet the definition of "third-party health care payer". The APD regulation at 10 NYCRR Section 350.2(a) requires "third-party health care payers" to submit APD data pursuant to the Department's submission specifications. Section 350.1(k) defines the term "third-party health care payer" as: • an insurer, organization, or corporation licensed or certified pursuant to article 42, 43, or 47 of the Insurance Law or Article 44 of the Public Health Law; or • an entity, such as a pharmacy benefits manager, fiscal administrator, or administrative services provider that participates in the administration of a third-party health care payer system, **including any health plan under 42 USC section 1320d**. Health plans covered under ERISA may report APD data on a voluntary basis. Medicaid Advantage and MAP health plans have a requirement through their Model Contract (18.5 Reporting Requirements) to submit Medicare encounter data for their dual-eligible enrollees.
We are trying to better understand what specific lines of business should be include Medicare Advantage. Within the Data Submitter Companion Guide, we see that Medicare Advantage is there separate file with a Program Suffix = "A".	You can find the following Medicare file specific information in the Data Submitter Companion Guide located on page 10. Off-Exchange Commercial and Medicare Advantage Data Submitters • 834 X318 must precede the submission of 837 and NCPDP encounters files. Unsuccessful submission of the 834 X318 will cause rejections at the member level for encounters • The 834 X318 is only a requirement for Off-Exchange Commercial and Medicare Advantage Data Submitters
For Medicare submission, does this entail straight Medicare that currently goes to CMS or the Medicare component of a Dual Program?	The Medicare Fee for Service population that is not what is intended to be reported. The Medicare Advantage plan or dual eligible Medicare member are the entities who are representing your submission of Medicare. Currently, the NYSDOH collects the Medicare Fee for Service (FFS) population from CMS. For a Medicare Part C recipient who is receiving benefits through your entity, they would need to be submitted as well, this would not just include the dual eligible population.

Medicare Reporting	Answer
For Dual members would we submit two claims? If only one, would that cause duplication?	We would want two claims submitted as there will be two separate lines of business. These would not run into an issue with the duplication check as you would have the Medicaid Line of Business (LOB) and the Medicare Advantage Line of Business. The delineation would be line of business.
For the Medicaid-Medicare dual eligible population, should a claim that has been processed under both of these coverages be sent as two submissions to the OSDS (one under Medicaid and one under Medicare)?	Yes, this is correct. There would be a submission under Medicaid and one under Medicare.
In the Stakeholder meeting, it was mentioned that NYSDOH is already receiving Medicare Part D data from CMS. Do plans need to submit this data?	Plans do not need to submit pharmacy claims that are included in the PDE's submitted to CMS as NYS receives this information from CMS. However, any other claims that the plan pays for should be included. This will include, but is not limited to, drugs not covered by CMS, OTC drug, and Part B drug claims.
For members enrolled in our Medicare Advantage product do we submit dual and non-dual members?	Plans are required to submit Medicare Part C data to the OSDS for both dual and non-dual members for enrollment and encounters. For the dual members, we would expect to see the Medicare Part C submission regardless of if they were in your Medicaid product, were in another Medicaid product or were Fee For Service Medicaid.
For the Commercial and Medicare Part C encounters, is the expectation that these include sensitive condition diagnosis, or should we be masking sensitive conditions?	There is no requirement to mask these conditions.
Is there any additional guidance/Companion Guides available for Medicare data submissions?	There are not separate guides for Medicare submissions, we are continuously working on adding new information to the Companion Guides and the Question and Answer Document to support Medicare submissions.
Members enrolled in the PACE plan may have 1 of 4 types of enrollment: • Duals (Medicaid and Medicare) • Medicare-only (no Medicaid), • Medicaid-only (no Medicare), or • Neither Medicare no Medicaid. Currently we submit encounters for duals and Medicaid-only. Which of these 4 groups should we submit encounters for as part of the OSDS Project?	Any PACE member that has a portion covered by a payer other than Medicaid (either Medicare or private pay) would require an 834 submission in addition to the encounter. If it is Medicaid only, continue to follow the current process for submission of the encounter. If this something the plan is not prepared to produce at go-live, we are open to working with you on a timeline for when this would be available to be submitted.
Do the technical requirements in the *OSDS Standard Companion Guide – X12 834 Plan Member Reporting* document apply to off-exchange commercial only or do they also apply to Medicare?	The technical requirements also apply to Medicare Advantage.

Medicare Reporting	Answer
Will Medicare encounters be subjected to the same Tier 2 edits as Commercial encounters?	Yes, they are treated the same.

7. X12 837 PACDR Reporting

Information in this section is supplemented by the OSDS STANDARD COMPANION GUIDE - X12 837 Post-Adjudicated Claim Data Reporting (PACDR)

https://nyshc.health.ny.gov/documents/39436/108308/osds_transaction_information_companion_guide_x12.pdf

