Cost-sharing Reduction (CSR) Reconciliation Technical Assistance

March 23, 2016

Health Insurance Exchange Program Training Series

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

HTTPS://WWW.REGTAP.INFO/

Session Guidelines

- This is a 60-minute Q&A Session.
- FAQs will be posted in the coming weeks.
- For questions regarding content, please submit inquiries to REGTAP at https://www.REGTAP.info/.
- For questions regarding logistics and registration, please contact the Registrar at: 1-800-257-9520.

CSR Technical Assistance Training

- The Centers for Medicare & Medicaid Services (CMS) will continue to roll out technical assistance sessions through April 2016.
- As part of this series, CMS will conduct weekly question and answer sessions each Wednesday from 3:00 – 4:00 p.m. ET.

CSR Technical Assistance Training Dates

Day of Session	Date of Session	Time	Session Title
Wednesday	March 30, 2016	3:00 – 4:00 p.m. ET	Q&A Session
Wednesday	April 6, 2016	3:00 – 4:00 p.m. ET	Q&A Session
Wednesday	April 13, 2016	3:00 – 4:00 p.m. ET	Q&A Session
Wednesday	April 20, 2016	3:00 – 4:00 p.m. ET	Q&A Session
Wednesday	April 27, 2016	3:00 – 4:00 p.m. ET	Q&A Session

Intended Audience and Purpose

- The intended audience includes issuers that received the Cost-Sharing Reduction (CSR) portion of the advance payments for the 2014 and/or 2015 benefit years.
- The purpose of this presentation is to allow issuers who will be participating in the CSR reconciliation process with CMS to ask questions related to the CSR Reconciliation Process.

Announcements and Reminders

- Testing is occurring in MIDAS's production environment, so **issuers should submit all test files with a .P filename extension.**
- Issuers should receive a confirmation email and summary/error report within 24 hours of submitting a test file. Please email CMS at CSRreconquestions@cms.hhs.gov if you have not received the summary/error report in your EFT.
  - Note: If your test file fails the file structure validations, the confirmation email and summary/error report are not currently being sent to issuers. CMS is working on fixing the issue. Please email CMS at the above address if you have not received the summary/error report, and CMS will send it to you over email.

Announcements and Reminders

- Issuers should submit test files that include their correct business and technical POCs, including their email addresses. After the testing window closes, we will update our system to ensure that attestation form confirmation emails are sent to those POC email addresses. In the meantime, issuers may email CMS at CSRreconquestions@cms.hhs.gov to inquire about the status of attestation forms submitting during the testing period.
- CMS has identified an issue related to how the validation is working for “Total Number Exchange Subscriber IDs In This Plan Variation For The Benefit Year”.
  - We are working to fix this issue to ensure that the Total number of Exchange Subscriber IDs for which the issuer is submitting data in the plan variation matches the count of records listed in policy details (03 records).
  - In the meantime, issuers may ignore this error during the testing window if the issuer has confirmed they have populated the field correctly.

Announcements and Reminders

Attestation Forms A, B, and C

- Attestation forms submitted via EFT should be zipped by HIOS ID and benefit year.
  - For example, if reconciling data for 5 HIOS IDs for 2014 and 5 HIOS IDs for 2015, the issuer should submit 10 zip files with attestation forms.
  - If submitting multiple attestation forms for a HIOS ID for a benefit year, do not zip and send the forms separately.

