

CMS Issuer Technical Work Group

- ***Housekeeping***
 - ***Webinar Schedule***
 - ***Enrollment Operations Updates:***
Intermittent EFT Downtime
Enrollment Pre-Audit
&Reconciliation
- ***ER&R***
- ***Compliance and DE/EDE Updates***
- ***Direct Enrollment Updates: Enrollment Team***
- ***HICS Change***
- ***Q&A***

August 20, 2019

Sun	Mon	Tues	Wed	Thurs	Fri	Sat
	29	30	31	01 Data Recon & Inbound 834/BAA Workgroup 12:30-1:30pm	02	03
04	05 CCIIO Enrollment Webinar(Policy Focus) 12:00pm-1:00pm	06 CMS Issuer Technical Workgroup 3:00pm-4:30	07	08 Data Recon & Inbound 834/BAA Workgroup 12:30-1:30pm	09	10
11	12	13 CMS Issuer Technical Workgroup 3:00pm-4:30	14	15 Data Recon & Inbound 834/BAA Workgroup 12:30-1:30pm	16	17
18	19 CCIIO Enrollment Webinar(Policy Focus) 12:00pm-1:00pm	20 CMS Issuer Technical Workgroup 3:00pm-4:30	21	22 Data Recon & Inbound 834/BAA Workgroup 12:30-1:30pm	23	24
24	25	26 CMS Issuer Technical Workgroup 3:00pm-4:30	26	27 Data Recon & Inbound 834/BAA Workgroup 12:30-1:30pm	28	29

Requesting Updates to the CMS Issuer Distribution List

The CMS Issuer Communications Distribution List sends e-mail messages pertaining to :

- ✓ Alerts on Deliveries for Enrollment Pre-Audit files; Enrollment Reconciliation Files; Open Enrollment Activities; IC834 Activities (Specifically processing schedules, delays in processing or reporting), and other alerts.
- ✓ Daily IMP1A status

The CMS Issuer Communications Distribution List sends e-mail alerts:

- ✓ Daily between 10:30 and 11:00 AM EST.

To add yourself to the distribution list:

- ❖ Send an e-mail to CMS_Issuer_Communications@cms.hhs.gov with the subject line: "Add POC to Distribution List"

To remove yourself from the distribution list:

- ❖ Send an e-mail to CMS_Issuer_Communications@cms.hhs.gov with the subject line: "Remove POC from Distribution List"

To add multiple contacts to the distribution list:

- ❖ Send an e-mail to CMS_Issuer_Communications@cms.hhs.gov with the subject line: "Add POC to Distribution List"
- ❖ Include the email addresses of all desired contacts to be added in the body of your message

To remove multiple contacts from the distribution list:

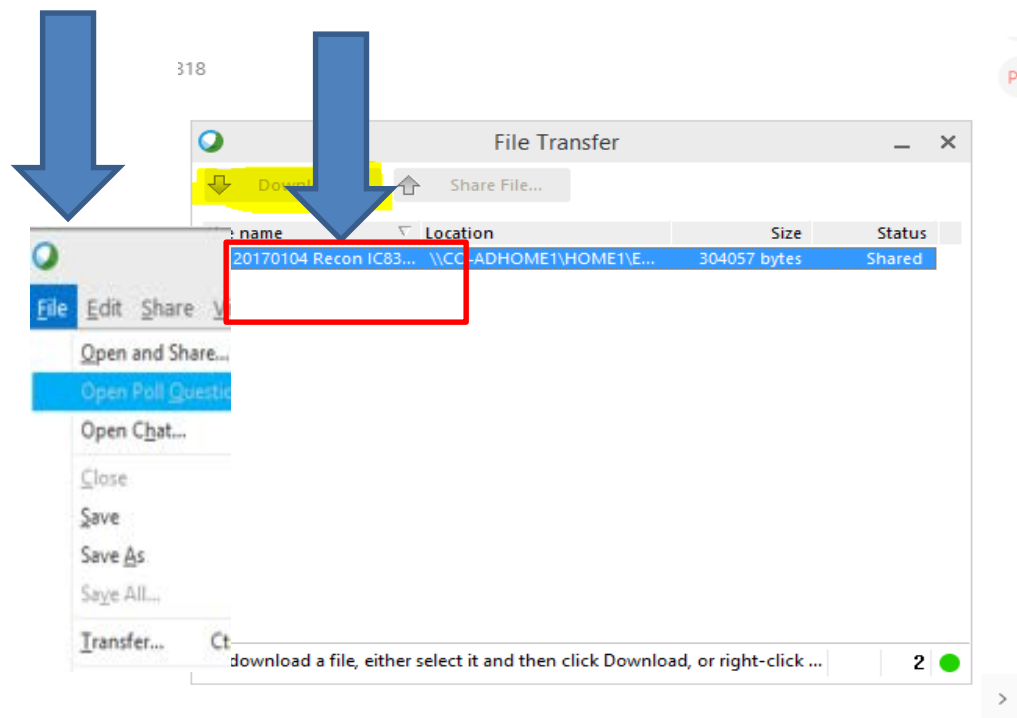
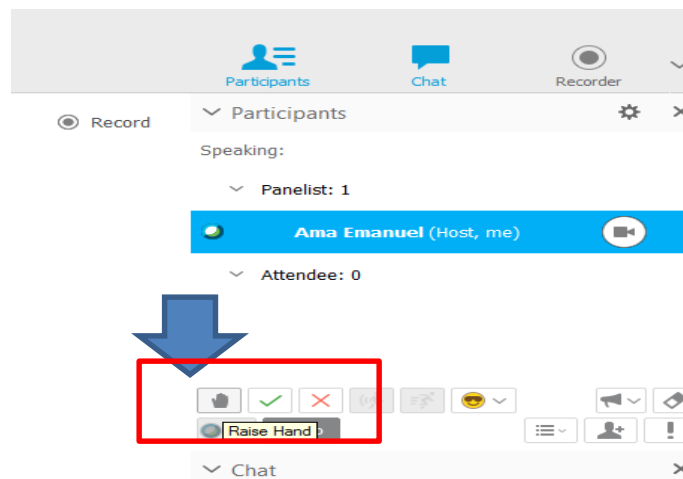
- ❖ Send an e-mail to CMS_Issuer_Communications@cms.hhs.gov with the subject line: "Remove POC to Distribution List"
- ❖ Include the email addresses of all desired contacts to be removed in the body of your message

***PLEASE NOTE:** Any email addresses included in the body of your distribution requests may be subject to the action requested. Please ensure you omit any superfluous addresses not intended for receipt of your requested action (i.e. IT support distributions, alternate personal email, etc.)

Asking a Question/downloading the Meeting pdf slides in the Web-Ex Platform

To ask a question, please select the raised hand icon at the start of Q&A session. It is the icon at the bottom of the participant list. Please deselect by clicking on the hand again. This would apply whether you no longer have a verbal question or once our question is answered.

To download the pdf version of today's deck, open the "File Transfer" box on your screen. If not, please select "File, then "Transfer" and "Download" (as captured below.) The "Download" button will be grey.