837 PACDR 837 Question	Answer
Will the 837 PACDR versions be moving to the errata version when we move to commercial (i.e. x298A1, x299A1, x300A1)?	No.
The 837 PACDR Companion Guide is asking us to populate non-Tax IDS in Loop 2010AA Ref02 Segment, whereas the EDI 837X298 is asking for a tax id in REF02. Is our understanding right that NY doesn't need Tax id in Ref 02?	There are multiple iterations of the REF segment in that position and the Tax ID is required but in addition if you have a non-Tax ID Identifier for a billing provider they should be reported as well.
In the Companion Guide Appendix, A - The Category of Service codes, descriptions, and form types are identified. However, there is no criteria that specifies how to group claims into the categories of service. Does this exist anywhere else in the document, or in the Health Connector website?	This is the map that has been used in two previous EIS systems to help identify what EDI format potentially maps to a category of service code. The OSDS system does not go to the level of directing specific codes into podiatry or physician services, the data reporter should choose the actual Category of Service based upon the information they have received as a claim.
Are plans expected to provide the Category of Service (COS) and Specialty for Off exchange data? We currently do not provide this information for on-exchange.	No. the COS and specialty code are required for Medicaid, Essential Plan and Child Health Plus. Exchange and commercial off-exchange will not require a COS and Specialty Code
Do PACDR 837s need to be separated by LOB?	Yes. That is the major change between the EIS and OSDS system.
With the split of CHP into its own file, will there be a specific file name to follow with 'CHP' in the file name?	“K” will be used for CHP and “C” for Commercial. This is specified in the OSDS Standard Companion Guide - Data Submitter Information, section 3.1.4
Will PACE and MLTC lines of business need to be split or are they both considered Medicaid?	Both are considered Medicaid.

837 PACDR 837 Question	Answer
If a provider has multiple addresses in the Information Source System, which one do you want to receive? If a provider has multiple taxonomy codes in the Information Source System, which one should be sent?	The OSDS system expects to receive all provider address in the issuers information Source System.
Will there be changes to the actual 837 file formats or just the submission process?	There are no actual changes to the 837 file formats. However, there will be changes to the submission process as described in the OSDS informational materials.
Does the 837 transaction contain the 16-character HIOS ID at the claim level?	Yes, for Issuers with HIOS IDs, NYSDOH expects to receive the 14-digit HIOS ID. 14-digit HIOS IDs are required for all LOBs that have a HIOS. This excludes Medicare Advantage because MA does not have a HIOS
Is there a default date a data submitter can use to provide in the EOB dates, for claims where another payer is primary, and the data submitter is secondary? Some of our systems do not have the EOB date from the other payers - In 2330B DTP03 when EOB date from primary carrier is not present.	In Loop 2330B, for DTP03 Adjudication or Payment Date, data submitters may use the date of service as a default when they did not receive the primary payer's adjudication date from the provider. The default date may be used only when necessary.
Please provide detailed description for claim status code 755-Entity's Primary Identifier in the Tier 2 Disposition. What are all the different scenarios under which this error could occur?	The 755-Entity's Primary Identifier is further clarified with the use of the Entity Identifier Code populated in the STC01-03. A complete list can be found in the 277DRA.
Will there be a change to the 277DRA that will refer to the OSDS Edit Code rather than the Health Care Claims Status Code?	The OSDS system will produce the standard 277DRA response. Data Submitters should use the Tier 2 Edit Disposition Spreadsheet to associate the Health Care Claim Status Code with the internal OSDS Edit Code.
What is the best way to stay informed of changes in the Outbound 837 and the 277DRA, using the Companion Guide or some other documentation?	Data Submitters should use 277DRA implementation guide to stay informed of changes to the Outbound 837 and the 277DRA.
Will there be a cross-walk if there is a different edit number between EIS and OSDS?	The OSDS system has tried to maintain the same internal edit numbers from the EIS. However, some edits have been removed and that may cause realignment. Please use the Tier 2 Edit Change Log EIS to OSDS spreadsheet located on the NYS Health Connector. https://nyshc.health.ny.gov/web/nyapd/information-library
About data continuity in the event of a 6-year audit, and the implementation of the OSDS, how is the state planning on validating data migrating into the OSDS platform?	The OSDS is replacing the EIS and will be migrating all history data within the EIS to support auditing activities.
For X12 837 Loop 2330B NM109, is this a requirement is for all LOBs or just for the Commercial submission?	All Lines of Business will need to be separated in the OSDS system.

837 PACDR 837 Question	Answer
In regard to X12 837 Loop 2330B NM109, is this requirement for all LOBs or just for the commercial submission? Previous communication suggested this is an OSDS change and therefore, the requirement is for all lines of business?	For all Lines of business, the X12 837 PACDR Companion Guide is an explanation of how NYSDOH expects to receive a composite record consisting of the Issuer, Plan, and Product ID "trio" for this member in Loop 2330B.
For the 298P and 299I files, for the Segment SVD01 Loop 2430, are we to maintain the 5-character HIOS ID or use the 16 Character HIOS ID?	The SVD01 Loop 2430 must equal what is submitted in the 2330B NM109 other Payer Primary Identifier field. For Issuers with a HIOS ID, NYSDOH expects to receive the full fourteen (14) digit HIOS ID. For Issuers with NIAC numbers, NYSDOH expects to receive a prefix "N", the NIAC ID, plan identifier and product identifier in a delimited format. Please use the OSDS Standard Companion Guide – X12 837 PACDR (https://nyshc.health.ny.gov/web/nyapd/apd-osds-guidance-manuals) for reference on the 2330B NM109 Other Primary Payer Identifiers.
How is the Member ID to be submitted on the commercial off exchange encounters?	Member ID should be submitted in the NM109 segment on both 2010BA and 2010BB, please see the X12 837 Transaction Information Companion Guide.
Could the State please provide some guidance regarding the use of SBR06? The standard 837 implementation guides note that SBR06 is not a used field. Is SBR06 something that the State is looking to include when the OSDS system rolls out?	This is a NYS requirement. Per the X12 837 PACDR Companion Guide Loop 2320 shows that NYSDOH expects to receive SBR06.
For the 837 files, what should be populated in Loop 2300 AMT (Patient Paid Amount) – AMT02 – Monetary Amount? Seems like it should be what the patient paid, but could it also be the balance of a CAS segment?	The 2300 AMT is the amount paid by the patient. If they have it, it would have been submitted on the 837 from the provider.
Can you please confirm if ISA08/GS03/2010BB NM109 segment on the 837 File should be populated as 'OSDS' along with 1000B/NM109 value as per the OSDS 837 Companion Guide Information?	NYSDOH expects to receive "NYSDOH-APD" in the following fields: Data Submitter Companion Guide • ISA08 Interchange Receiver ID • GS03 Application Receiver's PACDR Companion Guide • 2010BB NM103 Data Receiver Name • 1000B NM103 Receiver Name NYSDOH expects to receive "OSDS" in Loop 1000B NM109 Receiver Primary Identifier (PACDR Companion Guide).

