Cost-sharing Reduction (CSR) Reconciliation Technical Assistance

April 13, 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 continue to 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, in April CMS will conduct weekly question and answer sessions every Monday from 4:00 - 5:00 p.m. ET and Wednesday from 3:00 - 4:00 p.m. ET.
  - CMS has added a TA call on Friday, April 15, 2016 from 2:00 – 3:00 p.m. EDT. The call will focus on file name convention issues, but will provide another opportunity for issuers to ask questions.

CSR Technical Assistance Training Dates

Day of Session	Date of Session	Time	Session Title
Wednesday	April 13, 2016	3:00 – 4:00 p.m. ET	Q&A Session
Friday	April 15, 2016	2:00 – 3:00 p.m. ET	Q&A Session
Monday	April 18, 2016	4:00 – 5:00 p.m. ET	Q&A Session
Wednesday	April 20, 2016	3:00 – 4:00 p.m. ET	Q&A Session
Monday	April 25, 2016	4:00 – 5:00 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.

New Announcements and Reminders (4/13)

New Issues

1. A new issue has been identified that is continuing to cause some issuers to receive invalid QHP ID errors (CSRIFIL67). The issue is also causing invalid Exchange Assigned Subscriber ID errors (CSRIFIL50).
2. As noted on Monday's (4/11) TA call, some files are also being rejected because of error code CSRIFIL58 "03 - Value exceeds the TOTAL ALLOWED COSTS FOR EHB at the plan summary level (02)." If the difference is less than a dollar, the system is inappropriately triggering an error.

- We anticipate the above issues will be corrected this Friday (4/15). Files affected by these errors will be reprocessed on Friday and a new summary/error report will be sent to issuers' EFT within 24 hours.

New Announcements and Reminders (4/13)

Reporting QHP IDs

- For purposes of CSR reconciliation for the 2014 and 2015 benefit years, CMS is referring to QHP IDs for which APTC and CSR payments were provided to issuers.
- If an issuer is reporting a QHP ID that it has received from an SBM, but that is not included in CMS reference data, then the issuer will receive an invalid QHP ID error for that QHP ID.
- However, in this scenario, the issuer's summary/error report should also include a list of missing QHP IDs (Missing QHPs are reflective of the QHP IDs that CMS does have in our reference data but that the issuer didn't include in their file). Issuers should resubmit their file(s) using the QHP IDs from the list of missing QHP IDs in their summary/error report.
- CMS did not provide advance payments to some AI/AN plans in 2014. The system will be updated on Friday capture AI/AN plans with "02" and "03" variants that may be being rejected in 2014 data submissions.

New Announcements and Reminders (4/13)

- Be sure to update your file names to ensure they are unique for every submission/resubmission. If you try to submit a file with the same name as a file you previously submitted, CMS will not recognize and process the file, and a new error report will not be generated.
  - Update Date and Time in the file name to reflect when you are sending the file to CMS. If resubmitting files on the same day, update the Time in the file name accordingly.

Previous Announcements and Reminders (From 4/11 TA call)

CMS has identified the following issues since our last TA call on April 6, 2016:

1. Invalid QHP ID errors – Issuers may have received invalid QHP ID errors for American Indian/Alaska Native (AIAN) variant plans that they included in their CSR reconciliation files.
2. "Total Actual Amount the issuer paid for EHB' cannot exceed the Total Allowance Cost for EHB errors" - Files were rejecting if both amounts were equal.
3. Issuers using the Simplified AV method for 2014 and/or 2015 benefit years were receiving inaccurate methodology errors.

- o We corrected the above issues and reprocessed files that were affected by this error. Issuers that submitted data files and received the above error(s) should have received a new summary/error report in their EFT late last week.
- o Issuers may also resubmit their file(s) to receive an updated summary/error report

Previous Announcements and Reminders

- As noted on the April 4, 2016 TA call, there was an issue identified related to the validation for "Total number of Exchange Subscriber IDs in this plan variation for the benefit year". It was corrected on April 5, 2016. MIDAS reprocessed all files submitted between 4/1-4/5 that were affected by this error.
  - Issuers that submitted a data file between 4/1-4/5 and received an error(s) related to this validation should have received a new summary/error report in their EFT on 4/6.
  - Issuers may also resubmit their file(s) to receive a new summary/error report.
- For the time being while issuers are working through data quality issues and errors, issuers may submit data files without attestation forms.
  - *Attestation forms are still required to be submitted with final data submissions as of 5/2 when the submission window closes*
- Exchange Assigned Subscriber IDs – For FFM plans, issuers need to report Exchange Assigned Subscriber IDs with any leading zeroes that the IDs originally had when generated by the FFM. FFM Exchange Assigned Subscriber IDs should be 10-digits in length.
- If you have questions about specific errors in your summary/error report, please email CSRreconquestions@cms.hhs.gov with your question and include the applicable file name and date of submission for the file associated with the report.

Previous Announcements and Reminders

- Issuers should use the April submission window as an ongoing opportunity to submit data files and attestation files for purposes of troubleshooting issues and errors associated with the files.
- **Issuers should submit all files with a .P filename extension.**
- Issuers should receive a confirmation email and summary/error report within 24 hours of submitting a file. The report will have “CSRO” in the file name. Summary/error report naming convention:
  - CSRO.TPID.Dyymmdd.Tnnnnnnnnn.P
- For pipe delimited data files, do not include any blank lines or spaces in between records in your file. The file will be rejected.

Previous 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.