Access to CMSzONE & the Private Issuer Community

User Access Quick Guide

A copy of the comprehensive User Access Quick Guide is posted on zONE @:

<https://zone.cms.gov/document/zone-access-troubleshooting> (pre-log in required to access zONE links)

Three audiences:

1. **New Users** (new to zONE & EIDM)
2. **Existing EIDM Users** (new user to zONE)
3. **Existing zONE Users** (unable to log-in since the EIDM transition)

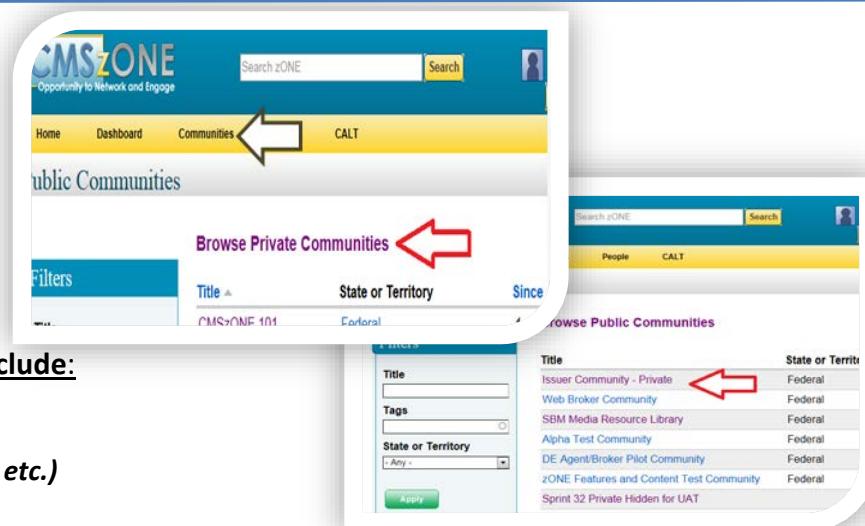
EIDM Registration Process: (Pre-requisite to CMSzONE Access)

1. Register for access at EIDM Enterprise Portal Here: <https://portal.cms.gov/>
2. Log in with your EIDM credentials and click on “Request Access Now”
3. Click on “Request New Access” and choose CMSzONE

CMSzONE Private Issuer Community

Access: (After being granted EIDM access)

1. Log into zONE; click on the **Communities** tab
2. Click **Browse Private Communities**
3. Click **Issuer Community – Private**
4. Click **Join Community**
5. Provide explanation of why you need access to this community; **Include:**
 - name and contact information
 - issuer POC contacts
 - specific work for issuer (i.e. fill out QHP templates, processing 834's, etc.)



Troubleshooting access to CMSzONE

REGISTRATION, PASSWORD RESETS, & FORGOTTEN PASSWORDS

- **New Users:** Registration & community approval are typically completed in 1-3 business days, if not sooner.

If you are unable to access zONE, and/or the issuer community after 3 business days you may email a follow up request to the helpdesk & the issuer communications team (addresses below) for an update. Please include any provided ticket numbers & applicable context for reference.

- **Existing zONE Users :** Password resets are also typically completed in 1-3 business days, if not sooner.

If your request is not completed after 3 business days, you may email a follow up request to the helpdesk & the issuer communications team (addresses below) for an update. Please include any provided ticket numbers & applicable context for reference.

ALL OTHER CMSzONE ACCESS ISSUES

Prerequisite Details

- Capture screenshots of any errors received so our teams can troubleshoot

☐ PC = Ctrl + PrtScn to capture, Ctrl + V to paste / Mac = Command+Shift+4 to capture & send to a desktop file

Email

- Provide screenshots and applicable prerequisite information above, in an email body, as follows:

- ❖ With the subject line: **“zONE Access Issues”**
- ❖ To: CMS_FEPS@cms.hhs.gov
- ❖ Cc: or Bcc: CMS_Issuer_Communications@cms.hhs.gov

Reminder: Supported Browser Versions

- ✓ Internet Explorer Version 9.0
- ✓ Internet Explore Version 10.0
- ✓ Google Chrome
- ✓ Safari

Follow-Up

- If the issue is not resolved within 3 business days, you may email a follow up request:

- ❖ With the subject line: **“zONE Access Issues : 3+day follow up”**
- ❖ To: CMS_FEPS@cms.hhs.gov & CMS_Issuer_Communications@cms.hhs.gov
- ❖ Include (where possible) explanation message, screenshots, ticket #(s) received, and number of days outstanding

New Series for the CMS Issuer Technical Workgroup Call (Series III)

The Tuesday Issuer Technical Workgroup started a new series on today Tuesday, August 6, 2019 at 3:00 PM EST.-

If you have not already; please register here <https://meetings-cms.webex.com/meetings-cms/k2/j.php?MTID=t1ee33e596961101e4a00ce2fdd928fce> one time for the entire Tuesday Issuer Technical Workgroup Call Series III (through February 26, 2020).

Once the host approves your registration, you will receive a confirmation email with instructions for joining the session.

- Please continue to use the Thursday Recon-IC834 Workgroup call registration that they have stored and receive e-mail updates from messenger@webex.com. For reference registration information is below:

Note: CMS will continue to keep call participants informed of any further changes of the Cisco Web-EX platform.

Housekeeping: Enrollment Operations Updates

August 20, 2019

CCIO Issuer Technical Workgroup

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Intermittent EFT Downtime

- As communicated in the August 16 Issuer Communications daily email blast message, files sent through EFT have been experiencing intermittent delays for the past week.
- Issuers may have noticed delays in receiving daily files from the FFM such as 1834s, functional acknowledgements, etc.
 - When evidenced, average delay time has been 10-24 hours. However, some Issuers may have been experiencing longer delays as some files have required manual intervention in order to be pushed to Issuers.
- Active investigation is underway and CMS is looking to quickly resolve all outstanding issues and resume normal cadence of file delivery.
- If Issuers feel they are missing 834s, or other files, please open a help desk ticket (CMS_FEPS@cms.hhs.gov) and identify the date for which you are missing files.

Housekeeping: Enrollment Pre-Audit & Reconciliation

Enrollment Pre-Audit & Reconciliation

August 20, 2019

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Housekeeping: Pre-Audit & Reconciliation

- **Prior Plan Years (2014-2018)**

- The next set of 1095-A Consumer-Initiated Dispute Update (1095Ax) Files are scheduled for distribution to Issuers tomorrow, Wednesday, August 21st

- **Plan Year 2016**

- This month's 2016 FFM extract was taken on Thursday, August 15th at 6PM EDT
- Comprehensive Enrollment Pre-Audit (AUD16) Files based upon that extract are scheduled for distribution to Issuers tomorrow, Wednesday, August 21st
- The RCNI16 submission deadline for the next 2016 off-cycle Reconciliation process is **Wednesday, September 4th at 3PM EDT**
 - As a reminder, these files must be submitted in the new v5.11 format
 - Issuers are encouraged to submit as soon as possible to allow sufficient time for possible correction and resubmission in response to any file-level validation issues resulting from the format change

Housekeeping: Pre-Audit & Reconciliation

- **Plan Year 2017**

- This month's 2017 FFM extract was taken on Thursday, August 15th at 6PM EDT
- Comprehensive Enrollment Pre-Audit (AUD17) Files based upon that extract are being distributed to Issuers today, Tuesday, August 20th

- **Plan Year 2018**

- This month's 2018 FFM extract was taken on Thursday, August 15th at 6PM EDT
- Incremental Pre-Audit (ISIPA8) Files based upon that extract were distributed to Issuers yesterday, Monday, August 19th

Housekeeping: Pre-Audit & Reconciliation

- **Plan Year 2019**

- This month's 2019 FFM extract was taken on Thursday, August 15th at 6PM EDT
- Comprehensive Enrollment Pre-Audit (AUD9) Files based upon that extract were distributed to Issuers yesterday, Monday, August 19th
- The RCNI9 submission deadline for August's Run 9 is **Thursday, August 22nd at 3PM EDT**
 - As a reminder, these files must be submitted in the new v5.11 format
 - Although not required, Issuers are encouraged to populate Cancellation and Termination Reason Codes to facilitate early analysis and troubleshooting of the data populated in those new fields
 - As of 1PM EDT today, we have received RCNI9 Files from **58.4%** of 2019 FFM Issuers
 - **Please note:** Only two reconciliation cycles (Runs 9 & 10) remain prior to Batch Auto-Renewal for PY2020