837 PACDR 837 Question	Answer
For 837 submissions, can you please confirm if we can use OSDS Assigned Submitter ID for GS02 "Application Sender's Code"? As per OSDS Data Submitter Information Companion Guide, verify that the HIOS ID, NAIC ID or the OSDS assigned payer ID is in GS02 Application Sender's Code. We are trying to verify if the OSDS assigned submitter ID is the same as OSDS assigned payer ID and if the OSDS Assigned Submitter ID can be used for the GS02 segment.	Submitter Id: Z00000 HIOS: 12345 TR.Z0000012345.837IM.W.200107002004.001. ISA*00* *00* *ZZ*Z0000 *ZZ*NYSDOH-APD *200107*0020*^*00501*100014426*1*P*:~. GS*HC*12345*NYSDOH-APD*20200107*0020*100014426*X*005010X299~ Yes, the HIOS, NAIC or Payer ID will need to be identified in GS02 (see example above). A Payer ID # and a Submitter ID # are two different identifiers. Every submitter is assigned OSDS Submitter ID number upon completion of their EDI registration process, this number begins with a "Z". A Payer ID is only given to selected submitters based on their circumstance (i.e.; no applicable HIOS ID or NAIC).
If the 14-digit HIOS ID excludes Medicare Advantage then what value is expected to replace the 14-digit HIOS ID?	For Loop 2330B (within the 837 Companion Guide) and Field Number 396 (within the NCPDP Companion Guide) the following guidance is provided "For non-ACA commercial or Medicare Advantage, the expected composite must be the same as reported in the 834 2750 Loop for the member. The composite consists of up to three components (Issuer, Plan, and Product). The components are separated using a right square bracket "]" and limited to 50 characters."
From our understanding, based on the X12 Implementation Guide, the Line Adjudication Identification code (Loop 2430 SVD01) must match the Other Payer Identification code (Loop 2330B NM109). When we are submitting a claim with COB (where SBR06=1) what value is OSDS looking for in Loop 2330B NM109?	The SVD01 value must match the 2330B NM109. The Companion Guides acknowledges that this is contrary to the note in the Implementation Guide.
Are encounters that are accepted at the header level, but rejected at the service line level, accepted?	The OSDS system will reject the encounter record because it was rejected at the service line level. Regardless of encounter type, all records have to be accepted at the header level and the service line level to be considered an accepted record.
Is the file name and ISA stored for encounters rejected at the Info Receiver label or can I repair and reissue the file without causing a duplicate error?	You will need to do the following: • Change the file name. Change the ISA13 and IEA02 (ISA13 and IEA02 should be the same number).

837 PACDR 837 Question	Answer
If a National Provider ID (NPI) is not available for 837 dental claims, what should we use to identify the provider in the REF for the provider loops?	You should use the REF-G2 qualifier. This is your internal assigned provider number, license number, tax ID, or social security number. Optum expects the REF02 to be populated when the REF01 is G2 be used.
What value should be in 2330B NM103?	This value represents the other payer last name or organization field. It is up to the submitter to decide how to populate it.
Please clarify the requirements for Patient Primary Identifier. Our understanding is that Patient IDs are unique to QHP and Commercial plans, but for all other LOBs the Subscriber ID is the same as the Patient ID. Same question for NCPDP 332-CY Patient ID and 302-C2 Cardholder ID fields.	The OSDS implementation expects the subscriber in all instances. We recognize the patient is always the subscriber for Medicaid, CHP and EP. For QHP, Commercial, and Medicare Advantage the subscriber may have dependents. For 837 encounters, the subscriber is expected in 2010BA and 2330A with the patient reported in 2010CA and 2330C. Both the Subscriber and the patient are expected to have unique identifiers reported in NM109 of the corresponding loops. Similarly, for NCPDP, the subscriber ID is expected in 302-C2 (Cardholder ID) and the patient ID is reported in 332-CY (Patient ID).
How should plans derive the EIS number from the 277 DRA if the EIS number is not sent in the 837s? There are instances where the 277 category and identifier are the same, but the EIS number is different.	The Tier 2 Edit Disposition Spreadsheet includes this information.
For X298 and X299, should the 2000C (Subscriber Hierarchical Level) detail be submitted for Medicare Advantage encounters to OSDS?	No, the 2000C is not required for Medicaid and Medicare subscribers. As noted in the Patient Hierarchical Level section of the x298 and x299 Implementation Guides, “when submitting Medicare and/or Medicaid encounters, the patient is always the subscriber and the Patient HL in Loop 2000C is not used”.
We do not store accident date for the 837 Dental in our system. Should we send the service date instead?	No. If the data is available, it should be submitted. NYSDOH strongly encourages the collection and submission of this data. It is critical to the intended analytics anticipated to be part of quality measures.
What are the values for Claim Frequency Type Code (CLM05-03)?	The valid values for the 837P and 837D are: 1 – Original, 7 - Adjustments, 8 – Void. These three codes are also the primary codes expected within the 837I. The accepted values for the 837I are any which are valid within the NUBC code set. It is important to note NUBC code values other than 7, or 8 are treated as originals

837 PACDR 837 Question	Answer
Why am I receiving a duplicate edit on my Dental Encounters?	When all elements within a line are the same, the duplicate edit will trigger (See edit 00214 in <edit disposition log>. When there are multiple procedures that meet the duplicate definition for the claim type, you will need to consolidate those into a single line where the charge, payment, and units for those procedures are summed appropriately.