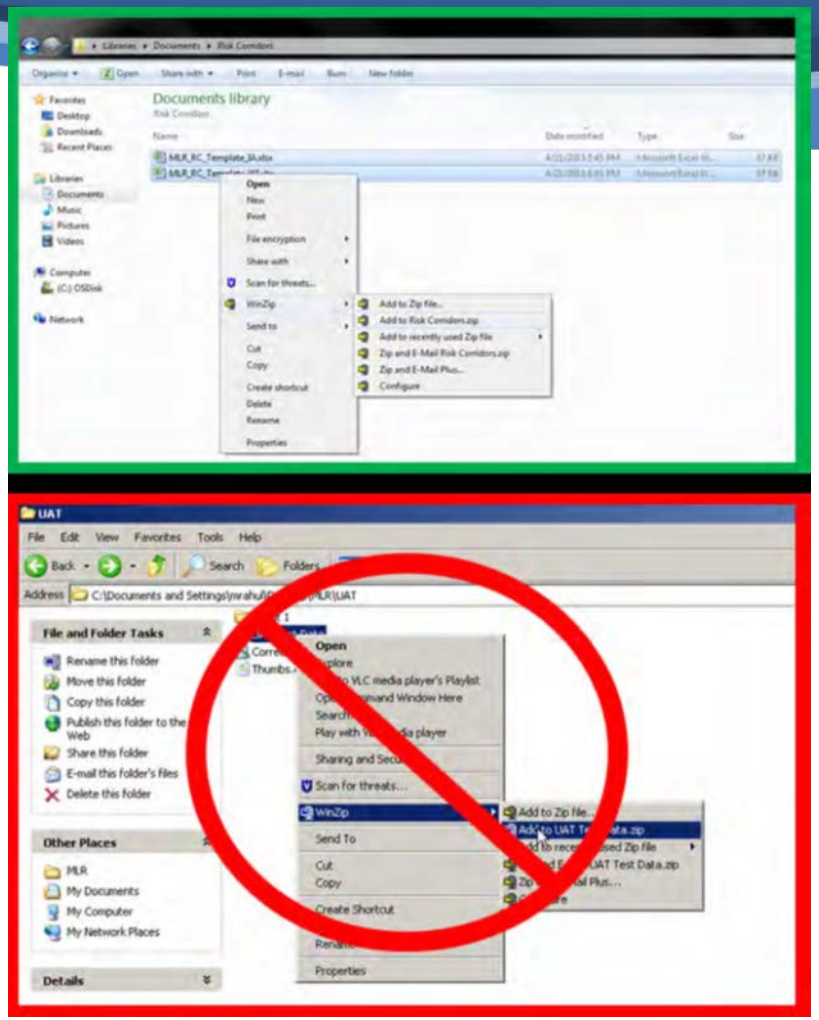
Announcements and Reminders

- If issuers are having trouble with the file name requirements and sending files without suffixes (i.e., with “.zip” or “.txt” suffixes), try to rename files using the file name convention after creating the file.
  - File name convention for data files:
    - 12345678.MID.CSRI.D151027.T123136760.P.IN
  - File name convention for attestation files:
    - 1234567890.MID.CSRATI.D130223.T145543452.P.IN

Announcements and Reminders

Zipping Attestation Forms

- **CORRECT:** Open the folder. Select all Attestation Form files. Right-click on the selected files, choose “WinZip” and “Add to Zip file…” option, and type a file name at the end of the directory.
- **Note:** No spaces are allowed in the zip file name.
- **INCORRECT:** Do **NOT** zip the files at the folder level.



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Announcements and Reminders

- CMS may not respond to all issuer inquiries by the end of the testing window on 3/25, but we still plan to respond to your inquiry so you can understand the status of your file(s).
- CMS is making several system fixes after the testing window closes on March 25, including improving the summary report descriptions and ensuring issuers receive the summary reports if their files have failed structural validations.
- Issuers should use the April submission window as a continued opportunity to submit data files and attestation files for purposes of troubleshooting issues and errors associated with the files.

Announcements and Reminders

- In order to help address system issues identified during the testing phase, CMS is asking certain issuers to confirm their methodology selection for the 2014 and 2015 benefit years.
- By the end of the week, CMS plans to send an email to issuers requesting this information. Please be on the lookout for that email, which may be sent to your organization's EDI technical point of contact.

Updates

For the remainder of the testing period, to avoid file rejection, issuers using the simplified AV method exclusively for all plan variants should complete “Attestation C for AV Plans” - Tab 3 of Form C, which requires issuers using the AV method to list their QHPs. If the issuer has no parameters to report, then, the issuer is not required to fill out the Form C parameters report.

Issuers using AV exclusively

We are aware that in previous guidance, CMS has told issuers using AV exclusively that they do not need to submit Attestation Form C. We are working on ways to solve file rejection problems for issuers using AV exclusively, so that such issuers do not have to submit Form C during the normal submission window. In order to accomplish this and eliminate file rejections, we are requesting that any issuer using the AV method exclusively email us at CSRreview@cms.hhs.gov

New FAQs

Question: Are non-formulary drugs considered EHB?