Issuer Enrollment Ops Training for 2020

- CMS has scheduled a series of training sessions targeted at Issuers new to the Marketplace for Plan Year 2020, any new Issuer personnel working with enrollment data, and any Issuer personnel interested in a refresher on the fundamentals of aligning enrollment data with the FFM
- This series will kick off on Wednesday, September 18th at Noon EDT and will continue each Wednesday for five weeks
 - Topics to be covered include Inbound 834 (IC834), Enrollment Pre-Audit and Reconciliation, Enrollment Disputes, Unmatched Issuer Records (UIRs), and the Enrollment Alignment Performance Summary (EAPS) Reports
- The September 18th session will cover:
 - Data Alignment 101
 - Introduction to IC834
- Registration will not be required for this series; webinar details will be shared in advance of the first session

ER&R

✓ *Topics*

- ✓ AM Approval for 2016 Disputes
- ✓ Refresher: Avoiding RU9 Disposition Codes
- ✓ Avoiding HU1 Disposition Codes

✓ *Q&A*

August 20, 2019

AM Approval for 2016 Disputes

- Due to the 2016 off-cycle RCNO run, issuers may submit 2016 disputes without AM approval until 3:00 PM ET on September 30th.
 - For corrections to be included in the October off-cycle, issuers will need to submit disputes on or before September 23rd.
- ER&R will require AM Approval for 2016 disputes submitted after 3:00 PM ET on September 30th if they do not include a supporting HICS case.

Refresher: Avoiding RU9 Disposition Codes

- Issuers receive disposition code RU9 for current year disputes when attempting to change the Premium Paid Indicator to “Y” when the RCNI has not been updated to reflect this change.
 - Rule Description: Premium Paid Indicator is blank, “C”, or “N”
 - Verbiage Returned to Issuer: *The issuer did not indicate the premium paid status should be “Y” on the latest RCNI submission. The issuer must indicate the enrollment is effectuated before ER&R can apply any updates. If you have questions or need assistance with updating the premium paid status, please contact the FMCC help desk at fmcc@cms.hhs.gov.*
- To prevent these errors, issuers should submit the PPI value of “Y” for the disputed record on the next RCNI submission.

Avoiding HU1 Disposition Codes

- ER&R returned several HICS Direct Disputes with the HU1 disposition code because the disputes are current year retroactive date changes that should be resolved through the next RCNI submission.
- ER&R assigns the HU1 disposition code when:
 - The HICS case is not an Enrollment Blocker scenario.
 - There is a segment with FFM data that already reflects the correct members and financial data.
 - Only the start and/or end date(s) of the disputed policy or segment must be corrected.
- Verbiage Returned to the Issuer: *ER&R is unable to accept the requested change through the HICS Direct Dispute process. The FFM is already reporting a coverage span with the requested financial amounts supported by the HICS case. In order to resolve the HICS case, a retroactive start/end date or reinstatement should be updated through the RCNI process. The HICS Direct Dispute process is reserved for disputes that cannot be resolved through the Reconciliation or Issuer Dispute process because a HICS case is required to verify the request. If you have questions or need technical assistance with updating the RCNI to ensure it is correct, please contact the FMCC help desk at fmcc@cms.hhs.gov.*

Avoiding HU1 Disposition Codes (Cont.)

- HICS Case Narrative: Consumer, Iris West, is requesting that the policy that only has the husband enrolled, which starts 03/01/2019, be retroactively changed to start on 01/01/2019 so that Iris West is not enrolled this year.

ISSUER_PRN N_1ST_NAM E	ISSUER_PRN N_LAST_NA ME	FFM_PLAN_ PLCY_ID	ISSUER_PLA N_PLCY_ID	FFM_PLAN_ BNFT_STRT _DT	ISSUER_PLA N_BNFT_ST RT_DT	FFM_PLAN_B NFT_END_DT	ISSUER_PLAN _BNFT_END_ DT	FFM_PLCY_ APTC_AMT	ISSUER_PLC Y_APTC_AM T	FFM_PLCY_ TOT_PRM_A MT	ISSUER_PLC Y_TOT_PRM _AMT	PLAN_EXCH G_ASG_PLC Y_SEG
Wally	West	12345678	12345678	1/1/2019	1/1/2019	2/28/2019	2/28/2019	\$650	\$650	\$1,100	\$1,100	11111111
Iris	West	12345678	12345678	1/1/2019	1/1/2019	2/28/2019	2/28/2019	\$650	\$650	\$1,100	\$1,100	11111111
Wally	West	12345678	12345678	3/1/2019	3/1/2019	12/31/2019	12/31/2019	\$450	\$450	\$800	\$800	22222222

- Issuer Comment on HICS Case: *Remove Iris West from Segment 11111111, change APTC to \$450, change Total Premium to \$800. Subscriber Wally West should remain on the policy.*
- This scenario results in an HU1 disposition code because Iris West has been removed from coverage beginning 03/01/2019, as mentioned in the narrative, and no financial corrections are required.
- The issuer can resolve the discrepancy through RCNI by making the following changes:
 - Cancel segment 11111111 for policy 12345678
 - Change start date to 01/01/2019 for segment 22222222 for policy 12345678

Eligibility Team Updates



*Center for Consumer
Information and Insurance
Oversight (CCIIO)*

August 20, 2019

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Updated Eligibility Documents on zONE

- CMS recently released updates to the following eligibility documents on [zONE](#):
 - An updated CMS-Initiated Change Request Tracker is now available with **one** new change request for partners
 - Change Request #27
 - An updated Sample Eligibility Results Messaging resource
 - New: Examples 16 and 17
 - Updated: Examples Two – Five
- Please refer to both the Sample Eligibility Results Messaging resource and CMS-Initiated Change Request tracker to view the full scope of the updates

CMS-Initiated Change Request Tracker

- The following change to the Eligibility Results page must be implemented by 1/1/20 (All Phases):
 - When consumers are found Medicaid or CHIP eligible in an Assessment state, the state makes the final Medicaid or CHIP eligibility determination for the consumers. Because of this, messaging for these consumers on the eligibility results page should state "May be eligible for Medicaid" or "May be eligible for CHIP" when appropriate
 - Partners should use the State Reference Data API to identify Assessment states and Determination states
 - When consumers are found Medicaid or CHIP eligible in a Determination state, the eligibility results page should state "Eligible for Medicaid" or "Eligible for CHIP" **unless their eligibility status is pending**. In these cases, the eligibility results page should state "May be eligible for Medicaid/CHIP"
 - To identify a pending status for consumers who are found Medicaid/CHIP eligible in a Determination state, partners should use the Submit App and Get App response upon a successful application submission

Sample Eligibility Results Messaging Resource

- Examples 16 and 17 are new examples for Eligibility Results page messaging when an applicant is both QHP and non-MAGI Medicaid eligible in either a Determination state or Assessment state
 - Change Request #22
- Clarifications were made to Examples 2-5 for Eligibility Results page messaging when an applicant is found Medicaid eligible in a Determination state and has a pending eligibility status
 - Change Request #27
- Red text denotes clarifications to the Sample Eligibility Results Messaging Resource
- Blue text denotes optional language for EDE Partners to implement