8. NCPDP Reporting

Information in this section is supplemented by the OSDS STANDARD COMPANION GUIDE - NCPDP Post-Adjudication Standard

https://nyshc.health.ny.gov/documents/39436/108308/osds_transaction_information_companion_guide_ncpdp.pdf

NCPDP Question	Answer
Does the state require that the commercial RX file be split out or can be combined with the existing submissions?	Commercial will be a separate line of business from QHP and would be submitted in its own encounter submission file.
For the embedded RX coverage (where members RX Coverage is embedded in the Medical Plan), should it be sent as two separate records with two HD Segments?	This should not be separated; this would be reported with one HD Segment.
Please confirm the Receiver ID for Field ID 880-K7 should be listed as “NYSDOH-APD” and not “NYSAPD-OSDS” as listed within section 5.2.3 (Comma Delimited Text File Converted to Excel) of the NCPDP Companion Guide.	This should be listed as NYSDOH-APD. This revision was made within the recent release of the NCPCP Companion Guide.
What is the maximum file name length for the NCPDP file? Do we need to include both Optum assigned ID and HIOS ID in the file name?	There is no a maximum length, as the User ID for that node is variable, but relative to the HIOS ID. You would include both your HIOS ID and Optum assigned Submitter ID together.
We have dual plan and we submit Medicare (MAPD) portion under NCPDP. What submission program suffix we should we be using for this plan? Would we submit it under Medicaid “M” or Medicare Advantage “A”?	If this is for the Medicare portion of the payment, then it should be reported as "A" for Medicare Advantage.

NCPDP Question	Answer
Is NCPDP field 396 (Processor-specific data – TRIO information) applicable to all LOBs or just off-exchange plans?	A TRIO number is used when a submitter is not using the 14-digit HIOS ID. A submitter should use a TRIO number or a 14-digit HIOS number as applicable to the plan being submitted. 14-digit HIOS IDs are required for all LOBs that have a HIOS. This excludes Medicare Advantage because MA does not have a HIOS.
What Drug Database Files are used in order to validate NDC codes?	We are using files from First Data Bank and Medispan to validate NDC codes. These files typically get updated on a weekly basis. Validation results will be based on the latest file loaded. Please note: fallout/rejects may occur due to the timing of the snapshot file loaded.
Please, confirm if NYS wants NCPDP administrative denials?	NYS expects all valid services (prescriptions) to be submitted on enrolled members. This includes but is not limited to: (1) Global Bills – The continued reporting of services that were covered under a global billing situation (think maternity services). (2) Capitated Arrangements – The reporting of services that are covered under a capitated relationship. (3) Prior Authorization – The reporting of services that occurred but were not paid for because they required prior authorization. (4) Prompt Pay Rules – Valid services that were denied because they were billed for outside of established billing timeframes The listed examples are not specific solely to pharmacy, however for pharmacy OSDS would expect all dispensed drugs/dme to be reported on covered members. As the application of the CARC codes differs between insurers we do not provide a defined set of codes.

9. Edits

This information is supplemented by the TIER 2 EDIT DISPOSITION SPREADSHEET on the NYS Health Connector

https://nyshc.health.ny.gov/documents/39436/108308/tier_2_edit_dispositions.xlsx

Edit Question	Answer
Will the submitted data have Tier 1 and Tier 2 editing like the Medicaid encounter submissions have today?	Yes, like the current EIS, the OSDS system will have Tier 1 and Tier 2 editing.
Will there be a new list of Tier 2 edits with the OSDS? Will there be Tier 2 edits specific to the 834 X318?	Yes, there will be a new list of Tier 2 edits for the OSDS. Yes, there will be Tier 2 edits specific to the 834 X318.
On the 834 X318, can there be more than 1 edit?	Yes.
Will we be able to differentiate between soft edits and 834 X318 files that have hard edits? Do we only need to resubmit 834 X318 records that received hard edits?	The OSDS system Record Disposition is either Accept, Accepted with Error, or Reject. For both Reject and Accepted with Error dispositions, the issuer is expected to resubmit the corrected record.
How can a member record fail for soft edit when it was not accepted for hard edit?	The OSDS system does not stop processing once it triggers a hard edit. All edits will be processed.
To what SNIP level are you validating the X12? The rejected examples appear to be those that would be caught in compliance validation vs business edits. May just be because it's an example but wanted to check.	The tier 1 edits cover both SNIP levels 1 and 2, which include envelope checking and basic X12 syntax.
Will there be a crosswalk of the EDIT ID to the 834 X318 834 X318 -file field that is in error?	The intent is to make the edit description enough to identify the specific field(s) in error.
Will there be an eligibility hard edit check performed on encounter voids? If we retro terminate a member on the eligibility file, would the encounter void record reject?	The OSDS system will not perform eligibility checks on void transactions.
When a record level rejection occurs on a non-Subscriber Member, is only the non-Subscriber Member rejected or is the entire Subscription rejected? What if the rejection is on the Subscriber, will all dependents also be rejected? Does this answer change if the entire Subscription is an Add or Cancel/Terminate as compared to a Change?	A dependent member record does not rely on an accepted subscriber member record in order to be accepted by the OSDS system.
Can data elements be specified in the response?	The indicator and value will point to the field hitting the edit.
Initial comparison of the Tier 2 Edit Disposition spreadsheet indicates this document is the same as its EIS counterpart. Kindly advise if any changes or new edits have been added. A change log would be most helpful.	The Information Library section in the NYS Health Connector website lists the change log document.
Are there edits for pharmacy?	There are edits specific to NCPDP Pharmacy on the Tier 2 Edit Disposition Matrix.
How do we submit corrections?	It is the same transaction, but rather then submitting the full file, you will only be including transactions that you would like to correct. The only difference is in the file name, where you are indicating whether it's a corrected file.