Answer: As stated in the *Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule* (78 FR 12834; February 25, 2013), plans are permitted to go beyond the number of drugs offered by the benchmark without exceeding EHB. Specifically, as discussed in the *HHS Notice of Benefit and Payment Parameters for 2016 Final Rule* (80 FR 10750; February 27, 2015) under 45 CFR 156.122(c), a health plan providing essential health benefits must have processes in place that allow an enrollee to request and gain access to clinically appropriate drugs not otherwise covered by the health plan and in the event that an exception request is granted, the plan must treat the excepted drug(s) as an essential health benefit, including by counting any cost-sharing towards the plan's annual limitation on cost-sharing. In such cases, non-formulary drugs are also eligible for cost-sharing reduction reimbursement.

New FAQs (Continued)

Question: Do Cost-sharing Reduction (CSR) subsidies only apply to in-network Essential Health Benefits (EHB)?

Answer: Plans are permitted to provide cost-sharing reductions on covered out-of-network EHB benefits, for example to simplify plan design. In such cases, the issuer is permitted to include these out-of-network EHB claims when calculating cost-sharing reductions provided. Additionally, in the zero cost-sharing plan for American Indians/Alaska Natives, enrollees pay no cost sharing for EHBs, in-network or out-of-network, as long as the associated standard plan also covers EHB out of network. If the standard plan does not cover EHB out of network, then CMS will not reimburse issuers for any cost-sharing reduction provided to an enrollee for such non-covered services. See 78 FR 15481 (March 11, 2013) for discussion of 156.130(c), under which a plan is not required to count out-of-network cost sharing toward the annual limitation or reduced annual limitation on cost sharing.

New FAQs (Continued)

Question: Can issuers submit zero dollars for CSR provided for de minimis enrollment in certain plans (for example, American Indian/Alaska Native populations in bronze plans)?

Answer: If an issuer has few enrollees or enrollees with few or no cost-sharing reduction claims in any plan variation including the zero and limited cost-sharing plans during a benefit year, the issuer may elect to reimburse CMS the full advance payment amount for those plans rather than re-adjudicate such claims. In such cases, the issuer should email CMSreconciliationattestations@cms.hhs.gov for further instruction. Failure to submit a report for a plan will not trigger an error; however, CMS automatically calculates zero for CSRs provided for the plan.

FAQs

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FAQ 14964

Question: Will issuers have the option to re-adjudicate claims in chronological order regardless of claim type?

Answer: Issuers that do not use a third party administrator may reprocess claims in their original order but must first set accumulators to zero. Please see CMS guidance at:

- https://www.regtap.info/uploads/library/APTC_Claims_Readjudication_Guidance_110314_5CR_111714.pdf

FAQ 15101

Question: What happens if issuers receive reimbursement from a third party after a claim is adjudicated? Should claims that are paid by the Veteran's Administration and subsequently sent to the issuer for secondary payment be included in CSR Reconciliation?

Answer: Third party payments for a claim must be netted from the total allowed costs that the issuer or enrollee paid for EHB prior to re-adjudication of claims for a policy. If the issuer receives a third-party payment after the re-adjudication of a policy, the issuer must re-state and recalculate CSR provided for the policy. Issuers expecting a third party payment should wait until the payment is received before calculating CSR for that claim.

FAQ 15102

Question: How should issuers handle CSRs provided during a grace period?

Answer: Issuers that provide CSRs as allowed prior to the termination of coverage effective date (See 78 FR 15490 March 11, 2013) should seek reimbursement for CSR provided on services during the 30-day period that the enrollee was eligible for CSRs the same way it would seek reimbursement for any eligible enrollee, using the Subscriber ID and plan variation start and end dates for the period the enrollee was eligible.

FAQ 15103

Question: May issuers seek reimbursement for CSRs provided during the 2nd and 3rd months of a grace period, for example on pharmacy claims that because of contractual arrangements between the issuer and supplier cannot be pended?

Answer: No. Issuers may not seek reimbursement for CSRs provided after the termination of coverage effective date with respect to a grace period, since the terminated enrollee is no longer eligible for tax credits in the 2nd and 3rd months of the grace period and therefore no longer eligible for cost-sharing reductions under Section 1402(f) of the Affordable Care Act. The only exception is provided under 45 CFR 156.430(f)(3), which permits issuers to seek reimbursement for CSRs provided during a retroactive termination in which failure to terminate was not the fault of the QHP issuer, for example, when the QHP issuer receives a late termination notice from the Exchange.