Example 16

- This example outlines messaging when one consumer is found QHP eligible, one consumer may be Medicaid eligible, and one consumer is found both QHP and non-MAGI Medicaid eligible in an Assessment state
- If any consumers are found both QHP and non-MAGI Medicaid eligible in an Assessment state, DE Entities have one of the following options to display messaging for this consumer:
 1. "Eligible to buy a Marketplace plan"
 2. "Eligible to buy a Marketplace plan" AND "May be eligible for Medicaid"
- Additionally, they may be grouped with the following applicants on the eligibility results page:
 1. Any other QHP eligible applicants
 2. Any other applicants that "May be eligible for Medicaid"

Example 17

- This example outlines messaging when one consumer is found QHP eligible, one consumer is found Medicaid eligible, and one consumer is found both QHP and non-MAGI Medicaid eligible in a Determination state
- If any consumers are found both QHP and non-MAGI Medicaid eligible in a Determination state, DE Entities have one of the following options to display messaging for this consumer:
 1. "Eligible to buy a Marketplace plan"
 2. "Eligible to buy a Marketplace plan" AND "May be eligible for Medicaid"
- Additionally, they may be grouped with the following applicants on the eligibility results page:
 1. Any other QHP eligible applicants
- Non-MAGI Medicaid eligible applicants **may NOT** be grouped with any other applicants that are determined "Eligible for Medicaid"
- Non-MAGI Medicaid eligible applicants **may** be grouped with any other applicants that are eligible for Medicaid and have a pending eligibility status "May be eligible for Medicaid"

Examples Two through Five

- Examples two through five were updated to outline messaging on the Eligibility Results page when a consumer has discrepancies in the data on their application and data from Trusted Data Sources (does not have verified income, citizenship/immigration status, or residency), which results in a pending Medicaid/CHIP status
- In both Determination and Assessment states:
 - When either a Medicaid/CHIP eligible or non-MAGI Medicaid eligible consumer also has discrepancies in the data on their application and data from TDS this will result in a pending Medicaid status. Messaging should state:
 - May be eligible for Medicaid. Your state Medicaid agency will contact you if you need to provide more information.

Medicaid Block Indicators

- As a reminder, new **optional** Medicaid Block indicators were available in UAT0 on May 10th and production on June 14th
- Currently, partners have the choice to use either the legacy Medicaid Block indicators **OR** the new Medicaid Block indicators
 - In the future, the new indicators will be used for applications submitted on HealthCare.gov and we will update EDE partners when there is a timeline for required implementation of the new indicators
- The legacy and the new Medicaid Block indicators align with Items 133-142 of the UI Question Companion Guide

Medicaid Block Indicators: All Phases

Item #	UI Question	Legacy Indicators	New Indicators
133	Were any of these people found not eligible for [state Medicaid program name] or [state CHIP name] by [state] since [date of 90 days ago]?	<i>Name selected:</i> medicaidDeniedIndicator = true for that applicant <i>Any name not selected:</i> leave medicaidDeniedIndicator null	Same indicators
134	<i>If name is selected in Item 133 OR multiple names selected, and additional applicant(s) was not denied on the same date as first applicant:</i> When was [FNLNS] denied Medicaid or CHIP coverage?	medicaidDeniedDate = date entered	Same indicators
135	<i>If multiple names selected in Item 133:</i> Was [FNLNS] also denied on the date entered above?	<i>Yes:</i> medicaidDeniedDate = date entered above <i>No:</i> Display Item 134 for that applicant	Same indicators

Medicaid Block Indicators: All Phases

Item #	UI Question	Legacy Indicators	New Indicators
136	<i>If name is selected in Item 133 and a date has been provided:</i> Did any of these people apply for health coverage between [most recent OE start date] – [most recent end date]? NOTE: Partners should update the OE dates in this question between December 1st and December 15th to the OE dates for the upcoming coverage year.	<i>Name selected:</i> appliedDuringOeOrLifeChangeIndicator = true for that applicant <i>Any name not selected:</i> Display Item 137	Same indicators
137	<i>If name is not selected in Item 136:</i> Did [FNLNS] apply through the Health Insurance Marketplace after a qualifying life event?	<i>Name selected:</i> appliedDuringOeOrLifeChangeIndicator = true for that applicant <i>Any name not selected:</i> appliedDuringOeOrLifeChangeIndicator = false for that applicant	Same indicators
138	<i>If name is not selected in Item 133:</i> Did [FNLNS] have [state Medicaid program name] or [state CHIP program name] that will end soon or that recently ended because of a change in eligibility?	<i>Yes:</i> medicaidDeniedIndicator = true <i>No:</i> medicaidDeniedIndicator = false	<i>Yes:</i> medicaidEndIndicator = true <i>No:</i> medicaidEndIndicator = false

Medicaid Block Indicators: All Phases

Item #	UI Question	Legacy Indicators	New Indicators
139	<i>If “Yes” was selected in Item 138:</i> Has the household income or household size changed since [FNLNS] was told [his/her] coverage was ending?	<i>Yes:</i> medicaidDeniedIndicator = false <i>No:</i> medicaidDeniedIndicator = true	<i>Yes:</i> informationChangeSinceMedicaidEndedIndicator = true <i>No:</i> informationChangeSinceMedicaidEndedIndicator = false
140	<i>If “Yes” was selected in Item 138:</i> What's the last day of [FNLNS]'s Medicaid or CHIP coverage?	If the date selected is in the future 60 days or the current date, set the changeInCircumstance to FUTURE_LOSS_OF_MEC If the date selected is in the past 60 days, set the changeInCircumstance to LOSS_OF_MEC Set changeInCircumstance.changeDate = date selected If the user indicates that all applicants lost/will lose their coverage on the same date, set changeInCircumstance.changeDate = date selected for all applicants who attested to having Medicaid or CHIP that recently ended or will end soon Leave medicaidDeniedDate null	If the date selected is in the future 60 days or the current date, set the changeInCircumstance to FUTURE_LOSS_OF_MEC If the date selected is in the past 60 days, set the changeInCircumstance to LOSS_OF_MEC Set changeInCircumstance.changeDate = date selected If the user indicates that all applicants lost/will lose their coverage on the same date, set changeInCircumstance.changeDate = date selected for all applicants who attested to having Medicaid or CHIP that recently ended or will end soon Set medicaidEndDate = date selected

Medicaid Block Indicators: Phases 2 and 3

Item #	UI Question	Legacy Indicators	New Indicators
141	Were any of these people found not eligible for [state Medicaid program name] or [state CHIP program name] based on their immigration status since [current year minus 5 years]?	<i>Yes or name is selected:</i> medicaidDeniedDueToImmigrationIndicator = true <i>No or "None of these people":</i> medicaidDeniedDueToImmigrationIndicator = false	Same Indicators
142	<i>If "Yes" or name is selected in Item 141:</i> Has [FNLNS] had their current immigration status since [current year minus 5 years]?	<i>Yes:</i> medicaidDeniedDueToImmigrationIndicator = false <i>No:</i> medicaidDeniedDueToImmigrationIndicator = true	<i>Yes:</i> immigrationStatusFiveYearIndicator = true <i>No:</i> immigrationStatusFiveYearIndicator = false
143	<i>If "No" in Item 142:</i> Has [FNLNS] had a change in their immigration status since they were not found eligible for [state Medicaid program name] or [state CHIP program name]?	<i>Yes:</i> medicaidDeniedIndicator = false <i>No:</i> medicaidDeniedIndicator = true	<i>Yes:</i> immigrationStatusChangeSinceDeniedIndicator = true <i>No:</i> immigrationStatusChangeSinceDeniedIndicator = false

Direct Enrollment (DE) and Enhanced Direct Enrollment (EDE) Reminders and Announcements: Compliance Team