Edit Question	Answer
Per the Tier II Edit Disposition document, edit # 00018, 00114, 00115 has the same STC01 status code of 454. How do we identify which edit triggered on the claim? We were informed that in this case we will have different STC10 status code, but this column is blank in edit sheet.	Edit 00018 is for anesthesia related procedure, edit 0114 is for invalid procedure code (which is the institutional procedure code). Edit 00018 is only related to the professional, so if this is received as a response at the claim level, it is related to professional. Edit 00114 is for the ICD procedures, and this is the institutional only. If this is received at the claim level on the institutional, this is related to the ICD procedure. If you receive it at the line level for professional, institutional or the dental, it will be tied to that procedure code at that line level. It is an addition to the code values.
Is the OSDS edit number in the 277DRA file?	The Tier II Edit Disposition document lists OSDS edit numbers. It is available on the NYS Health Connector site.
Is Edit 145 triggered when the taxonomy code is missing or when the taxonomy code is invalid?	Edit 145 is only triggered when taxonomy code is present and invalid.
Is the identifier for OSDS Edits 00097 and 00160 (Invalid Patient Primary) a hard edit for all LOBs? This applies to all LOBs and relates to the 2330B NM109.	This is a hard edit for all LOBs. The 2330C in the NM109 contains the Patient and Member IDs. The subscriber is in the 2330A NM109, and 2330B is the payer ID for the HIOS ID/NAIC ID.
The current and previous version of the Tier 2 Edit Disposition Spreadsheet have a lot of differences, and many additions were changed to deletion. What version should be referenced?	You should always use the most recent guidance documentation published to the Health Connector.
How can I identify the edit that caused my claim to be rejected? We have multiple edit numbers corresponding to category code, status code, and identifier.	The Tier 2 Edit Disposition Spreadsheet lists OSDS edit numbers. It is available on the NYS Health Connector. This document includes edit numbers with descriptions as well as the associated STC category codes. You will need to take the STC code and its associated value into consideration when identifying the edit that rejected the claim. The *Tier 2 Edit Disposition Spreadsheet* has three columns of TRIO information that should also be considered. For example: • DR06 IL 680 Entity's Country Must be a valid Country Code -This edit will only be performed if the address is outside the US 00083 Invalid Other Insured Country Code • DR06 IL 680 Entity's Country Must be a valid Country Code- This edit will only be performed if the address is outside the US 00087 Invalid Other Subscriber Country Code DR06 IL 680 Entity's Country Must be a valid Country Code- This edit will only be performed if the address is outside the US 00158 Invalid Subscriber Country Code

Edit Question	Answer
Can you please clarify the difference between Claim level vs. Line level edits?	There are data elements that are at the claim level which apply to everything that is on the claim, and then you have the line level information. • If the edit is triggered based upon the claim level information, then it is reported at the claim level only. • If the edit is at the line level and you have a reject reason at that line level, it is reported there, and the entire claim is rejected. For example: If you have multiple lines and 1 of them has an invalid modifier, the line with the invalid modifier would be presented with the edit attached to it, and the entire claim would be rejected.
Can the OSDS handle HL at a provider hierarchy with claims for multiple members under different HLs?	Yes, OSDS is expecting to receive multiple members under the HL at the provider hierarchy level.

10. Data Response Files and Feedback Reports

Information on response files and other feedback reports that will be sent to APD Data Submitters from the OSDS system

Response File Question	Answer
Will we still receive IA (High Level Acceptance), HN (Detail Reponses) and FA (Full File Failure) messages for each outbound file?	Yes, these response files for 837 and NCPDP will remain the same in the OSDS system as they are in the EIS.
Will the data response files be in the same format as the Medicaid Encounter response files are today?	The NCPDP response files will remain in the same format as they are in the EIS. However, the 837 response files will change from the 277CA to the 277DRA. For the EIS, RJ files are not returned to data submitters if the file size is inappropriate, file naming convention is invalid, or a duplicate file name is submitted for NCPDP files. The capability to provide an RJ file for Pharmacy will be built into the OSDS to provide additional information to data submitters.

Response File Question	Answer
I see the 277 listed as a response, will this remain as the current 277CA or will it be the 277DRA?	The OSDS system will be using the 277DRA response (Data Reporting Acknowledgement X364)
Would you share an example of an 834 X318 -record level response file?	An 834 X318 -record level response file example is included in the 834 X318 Companion Guide
What does it mean for a record to be accepted with an error?	An error was detected but the record was processed and accepted.
Will a response file be for only one 834 X318 file? For example, if we send five 834 X318 files on a day, we would receive back five response files?	Each 834 X318 submission file will receive a corresponding response file.
On the response file, you will tell us what the error is; will you also tell us the offending field (Loop, segment, etc.)	The current proposed 834 X318 record level response file does not include a Loop or segment.
If there are multiple 834 X318 records for a given member on a single file, how will we understand which record was accepted/rejected? I don't see a way to get back to a specific record, given the response data elements.	A unique member ID, per issuer/product/plan, is required for each member submitted. The member ID would be how submitters would be able to identify the records that are accepted or rejected.
What would happen if two plans submitted the same member ID with an overlapping eligibility span? Could both plans technically have the encounters accepted?	Yes, you can be in multiple plans at the same time. The member record submitted will include the product/ plan/member ID. The same product/plan/member ID combination should never occur for two submitters.
Will there be a record limit on 834 X318 s, like how there are for 837s today? If they are truly full files, our entire commercial membership, that's a very large to transfer a single 834 X318.	50 MB will continue to be the file size limit in OSDS. The OSDS project team will continue to analyze the anticipated 834 X318 submission requirements to ensure ease of transfer.
Are we expected to implement a Reconciliation process as well while 834 X318 reporting process is implemented?	Yes. While not required, data submitters should implement a reconciliation process, and the OSDS system response files should be used as a basis for any reconciliation.
If two transactions are sent for the same member within the same file, how would we know which transaction was accepted vs. rejected.	Transaction ID will be included in the response file.
Should we be expecting to get only acceptance records or only rejected records?	Both accepted and rejected records are within the response file.
What does the create date represents?	The date the response file was created
Will we get one response file that will respond to multiple response file?	It will be a one to one. The file name will be repeated.
If there is a delay in getting our response file should we delay our next file?	A submitter should not delay a file waiting for response files.