FAQ 15104

Question: Can the Centers for Medicare & Medicaid Services (CMS) clarify how issuers should implement the Simplified Methodology if an issuer has a plan design where the percentage of Essential Health Benefits (EHB) not subject to a deductible falls between 20 percent and 80 percent?

Answer: If the percentage of EHB not subject to a deductible is less than 80 percent, the issuer should apply the parameters for the regular simplified methodology. The parameters for HMO-like plans may only be used for plans or subgroups of plans with more than 80 percent of total allowed costs not subject to a deductible as discussed at 45 CFR 156.430(c)(4)(vi).

FAQ 15105

Question: Are State-mandated benefits eligible for reimbursement if they are included in the Essential Health Benefits benchmark plan for that State?

Answer: Only benefits mandated by a State before Dec. 31, 2011 are considered EHB for the purpose of cost-sharing reductions. If the State required coverage for certain benefits after Dec. 31, 2011, regardless of whether such benefits are included in the State-selected benchmark plan, such benefits generally are not considered covered EHB for the purpose of CSRs, and CMS will not reimburse issuers for any CSR provided for such benefits. However, in the EHB Rule (78 FR 12837 through 12838), benefits required by a State through action taking place after Dec. 31, 2011 that directly apply to the QHPs are not considered EHB, unless enactment is directly attributable to State compliance with Federal requirements. Examples of such Federal requirements include: requirements to provide benefits and services in each of the 10 categories of EHB; requirements to cover preventive services; requirements to comply with the Mental Health Parity and Addiction Equity Act; and the removal of discriminatory age limits from existing benefits.

FAQ 15105 (Continued)

Answer: …Additionally, the 2016 Notice of Benefits and Payment Policy specified that a State may need to supplement habilitative services if the base-benchmark plan does not cover such services. We noted that if a State supplements the base-benchmark plan, the benefit(s) added is EHB.

Finally, a benefit required only in the large group market and reflected in a large group base-benchmark plan is not an EHB for QHPs offered in the individual or small group markets because such a benefit requirement does not apply directly to those plans, and to the extent it is included in the base-benchmark plan, it may be substituted for, in accordance with §156.115(b). Plans subject to the EHB requirements offered in the individual and small group markets in those States would have to be substantially equal to the base-benchmark plan, and therefore may cover the State-required benefit as EHB since it is embedded in the base-benchmark plan. In such a case, the benefit is an EHB because it is covered by the base-benchmark plan.

FAQ 15105 (Continued)

Answer: Since each State defines EHB within the federal parameters, based on the base benchmark plan that they select, issuers may contact the State Based Exchange or the State Department of Insurance for a list of State EHBS. Additionally, the EHBs for each State are listed on the CMS website:

- https://www.cms.gov/cciio/resources/data-resources/ehb.html

FAQ 15106

Question: Can you please clarify what we should be using to calculate the allowed amount, since CMS has said both that the coordination of benefit (COB) should be included in a claim and also, in the CSR Reconciliation Issuer to MIDAS Inbound Specification document, that the amount the enrollee(s) paid is the difference between the total allowed costs for EHB and the amount the issuer paid.

Answer: Issuers should reflect adjustments for COB claims when reporting total allowed costs. However, the amount paid by the issuer or by the enrollee would be reduced, as applicable, in both the standard plan and the plan variation by any amounts that have been paid by a third party. For example, if a claim costs $500, and the auto insurer pays the issuer $250, the total allowed cost for the claim is $250 in both the standard plan and the CSR plan. If the auto issuer also pays the enrollee's $10 cost sharing, the total allowed cost remains the same at $250, of which the issuer pays $240 and the (auto insurer on behalf of the) enrollee paid $10.

FAQ 15107

Question: Does the total amount the issuer paid for Essential Health Benefits (EHB) include per-member-per-month payments (PMPM) by issuers for capitated arrangements, e.g. full medical, pediatric, dental, and vision benefits) and that issuers using such arrangements may estimate reasonable allowed amounts for associated encounters using their internal pricing methodology for such encounters.

Answer: Yes, the total amount the issuer paid for EHB may include a PMPM payment, if applicable. Issuers may use their internal pricing methodology to establish a cost of a medical service in a capitated pay arrangement.

FAQ 15108

Question: What is CMS' stance on plans' inability to re-adjudicate capitated claims for the purpose of creating the base shadow claim? Is it acceptable to exclude capitated services from the reconciliation?