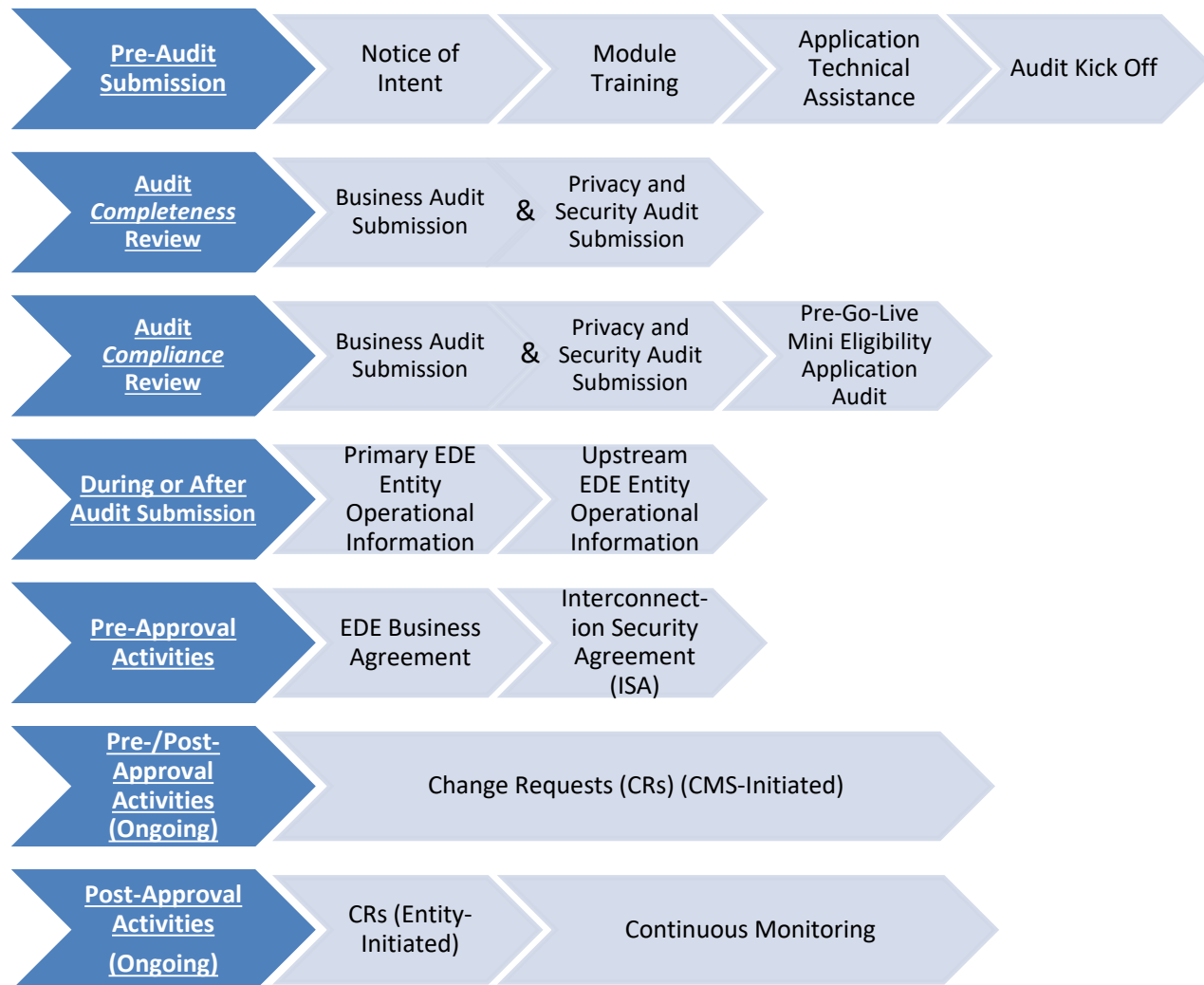


Tuesday, August 20, 2019

Announcement: EDE Program Participation Checklist

- CMS released a revised EDE Program Participation Checklist for prospective primary EDE Entities
- The checklist outlines the high-level steps of the EDE approval process, which are summarized in the next slide
- Entities in the review queue will receive individualized updated checklists every two weeks until they are officially approved to go live
- Individualized checklists will indicate:
 - If Entities have submitted the ***initial*** requested documentation for each step, and
 - If Entities still must submit documentation for one or more steps (i.e., outstanding steps in the approval process)
- CMS posted a template on [CMS zONE](#)

Summary of EDE Approval Steps in the Checklist



This is a high-level summary of the EDE approval process. In general, prospective primary entities complete each row before progressing to the next.

The dark blue chevrons summarize the gray blue steps in each row.

Summary of Checklist Columns

The checklist includes 6 columns:

- 1. Stage:** Identifies which stage of the approval process correspond to each submission and approval step
- 2. Subject Area:** Identifies the subject area of the approval step
- 3. Information/Document:** Contains a description of the information or document that the EDE Entity must submit
- 4. Document Location:** Identifies the location of the document or how the Entity receives the document, if applicable
- 5. Submission Notes:** Describes the method by which the EDE Entity must submit the information or document to CMS. Provides other pertinent information about the information, document, or submission, if applicable
- 6. Complete:** Provides a space to mark that the EDE Entity has submitted the **initial** information and/or documents required in each row
 - Note: CMS may provide feedback, ask questions, and/or request additional information once items have been marked as "complete"

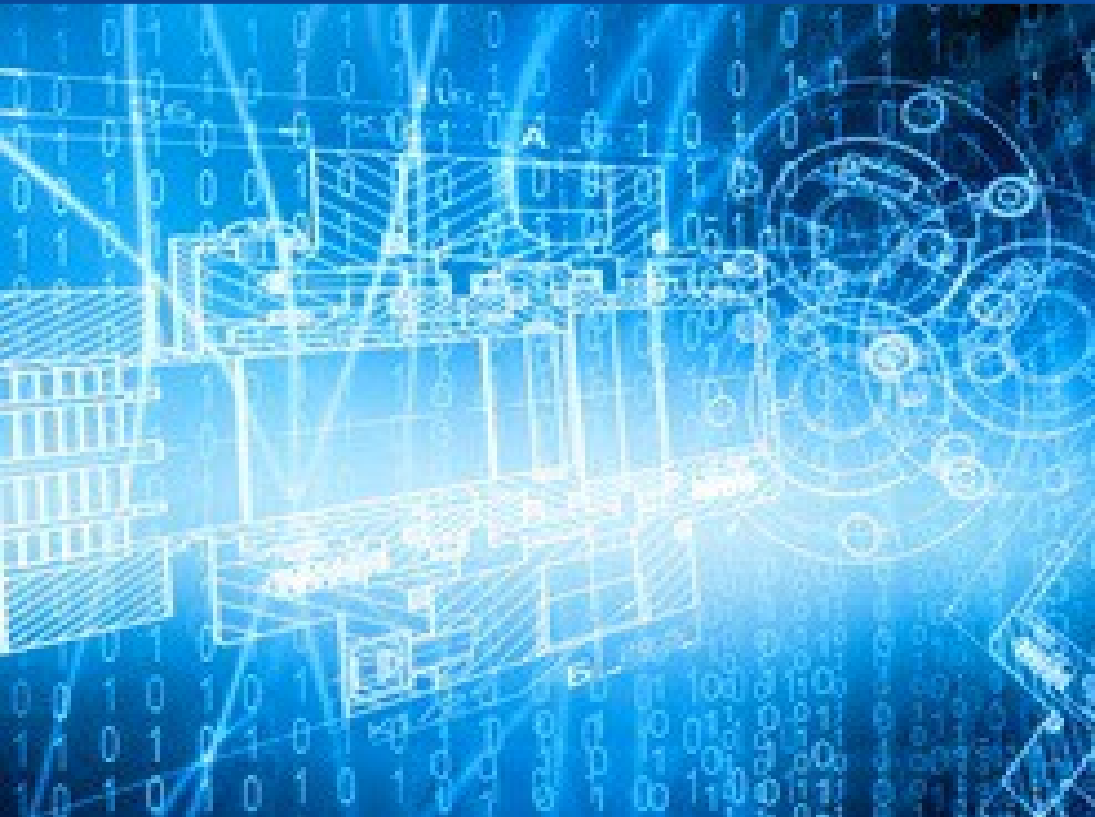
Table 1. EDE Program Participation Checklist