Response File Question	Answer
Will the OSDS system process files in the order they were received?	Yes.
Are the reject codes remaining the same or are they going to be different from the 277CA?	They will be consistent where it is appropriate. One of the differences is currently an issuer receives one trail of the category code reason code ST. The OSDS system will take advantage of all three possibilities and provides a stronger and cleaner message using multiple status codes in the 277 DRA.
Any major changes a health plan needs to know on moving from 277CA format to 277DRA?	There are no major formatting changes between the 277DRA and the 277CA. One change is that the 277DRA is compliant with properly showing soft edits at the line level.
Where can I find the 277DRA specifications?	The 277DRA guide is on the Washington Publishing Company (WPC) site under the 277 section, listed as '5010 | 277 Data Reporting Acknowledgment' http://store.x12.org/store/healthcare-5010-original-guides
Response files for Pharmacy will have an RJ file in OSDS, is this a change from the EIS?	For the EIS, RJ files are not returned to data submitters if the file size is inappropriate, file naming convention is invalid, or a duplicate file name is submitted for NCPDP files. The capability to provide an RJ file for Pharmacy will be built into the OSDS to provide additional information to data submitters.
Do the NCPDP edits cover PAH format?	OSDS NCPDP edits do cover NCPDP 4.2 format.
Are the NCPDP edits expected to change significantly related to the pricing reform conversations that are happening currently?	Currently, there are no anticipated changes for the OSDS NCPDP edits related to pricing reform conversations.
Will APD data submitters be sent 277DRA files in response to an 837D submission?	X12 277DRA files will be sent as a response to the 837D transaction. Along with the RJ, TA1 and 999 responses where appropriate.
Usually there is no correspondence between 837 file sent and 277 file received (meaning 277 file can have statuses on claims sent in different 837 files). Is there a possibility that the state could populate the 277-2100A:NM103 with the value from the 837-1000:NM103?	NYSDOH will return a 277DRA for each 837 file submitted. The 277DRA is the acknowledgement for the data reporting 837 transaction(s). Each file submission will receive a 277DRA acknowledgment. The ISA06 Interchange Sender ID, GS02 Application Sender's code and Transaction Set Control Number will be returned from the 837 file that was submitted, this can be used to identify which file the response is for.
Will plans be receiving any 999 acknowledgement or TA1 responses from OSDS?	Yes, OSDS will send out 999s and TA1s accordingly. The Data Submitter Companion Guide describes the response transaction types.

Response File Question	Answer
During the Stakeholder meeting the presentation included slides noting the Program Suffix to be included on the 837/NCPDP file and 277DRA/RxCA response files. There was no Program Suffix got Medicare. Has a Program Suffix for Medicare been determined?	We have updated our documentation to include Medicare submissions. Please see the "Data Submission Companion Guide" located on the Health Connector. Section 3.1.4 and 3.1.6 provides details on naming conventions.
Do you expect to release any 277DRA file example(s) any time in the near future? If so will they be placed on the website?	A 277DRA file example is published on the Health Connector under the "Transaction Examples" section.
Are 277DRAs pushed to a submitter via SFTP or does the submitter have to retrieve them?	All generated 277 DRAs are placed in the submitter's outbox folder. The submitter has to retrieve the files by copying them from the submitter's outbox.
What are the standard Service Level Agreements (SLA) for transaction response times?	The standard transaction response time SLA is 24 hours.
What will the 277DRA look like if there are multiple edits, both hard and soft?	There will be a STC segment for each edit that failed. The STC segment includes the STC category codes (DR02, DR06, and DR08) and the associated STC status code. You can use these to identify the edit. Please refer to the Tier 2 Edit Disposition Spreadsheet that is available on the NYS Health Connector.
Can we use a random number instead of a sequence number in our file?	The sequence number in the file is used to differentiate between files generated in the same second. It cannot be replaced by another value, including a random number.
Do you require a 999 in response to a 277DRA?	No.

Response File Question	Answer
How long will it take to receive the 277 DRA response file after we send an 837 file?	The 277 DRA is generated and sent to the submitter's outbox within 24 hours after a file is received.
Will we receive an RxTA (FA.*) acknowledgement file for all transactions, regardless of whether they were rejected or accepted? For the APD, we only receive RxTAs for rejected files. We noticed that 999 (FA.*) files are coming in for accepted 837 transaction submissions. Please confirm that FA files are to be expected for both NCPDP and 837 transaction submissions.	You will receive a 999 file for 837 transactions for files that are accepted or rejected. A 999 file is generated, regardless of status, and sent to the submitter's outbox folder. For NCPDP files, the RxTA is sent to the submitter's outbox folder to notify the submitter that the file passed or failed at the RxTA level.
The 277 files are to be wrapped or unwrapped in test and production?	The 277 files, along with other response files, will be wrapped.