Answer: No. How the issuer pays for services does not affect whether or not cost-sharing reductions were provided. Services that the issuer pays for in a capitated manner should be included in cost-sharing reduction reconciliation by measuring what the enrollee paid in cost sharing for the service under the plan variation against what the enrollee would have paid for the service under the standard plan.

FAQ 15109

Question: If a policy has no claims or no claims eligible for cost-sharing reductions, what should the issuer do?

Answer: The issuer does not need to submit a report for a policy with no claims or cost-sharing reductions. Failure to report CSR amounts for each subscriber will not trigger an error. CMS will automatically calculate zero for CSRs provided for this policy.

FAQ 15110

Question: If a QHP issuer has acquired another issuer and subsumed the issuer's policies under its own HIOS ID, should the issuer indicate that it has acquired and is reconciling here another HIOS ID's policies?

Answer: If the QHP issuer has changed the subscriber IDs and replaced the HIOS ID of the acquired issuer's business with its own, then the QHP issuer should answer Yes to the question of whether it merged with or subsumed another issuer and list the former HIOS ID of that issuer.

FAQ 15111

Question: On the Issuer Summary Record, one of the required fields is "Issuer Extract Time." Can you please tell me the format in which data should be entered in order to populate this field? For instance, if the data is extracted at 1:25pm, how should this time be entered?

Answer: The valid format for the Issuer Extract Time is HHMMSS (Hour, Minutes, and Seconds). If the data is extracted at 1:25:20 p.m., the Issuer Extract Time should be populated as “012520”. The requirements for the data element ID 106 “Issuer Extract Time” can be found on page 3 of the CSR Reconciliation Issuer to MIDAS Inbound Specification document.

FAQ 15112

Question: On the Issuer Summary Record, one of the required fields is "Reconciliation Methodology." If we are using the Simplified Actuarial Value method for the entire submission, what text should we enter for this data element? Should we simply enter "Simplified Actuarial Value "?

Answer: Please enter “SIMPLIFIED AV” if you are using the AV method exclusively for all plans being reported for CSR reconciliation. The requirements for the data element ID 110 "Reconciliation Methodology" can be found at the bottom of page 3 of the CSR Reconciliation Issuer to MIDAS Inbound Specification document.

FAQ 15113

Question: On the Policy Summary Record, one of the required fields is "Self-Only/Other than self-only." According to the Webinar from February 10th & 12th, it looks like an "S" should be entered for self-only policies. What should we enter for an Other than self-only policy?

Answer: For the Simplified methodology and Simplified Actuarial Value only, report whether coverage under this policy is self only, or other than self-only. This data element is required only if the methodology is SIMPLIFIED and SIMPLIFIED AV. Valid values are Self (S) or Other (O). The requirements for data element ID 306 “Self Only/Other than self-only” can be found on page 8 of the CSR Reconciliation Issuer to MIDAS Inbound Specification document.

FAQ 15114

Question: On the Policy Summary Record, one of the required fields is "Actuarial value amount of the Standard Plan." Can a percentage be entered for this variable? How many decimal places should be displayed?

Answer: Enter a decimal, not a percentage for this variable. In the final version of the CSR reconciliation Issuer to MIDAS Inbound Specification document that CMS will release, this data element will have a minimum of 4 characters and a maximum of 12 characters (Note: CMS counts the leading zero and the decimal point as characters). For example, if the issuer knows this value as 80%, they would enter that as 0.80.

FAQ 15115

Question: Can CMS clarify Exchange Subscriber ID reporting requirements?

Answer: For the purpose of cost-sharing reduction reconciliation:

If the issuer is aggregating policies in the same plan variation across a year, the issuer should report only one Subscriber ID associated with the member(for Data Element ID 302 “Exchange Assigned Subscriber ID” in the Policy Detail Record) and include only 1 Subscriber ID in the count of “Total number of Exchange Subscriber IDs in this plan variation for the benefit year” in the Plan Summary level.

FAQ 15116

Question: If the issuer submits an Exchange Subscriber ID that fails validation as a result of not matching FEPS records for the Federally-facilitated Marketplace (FFM), will the entire submission fail as a result of that single Exchange subscriber ID?