Stage	Subject Area	Information/Document	Document Location	Submission Notes	Complete
Pre-Audit Submission	Notice of Intent	Notice of Intent to participate in EDE	N/A	- Submit via email to DE Support by February 28, 2019 - Upstream EDE Entities do not need to email Notices of Intent (see "Upstream Documentation Package" below)	☐
		1. Prospective EDE Entity Name			1. ☐
		2. Auditor Name(s) and Contact Information (Business Requirements and Privacy and Security, if different)			2. ☐
		3. EDE Phase (1, 2, or 3)			3. ☐
		4. Prospective EDE Entity Primary Point of Contact (POC) name, email, and phone number			4. ☐
		5. Prospective EDE Entity Technical POC name, email, and phone number			5. ☐
		6. Prospective EDE Entity Emergency POC name, email, and phone number			6. ☐
		7. CMS-issued Hub Partner ID			7. ☐
	Module Training	Modules include: - EDE Regulatory and Compliance Standards - EDE Application User Interface (UI) Overview - EDE Privacy/Security Standards - EDE Operational Readiness Review (ORR) and CMS Reporting Requirements - Non-Eligibility Application Programming Interface (API) Guidance - Other modules as required by CMS	REGTAP	- Trainings must be completed by prospective primary EDE Entities and Auditors, as described in the Guidelines - Submit complete course conclusion pages at the end of each module via secure portal, if requested	☐

ISA Appendix B - Data Sharing and Connection Form (reminder)

- The EDE Interconnection Security Agreement (ISA) Appendix B – Data Sharing and Connection Form is available on [CMS zONE](#)
- The form is intended to capture information about the data connections, functionality, and systems between a primary EDE Entity and its upstream EDE Entities
 - For example, entities must describe the information transmitted between primary and upstream entities (e.g., personally identifiable information [PII] data elements, enrollment information, eligibility information, 834s, etc.) and the privacy and security protections applied to such data (e.g. Memorandum of Understanding [MOU], Business Agreement, etc.)
- **Note**: Primary EDE Entities need to complete all four sections of the form annually and **when onboarding a new upstream EDE Entity** as part of the Interconnection Security Agreement (ISA) and Information Security and Privacy Continuous Monitoring (ISCM) Strategy Guide
- A primary EDE Entity must complete this Appendix and return it via the Secure Portal to CMS
 - Please contact DE Support (directenrollment@cms.hhs.gov) with any questions

Direct Enrollment (DE) Updates: Enrollment Team



*Center for Consumer
Information and Insurance
Oversight (CCIIO)*

August 20, 2019

Classic DE and EDE Partners: Updated Quality Rating Guidance Published

- Classic DE and EDE Partners, please be advised that CMS published updated Quality Rating guidance on 8/15/2019
- As a reminder, the purpose of the Quality Rating System (QRS) is to: (1) help consumers make informed healthcare decisions, (2) facilitate oversight of health plans, and (3) provide actionable information to health plans to improve the quality of services they provide
 - Star ratings give consumers a snapshot of how each health plan's quality compares to that of other Exchange plans in each state and across the country
 - Under the Quality Rating System, Exchange health plans are given an overall rating on a 5-star scale, with 5 stars representing highest quality
 - This rating is based on 3 categories: Member Experience, Medical Care, and Plan Administration
 - » Each of these categories also has its own rating that is based on a 5-star rating scale
- Beginning with the 2020 Open Enrollment Period (OEP), quality ratings for all states that participate with the FFE will be displayed on HealthCare.gov when consumers view the list of plans available in their area
 - Each plan will show the Overall Rating with the number of stars from 1 to 5 filled in towards the top of each plan within the list, or let the consumer know if the individual plan hasn't been rated
 - Consumers can see three additional ratings for Member Experience, Medical Care, and Plan Administration with the Overall Rating when selecting an individual plan's detailed information along with other coverage and benefits
- In addition to display by Exchanges, DE Partners that facilitate enrollments through the FFE and SBE-FPs are required to display the same quality data for consumers as required by 45 C.F.R. § 155.205(b)(1)
 - For the PY 2020 OEP only, if a web-broker DE entity is unable to display the federally-calculated QRS star ratings, it must prominently display the Plan Detail Disclaimer on its non-Exchange website, which will direct the consumer to HealthCare.gov for more information
 - This disclaimer is outlined in the FFE Enrollment Manual available on zONE at <https://zone.cms.gov/document/direct-enrollment-de-documents-and-materials>
 - Note that web-brokers will not be permitted to display this disclaimer in lieu of the quality data after the PY 2020 OEP, and instead, all DE Partners will be expected to display the necessary quality data
 - Issuers are not permitted to display the disclaimer in lieu of the actual quality data

Classic DE and EDE Partners: Updated Quality Rating Guidance Published

- Consistent with the display of QHP quality rating information by the FFE, DE entities should prepare to display QHP quality ratings assigned to each eligible QHP beginning with the individual market OEP for the 2020 Plan Year
 - DE entities will be required to display the federally calculated QRS global ratings and summary indicator ratings
 - DE entities should use the same consumer-facing labels that CMS displays on HealthCare.gov (i.e., “Overall Rating,” “Medical Care,” “Member Experience,” and “Plan Administration”)
 - If a QHP is not eligible for scoring or does not receive a rating for other reasons, DE entities will need to follow the same approach as the FFE and display “New plan – quality ratings unavailable” or “Not Rated” in place of the QHP quality rating information
 - DE entities are required to use language consistent with HealthCare.gov for the description and definitions of the quality ratings
- CMS will make the quality rating data available to DE entities through the Quality Public Use File (PUF) and the Marketplace API
 - The Quality PUF can be found at <https://www.cms.gov/ccio/resources/data-resources/marketplace-puf.html#>
 - Note that the Quality PUF for the 2020 Plan Year will be released closer to the start of OE
 - To review documentation for the Marketplace API, or to request an API key, visit <https://developer.cms.gov/marketplace-api/>
- QHP issuer and web-broker DE entities that display QHP quality rating information on their non-Exchange websites should also prominently display the following disclaimer language provided by CMS:
 - *Plan quality ratings and enrollee survey results are calculated by CMS using data provided by health plans in 2019. The ratings are being displayed for health plans for the 2020 plan year. Learn more about these ratings. [Link to appropriate explanatory/Help text on HealthCare.gov.]*

Classic DE and EDE Partners: Updated Quality Rating Guidance Published

- Additional documentation related the Quality Rating guidance that was published on 8/15/2019 can be found as described below:
 - The Quality Rating System guidance is available at:
 - <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Quality-Rating-Information-Bulletin-for-Plan-Year-2020.pdf>
 - <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/QualityRatingInformationBulletinforPlanYear2020.pdf>
 - The Plan Year 2019 nationwide Quality Rating System PUF is available at:
 - <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Plan-Year-2019-Nationwide-Quality-Rating-System-PUF.zip>
 - <https://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.html>
 - The results at a glance are available at:
 - <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Health-Insurance-Exchanges-QRS-Program-for-Plan-Year-2019-Results-At-A-Glance.pdf>
 - <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/HealthInsuranceExchangesQRSforPY2020-ResultsataGlance.pdf>
 - The Quality Rating System fact sheet is available at:
 - <https://www.cms.gov/newsroom/fact-sheets/health-insurance-exchange-quality-ratings-system-101>