11. Testing

Information in this section is related to testing of the OSDS system

Testing Question	Answer
Do you have any test data specifications?	There are currently no test specifications. The intent is that test file data would be no different than if sending to production for processing. It is anticipated that test data would mirror the production data submission.
Is testing going to be conducted in the same manner APD testing was conducted? I.E. 6 test files at 90% accepted for each transaction type, masked member data, etc.	Certification requirements will continue in the OSDS system. More information can be found in the Data Submitter Companion Guide. At this time, all submitters should be 100% certified for all transactions as indicated on EDI Registration Forms unless a timeline extension has been requested.
Will testing go "end-to-end" in the State system which would include showing the issuer that OHIP reporting statistics match OSDS acceptance statistics?	The end to end testing will start at the submission of the file through the delivery of the response files.

Testing Question	Answer
If 50% of a test file failed, instead of submitting the files that keep receiving 50% acceptance rates, does the APD want the issuers to hold off on submitting and get the failures fixed? Also, will the OSDS system test environment require Member Test Data (like the EIS) or live production data?	Data submitters will not have to hold off on submitting test files because they receive test record rejections. The test environment is open for data submitters to test various submission scenarios, both negative and positive; the test environment will accept live data.
Can both 837 and 834 X318 be tested with Live production data?	In the OSDS system, unlike EIS, a submitter will be able to submit test files using live production data. The test environment is secure enough to pull in this data. For off exchange commercial data submitters, an 834 X318 member file must be submitted prior to any 837 or NCPDP so the OSDS system can establish what enrollment is for that test submission.
Will our certification test files be labeled or handled differently than our negative testing files? We would want to knowingly submit claims that will reject to ensure we can translate the new 277 response.	The OSDS system will evaluate the test files based on the percentages of acceptance when they are sent. If you wanted to submit negative test files to evaluate what you receive on your end that would not impact anything for certification to production
Are test files still limited to 50 claims, or can they be larger?	The OSDS has not defined a claim limit on test files. However, test files cannot exceed 50 MB in size.
If a Third-Party Administrator is used, will both the TPA and Plan need to submit/pass testing file since the TPA has its own Submitter ID?	It depends on your relationship with Issuer. If you are Third Party Administrator that provides benefits on behalf of the Issuer where they provide you the enrollment, and you provide the services and you adjudicate any claims, and you submit those claims back to an issuer as some sort of negotiated part of the contract it would be between the issuer and you who would be responsible for submitting that data to NYS.
Will the OSDS system submitter ID provided be tied to the individual submitting the encounter data files or tied to the company?	User accounts will be set up for the SFTP data submitter, but then there are identifiers on the file associated with the company.
How many test files can be sent in a day?	There will be no daily limit on the number of test files that data submitters can send to the OSDS test environment.
How many claims can be in a test file?	OSDS test files will not have a constraint related to the number of claims within them, however, there will be a 50MB file size constraint.
Will we be given sample members/claims to use in the test files?	Fabricated member test data will not be needed in the OSDS test environment. Unlike the EIS, data submitters will be able to use production data in the test environment of the OSDS system as it is secure to host production data.

Testing Question	Answer
The requirement for a submitter to pass testing requires 6 test files with a minimum of 40 records with a 90% acceptance rate for each transaction type. During testing, can less than 40 records be included in the submissions?	To be certified for production a submitter will need to show a level of competency for each of the transaction types applicable to the submitter. This is defined as a minimum of 6 test files per transaction with a minimum of 40 records with a 90% acceptance rate. During testing more or less than 40 records can be sent in a transaction but for files to count towards a certification request they must have a minimum of 40 records.
Will the test portal will be available to all submitters immediately or only Alpha testers?	Testing will be available to all submitters that have completed their prerequisites. These include: • a completed DSA • an ECG connection has been established and tested If the Submitter is unsure if they have completed the final steps of the EDI Registration process, please reach out to the Help Desk.
Will there be history data within the Test system?	As the test environment is routinely updated, please refer to the release notes for any limitations with history data. Release notes will be provided when an entity has established their ECG connection and is ready to begin testing.
For the OSDS Submitter testing Prerequisites, can you elaborate on the type of file you are requesting (i.e.; any record minimum, etc.)?	For the test file submission, once the Submitter has established their ECG connection, the technical contact at Optum will reach out to the Submitter to request a test file submission and provide additional guidance. It is a small text file and does not include any claims data. The purpose is to ensure the file was successfully transmitted. Once this is completed, transaction testing can begin.
During testing, how long should before we receive a response file?	It is anticipated that you will receive a response within 24 hours. If a response is not received during this time period, please reach out to the Help Desk to escalate thee issue.
Is test data saved within the OSDS? Are we able to test adjustments to the data sent on previous test files?	During testing of the OSDS system, originals submitted will create a history. A submitter can submit voids and adjustments for previously submitted test files. For testing of the EIS LOBs, the system has prepopulated history up to the cycle indicated on the release notes. Claims not previously submitted to the EIS or submitted to the EIS after that cycle date can be submitted as originals. A submitter can test adjustment and voids to claims that were submitted to the EIS through the cycle specified in the release notes or by submitting a new original.