Answer: No. If an FFM issuer's Exchange Subscriber ID fails validation, only the policy record level ("03" record) associated with that Exchange Subscriber ID will fail. The issuer will receive an error report indicating the failure, but the rest of the file will process. However, if 50% or more of an issuer's policy records fail, CMS will reject the entire file, including any valid policy records, and the submission will not be processed. Policy records that fail will not be included in the calculation of the issuer's reconciled CSR amount. We note that CMS will only validate Exchange Subscriber IDs for policies offered through the FFM; the validation will not apply to policies offered through a State-based Marketplace.

FAQ 15117

Question: Both the Plan Summary Record and the Policy Summary Record include claims information in the form of allowed costs and amount the issuer paid for EHB, etc. Should the claim amounts include both in and out of network claims? Should the claims amounts include or exclude certain fees such as pooling charges, access fees, HCRA surcharges, prompt pay interest, and provider incentive payments?

Answer: Out-of-network claims are generally not eligible for cost-sharing reductions and do not need to be included. However, if the plan variation provides cost-sharing reductions on out-of-network services, they should be included (for example, with the zero cost-sharing plan variation, cost-sharing reductions are required because the enrollee pays no cost sharing for essential health benefits (EHBs), in-network or out-of-network, as long as the associated standard plan also covers EHB out of network).

FAQ 15117 (Continued)

Answer: …If the standard plan does not cover EHB out of network, then CMS will not reimburse issuers for any cost sharing reduction provided to an enrollee for such non covered services.

Total allowed costs for essential health benefits do not include fees, charges, interest or any other administrative costs for the issuer.

Questions?

To submit questions by phone:

- *dial ‘14’ on your phone’s keypad*
  - *dial ‘13’ to withdraw your question*

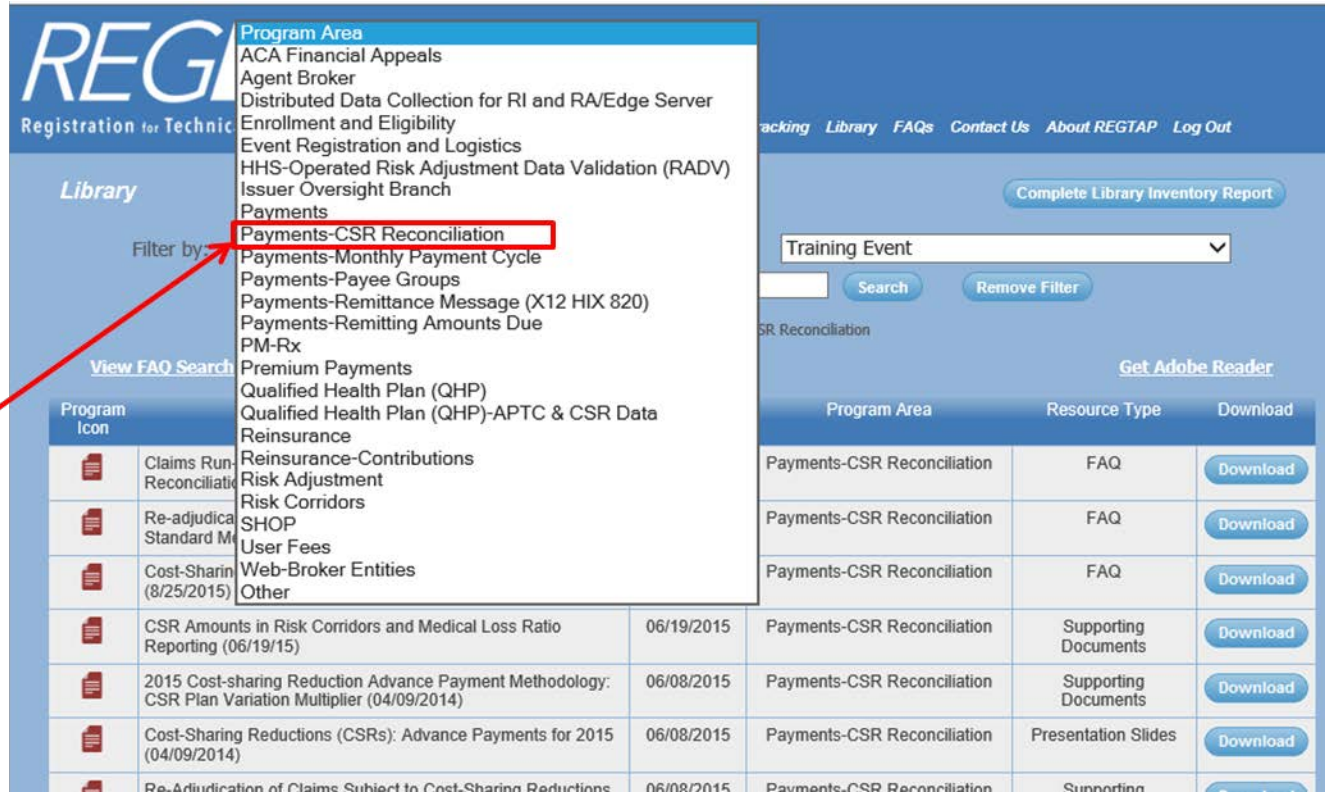
To submit questions by webinar:

- *type your question in the text box under the ‘Q&A’ tab*

Locating CSR Reconciliation Documents in REGTAP

Stakeholders can access additional documents at https://www.REGTAP.info in the REGTAP Library.

Under Program Area, select "Payment-CSR Reconciliation"



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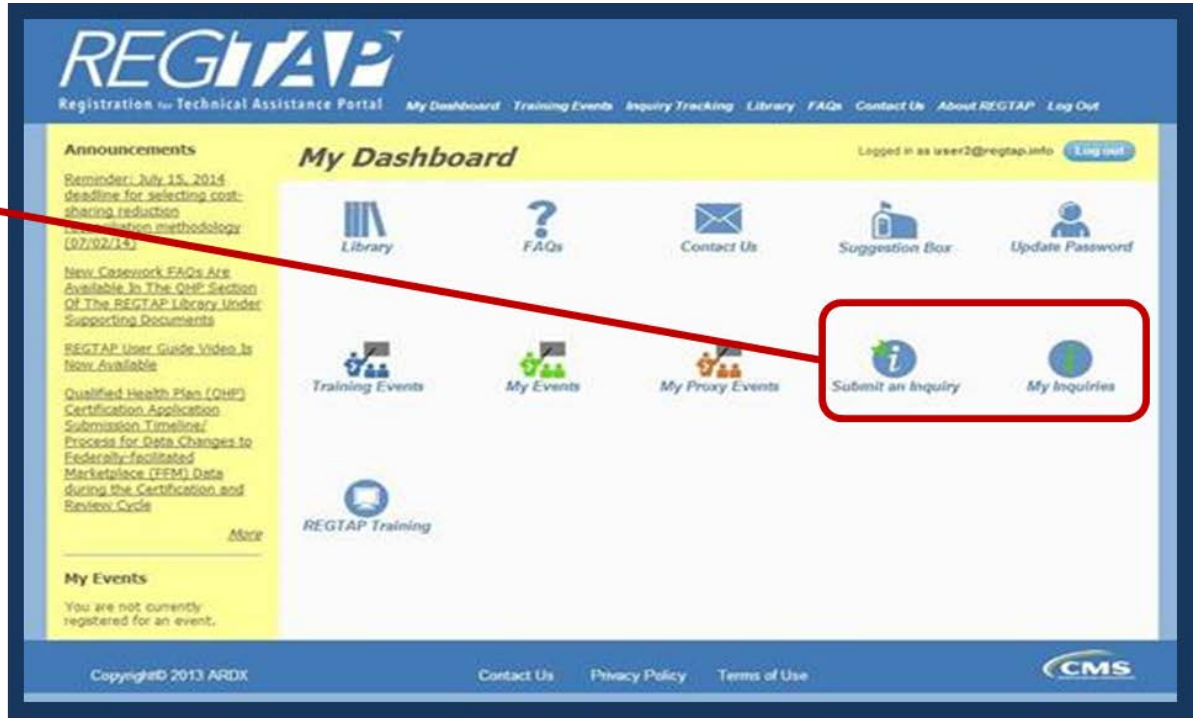
Resources

Resource	Resource Link
U.S. Department of Health & Human Services	http://www.hhs.gov/
Centers for Medicare & Medicaid Services (CMS)	http://www.cms.gov/
The Center for Consumer Information & Insurance Oversight (CCIIO) web page	http://www.cms.gov/cciio
Consumer website on Health Reform	http://www.healthcare.gov/
Registration for Technical Assistance Portal (REGTAP) - presentations, FAQs	https://www.REGTAP.info

Inquiry Tracking and Management System (ITMS)