Reminder and Update for Classic DE and EDE Partners: Upcoming Tobacco-Related Changes

- Classic DE and EDE Partners, as a reminder, there are a few tobacco-related changes occurring as follows:
 - The TobaccoUseIndicator (PolicyCreationActivity/EnrollmentGroup/InsuranceApplicant/TobaccoUseIndicator) will now be required in all Submit Enrollment Requests
 - This change has already been deployed to UAT0, and will be deployed to production on 9/15
 - The updated Hub Business Service Definition (BSD) and DE API Specs are available on zONE at <https://zone.cms.gov/document/direct-enrollment-de-documents-and-materials>
 - Tobacco rating will now need to be accurate during CICs, as a fix will be deployed for the defect that was allowing for incorrect updates of tobacco status during CICs
 - This fix has already been deployed to UAT0, and will be deployed to production on 9/13
 - » DE Partners are encouraged to test and submit any potential defects by 8/23, as code freeze for this release is 8/24
 - Potential defects should be submitted to both cms_feps@cms.hhs.gov and CMS.FFM.EDESsupport@accenturefederal.com
 - As a reminder, note that Section 7.3.2.7 in the DE API Specs now includes tobacco rating guidance/logic
 - DE Partners should be aware that the TobaccoUseIndicator and TobaccoLastUsageDate (PolicyCreationActivity/EnrollmentGroup/InsuranceApplicant/TobaccoLastUsageDate/Date) in the Submit Enrollment Request must reflect the tobacco rating for the given transaction
 - » In other words, if tobacco rating must be persisted during a CIC, the TobaccoUseIndicator and the TobaccoLastUsageDate provided in the Submit Enrollment Request should persist the values that were provided in the Fetch Eligibility Response
 - If a consumer can be rerated for purposes of tobacco use based on the tobacco rating logic in the DE API Specs, then the DE Partner must send the TobaccoUseIndicator and TobaccoLastUsageDate based on the consumer's current attestation within the DE Partner's UI
 - » The InsurancePremiumAmount (PolicyCreationActivity/ AffectedInsurancePremium/InsurancePremiumAmount) must also reflect the appropriate amount based on the tobacco rating logic in the DE API Specs
 - Otherwise, a Submit Enrollment transaction will fail with an IncorrectPremiumAmount error
 - » **Update:** If a DE Partner does not correctly persist the existing TobaccoUseIndicator value in a scenario where the consumer's tobacco rating cannot be updated, the DE Partner will receive a Submit Enrollment failure with an error response of InvalidTobaccoUseIndicator
 - The DE API Specs have been updated accordingly, as this error response had not been used previously
 - For a more detailed outline of the upcoming changes, please refer to last week's slides at <https://zone.cms.gov/document/slides-cms-issuer-technical-workgroups-tuesdays>

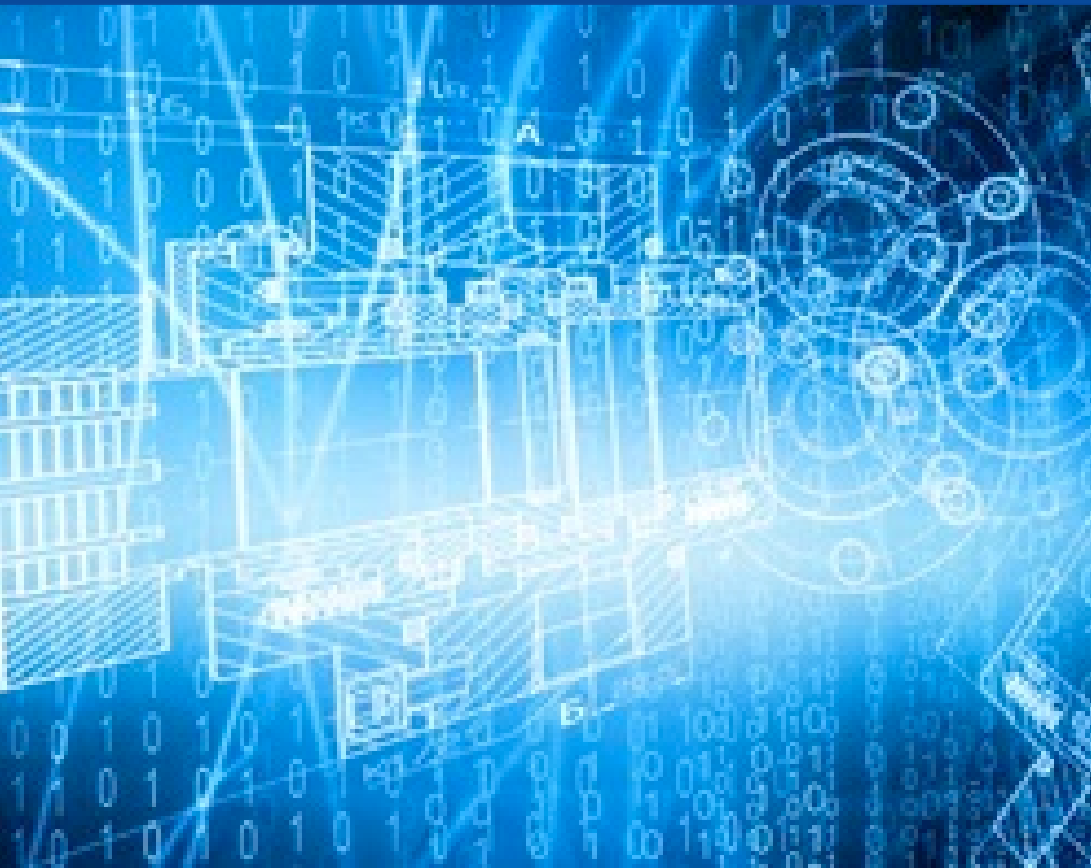
EDE Partners: Updated Document Upload API File Name Validation

- EDE Partners, please be advised that we will be updating our Document Upload API file name validation as follows:
 - The file name must only contain ASCII 32-126 characters, except:
 - 34 ["]
 - 39 [']
 - 59 [;]
 - 60 [<]
 - 61 [=]
 - 62 [>]
 - 92 [\]
 - Additionally, the file name cannot include the following sequence of characters:
 - %00
- If an EDE Partner attempts to upload a document with a file name that violates these rules, an error response of `invalid_filename` will be returned
- As a reminder, our previous validation only included a restriction on the following characters:
 - 34 ["]
 - 59 [;]
 - 92 [\]
- Please note that we don't have the UAT0 and production deployment dates available yet, however this change is expected to be deployed prior to the start of OE
 - EDE Partners should therefore make the necessary validation changes as soon as possible
 - An update will be provided once the UAT0 and production deployment dates have been established
- The updated Document Upload API Spec extract can be found on zONE at <https://zone.cms.gov/document/api-information>

Q&A



CMS Issuer Technical Workgroup Call Appendix



To view the full Appendix, please visit CMSzONE at the following url:

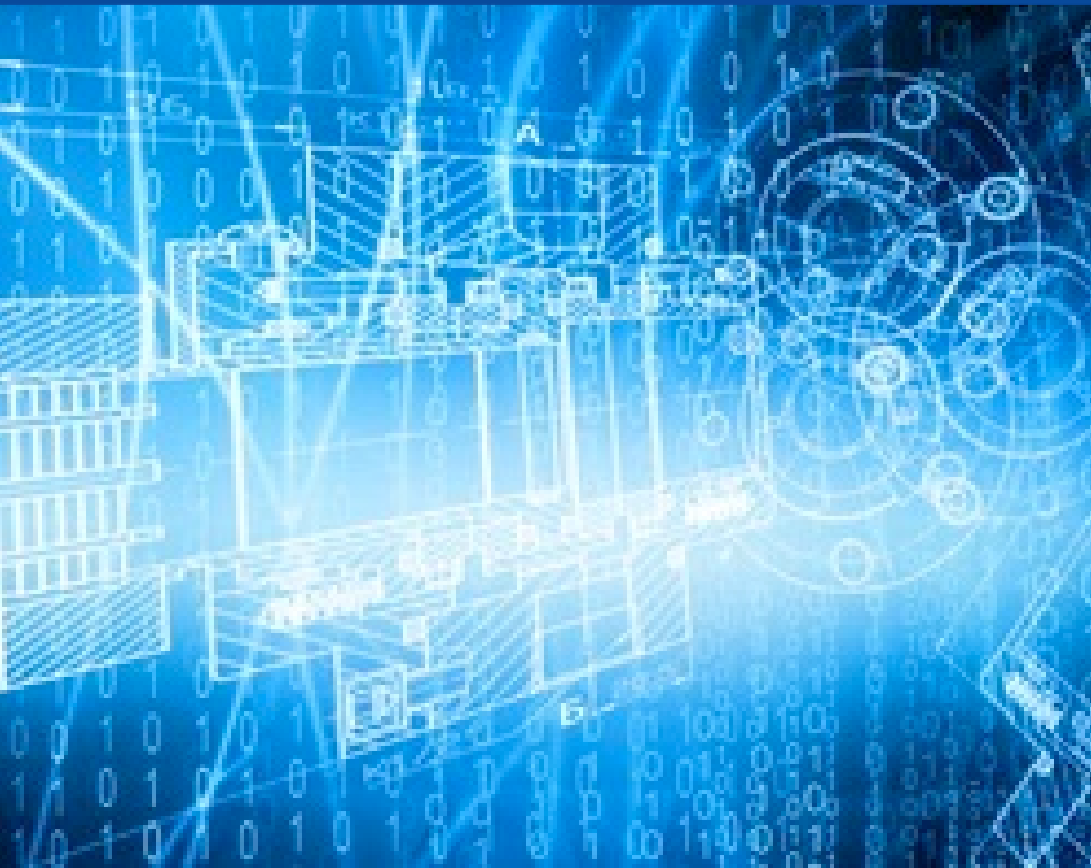
https://zone.cms.gov/system/files/documents/issuer_technical_slides_appendix_a_2018_3_20_v1.pdf

Updating Contact Information for the Marketplace

08/20/2019

confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Updating Contact Information for Marketplace Issuers

- 
- **New Series for the CMS Issuer Technical Workgroup Calls**
 - **Requesting Updates to the CMS Issuer Distribution List**
 - **Issuer Notifications: Updating IC834 Contacts**
 - **2018 Prep: Updated Recon Technical Contacts Needed**
 - **2018 Prep: Updated ER&R Contacts Needed**

July 15, 2019

confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Issuer Notifications: Updating IC834 Contacts

Inbound834 (IC834) Contacts

- Issuer Organization and Clearinghouse members may be contacted through Inbound834@bah.com with notifications for high volume failure, low success rates, and summary reports based on weekly Inbound 834 submissions
- CMS encourages Issuers to identify key technical POCs to receive both outreach communications and performance reports so any errors received for failed transactions can be corrected and resubmitted for application in the Marketplace
- To update the contact list for your HIOS IDs (add or remove members), please follow one of the two options listed below:
 - Create and send an updated EDI onboarding form or;
 - Send an e-mail to Inbound834@bah.com with the new contact addresses

2019 Prep: Updated Recon Technical Contacts Needed

Enrollment Data Reconciliation Technical Contacts

- Reconciliation Technical Contacts for your organization will be contacted by CMS resources in regard to any technical issues identified in Issuer-submitted Inbound Reconciliation (RCNI) Files
- Please designate a primary and secondary contact or group e-mail address to ensure any issues can be addressed in a timely fashion
- To submit the Enrollment Data Reconciliation Technical Contacts to CMS:
 - Send an e-mail to the Help Desk (cms_feps@cms.hhs.gov) with the subject line “RECONCILIATION – TECHNICAL CONTACTS”
 - Please include the name, e-mail address, and business telephone number for each contact provided

2019 Prep: Updated ER&R Contacts Needed

Enrollment Resolution & Reconciliation (ER&R) Contacts

- Cognosante, the Marketplace Enrollment Resolution & Reconciliation (ER&R) contractor, will be responsible for conducting analysis to resolve discrepancies between data provided by Issuers and FFM data
- As direct contact with the Issuers may often prove to be the most reliable method of resolving issues, CMS is requesting that each Issuer provide a primary and secondary contact with whom the ER&R contractor can have direct communications
- If there are distinct contacts for different lines of business within the Issuer organization, please clearly identify which contacts are appropriate for each HIOS ID and/or QHP ID
- The requested contacts are to be individuals able to assist in resolving conflicts with member information; **these individuals are more likely to be business end-users rather than EDI or IT representatives**
- To submit the Enrollment Resolution & Reconciliation Contacts to CMS:
 - Send an e-mail to the Help Desk (cms_feps@cms.hhs.gov) with the subject line "RECONCILIATION – ERR CONTACTS"
 - Please include the name, e-mail address, and business telephone number for each contact provided

Register for QHP Certification Updates

CMS sends updates and information during the certification period in several ways:

REGTAP

- Register for the [REGTAP portal](#) to get CMS technical assistance related to Marketplace and Stabilization programs that are not a part of the Marketplace Plan Management Group (MPMG). Registered users can access the library training resources, webinars, and the inquiry tracking and management system.
- Registered REGTAP users who are affiliated with an issuer organization and elect to receive notifications will automatically be subscribed to *Issuer Insights*, a bi-weekly e-newsletter that highlights upcoming deadlines, new trainings and webinars, and updates on guidance.

Application Notices

- CMS will send information about your specific application and needed corrections directly to each issuer during the QHP certification period.

HIOS Blasts

- To get QHP Application and certification announcement blasts from HIOS, make sure your contact information in HIOS is current and accurate.

Source - <https://www.qhpcertification.cms.gov/s/Register%20for%20Updates>

Plan Management QHP Certification Updates

Contact Information in HIOS

Add New Contacts

- In order for a contact to receive these notices, they must be assigned to the role of QHPValidator, QHPAttester, or QHPSubmitter in HIOS. For instructions on adding these roles, see section 5 of the Plan Management QHP Modules HIOS Quick Reference Guide.

Remove Contacts

- To remove contacts from the distribution list or from your organization, contact the Marketplace Service Desk (MSD) Help Desk at CMS_FEPS@cms.hhs.gov and use the language specified below.
 - Remove contacts from notice distribution list: Use the subject line “HIOS User Roles” and the following language: “Please remove contact: [Full Name], [Email Address], from the roles of QHPValidator, QHPAttester, and QHPSubmitter for issuer ID [XXXXX].”
 - Remove contacts from issuer organization: Use the following language: “Please remove contact: [Full Name], [Email Address], from all HIOS user roles associated with issuer ID [XXXXX].”

For a list of QHP Application Notices sent during QHP Certification:

<https://www.qhpcertification.cms.gov/s/QHP%20Application%20Notices>

HIOS Quick Reference Guide:

<https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIOS-PF-QuickGuideProd-000100.pdf>

Source - <https://www.qhpcertification.cms.gov/s/Register%20for%20Updates>

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