Testing Question	Answer
We are a TPA for 5 different plans for which we will submit NCPDP data. During testing, is it expected for us to submit test files for all 5 plans or do we only need to submit it for one plan and if all pass, we can move into production for all 5 plans?	Testing applies to each submitter. Once testing and certification is completed for a submitter, they are approved to submit files to production.
Can we now send full text files to the UAT directory or is another simple .txt exchange required first?	Yes, submitters may send full text files to the UAT folder. If you previously sent a UAT file to the production directory, please resend the file to the UAT folder. It is not necessary to send another test file.
Where can I get testing criteria for NCPDP data?	Please refer to the Data Submitter Standard Companion Guide that is available on the NYS Health Connector.
As the certification testing moves from one file type to another can issuers continue to test a file type earlier in the testing phase?	Yes. Submitters are encouraged to do this. We will not shut down UAT platform once a submitter is certified for production. This will enable submitters to continue testing.
When certifying, what 834 data will be used to validate commercial 837 files and what member validation edits will be applied?	The most recent 834 submissions available in the test environment will be used to perform member validation edits for the commercial or Medicare LOB. These 834s may be the files used for certification, however, there is no barrier to the plan submitting additional 834 files to the test environment after being certified. You should expect the member validation edits to perform as they would during production when preparing your test files for certification.
Will the test environment be cleared prior to certification testing?	The decision has been made to not clear the history prior to certification.
What is the process to notify OSDS/DOH that we are ready to be certified? How will we be notified when we pass certification for each transaction?	To indicate readiness for certification, please submit a Help Desk Ticket via Service Now (one ticket per transaction). In the ticket, you will include a statement that you are ready for certification in the specific transaction. The request for certification will be reviewed by the OSDS Project Team. Optum will reply to the help desk ticket to notify a data submitter if the certification requirements are met. **Service Now Web Submissions**: a. User must be registered with an Optum ID b. Incidents can be reported by logging into: https://optum.service-now.com/itss2 c. Protected Health Information (PHI) should never be included in the ticket description or an attachment/screenshot
If we have multiple Lines of Business (LOB) do we need to certify each transaction type per LOB?	No. Certification will be done by data submitter by transaction type.

Testing Question	Answer
Are we required to submit adjustment or void transactions to be certified for production?	No. This is recommended for best practice, but it is not a requirement.
Is it necessary to be certified in all transactions at the same time?	No. Certification is completed on a transaction by transaction basis. Submitters may be certified in one transaction and not others. The testing platform will remain open to enable submitters to continue testing.
Are there any 'minimum' volume requirements that would exempt us from the certification requirements?	We are willing to work with the data submitter to come up with an applicable test file for those that anticipate low production volume for a particular transaction.

ACRONYM DEFINITIONS

Acronym	Definition
ACA	Affordable Care Act
APD	All Payer Database
ASO	Administrative Services Only
CG	Companion Guide
CHP	Child Health Plus
COS	Category of Service
DOH	Department of Health
EDI	Electronic Data Interchange
EIS	Encounter Intake System
EP	Essential Plan
ERISA	Employee Retirement Income Security Act
FIDA	Fully Integrated Duals Advantage
HIOS	Health Insurance Oversight System
HIPAA	Health Insurance Portability and Accountability Act
HIX	Health Insurance eXchange
HMO	Health Maintenance Organization
ID	Identification
IRB	Institutional Review Board
LOB	Line of Business
MLTC	Managed Long-Term Care
MMC	Medicaid Managed Care
NAIC	National Association of Insurance Commissioners
NYS	New York State
NYSOH	New York State of Health
OSDS	Original Source Data Submitter

Acronym	Definition
PACDR	Post Adjudicated Claims Data Reporting
PACE	Programs of All-Inclusive Care for the Elderly
PBM	Pharmacy Benefit Management
QHP	Qualified Health Plan
SFTP	Secure File Transfer Protocol
SHOP	Small Business Health Options

CHANGE LOG

The following describes the changes to the Questions and Answers document since first published.

Version	Date	Change
Version 1.0	September 2019	Major Change to Format
Version 1.1	November 2019	Questions Added from September 2019 Informational WebEx Questions Added from the October 16, 2019 APD Stakeholder Meeting Added section for future guidance on Medicare Part C reporting
Version 1.2	December 2019	Based on new questions submitted to the NYSDOH mail inbox Updates to previous responses provided
Version 1.3	March 2020	Based on new questions submitted to the NYSDOH mail inbox Updates to previous responses provided Questions added from the December 2019 and February 2020 Informational WebEx
Version 1.4	April 2020	Based on new questions submitted to the NYSDOH mail inbox, Optum Trainings and Optum Help Desk Updates to previous responses provided Questions added from the March 2020 Informational WebEx

Version 1.5	May 2020	Based on new questions submitted during Optum Trainings and to the Optum Help Desk Updates to previous responses provided Questions added from the April 2020 Informational WebEx
Version 1.6	May 2020	Based on new questions submitted during Optum Trainings and to the Optum Help Desk Updates to previous responses provided Questions added from the May 2020 Informational WebEx
Version 1.7	June 2020	Based on new questions submitted during Optum Trainings and to the Optum Help Desk Updates to previous responses provided Questions added from the June 2020 Informational WebEx
Version 1.8	September 2020	Based on new questions submitted during Optum Trainings and to the Optum Help Desk Updates to previous responses provided Questions added from the July and August 2020 Informational WebEx
Version 1.9	October 2020	Based on new questions submitted during Optum Trainings and to the Optum Help Desk Updates to previous responses provided Questions added from the September 2020 & October 2020 Informational WebEx
Version 1.10	May 2021	Updates to previous responses provided and new questions added based on Submitter Forum calls, Optum Help Desk, Trainings, and other communications.
Version 1.11	November 2021 (Blue font indicates new and updated submissions)	Updates to previous responses provided and new questions added based on Submitter Forum calls, Optum Help Desk, Trainings, and other communications.