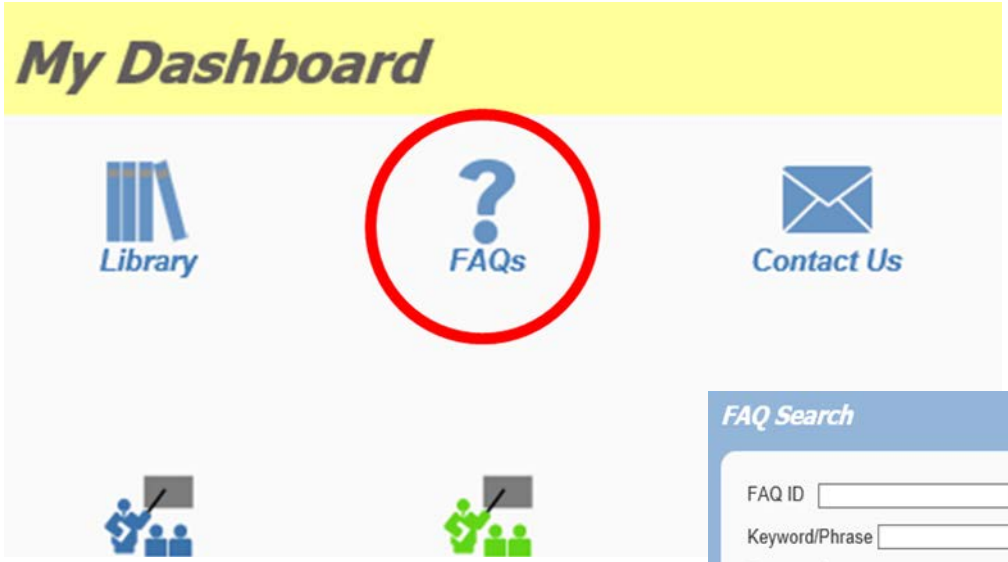
Stakeholders can submit inquiries to https://www.REGTAP.info through ITMS.

Select ‘Submit an Inquiry’ from My Dashboard.



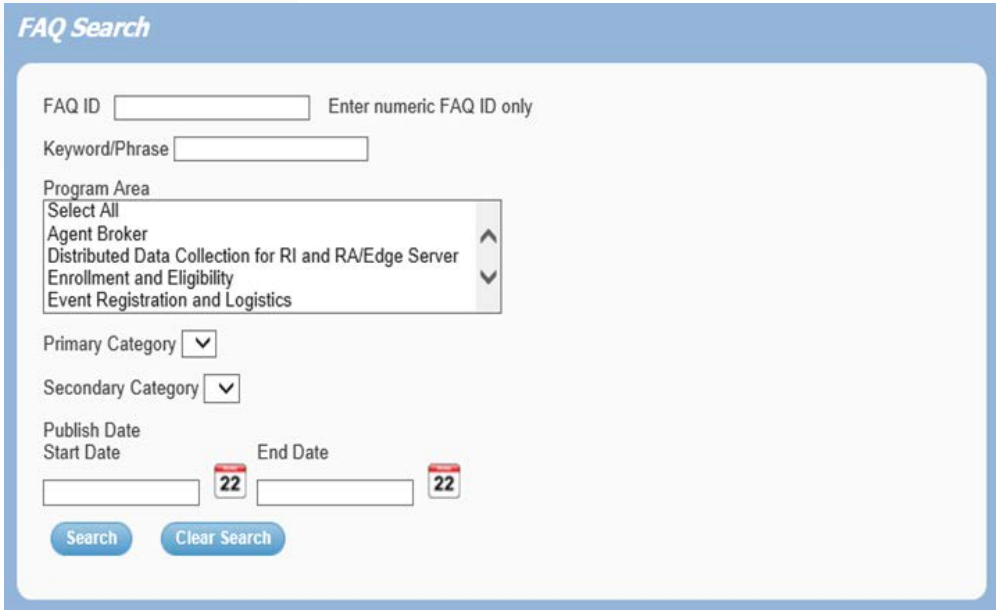
Note: Enter only one (1) question per submission.

FAQ Database on REGTAP



The FAQ Database allows users to search FAQs by FAQ ID, Keyword/Phrase, Program Area, Primary and Secondary categories, and Publish Date.

FAQ Database is available at https://www.regtap.info/



Closing Remarks

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