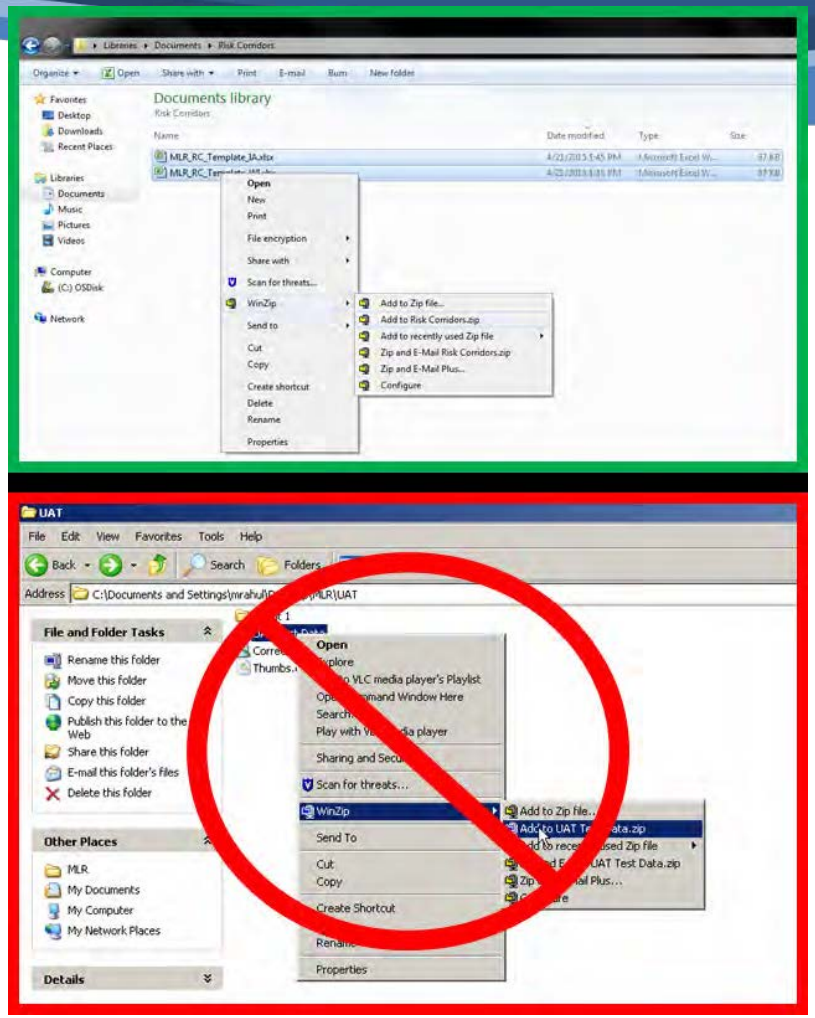
Previous Announcements and Reminders

- 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

Previous 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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FAQs

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New FAQs – Set #5

Q1: When standard plans have separate deductibles for Medical and Rx, but the annual out-of-pocket maximums to medical and RX is combined, how do you develop the separate parameters for Medical and Rx? What subgroups should we use?

A: For plans with separate medical and pharmaceutical deductibles but a combined annual limitation on cost-sharing, issuers should develop separate effective cost-sharing parameters for the medical and pharmaceutical claims. However, the total amount of cost-sharing estimated under the standard plan for any policy must be limited to the combined annual limitation on cost-sharing.

New FAQs

Q2: When using the Simplified AV method, should we pro-rate the annual limitation of cost-sharing for members who are not active for the full plan year? For example, if a member is only active for eight (8) months should we multiply the out of pocket maximum by 8/12ths?

A: Issuers must use the actual annual limitation on cost-sharing for the plan in the equation for the AV methodology, regardless of whether a member is enrolled for less than the full benefit year.

New FAQs (Continued)

Q3: In REGTAP FAQ 15117, CMS said taxes and administrative fees are not CSR eligible. Does that include dispensing fees and sales taxes on prescription drugs? Those amounts are included in the allowed amount for the drugs and often are covered by member co-pay.

A: Additional costs such as dispensing fees and sales taxes for prescription drugs are considered cost-sharing for EHB (and therefore CSR eligible) and part of total allowed costs if they are included in a plan's benefit design for the standard plan and the plan variations.

New FAQs (Continued)

Claims that Cross Benefit Years

Q4: If a member enrolled in a CSR plan for the 2014 benefit year goes into the hospital in December 2014 but is not discharged until January 2015, in which benefit year should the issuer report the claim and CSR paid? Is this a CSR provided in 2014, or in 2015?

A: For a hospital stay that crosses benefit years, the issuer should adjudicate CSRs based on the year for which accumulators for the CSRs applied, regardless of when the claim is presented for payment. For example, if cost-sharing (co-pays, deductibles, coinsurance) for part of the hospital stay was incurred in 2014, that cost-sharing and associated cost-sharing reductions should be adjudicated against 2014 benefit year plan designs, re-adjudicated with other 2014 benefit year claims, and reported as part of CSR reconciliation data for the 2014 benefit year, regardless of whether further related services for the stay were provided in 2015. However, for example, if the enrollee's entire cost for hospital coinsurance related to the stay is not incurred until 2015, such claims and associated cost-sharing reductions should be adjudicated against 2015 benefit year plan designs, re-adjudicated with other 2015 benefit year claims, and reported as part of CSR reconciliation data for the 2015 benefit year. The issuer must apply accumulators consistently for all enrollees in the standard plan and plan variations. (*The EDGE server data submission rules regarding discharge dates for claims that cross benefit years do not apply to the CSR reconciliation data submis*sion.)

New FAQs (Continued)

Q5: What if the subscriber does not renew coverage in the second year of a claim that crosses benefit years?

A: Whether or not coverage is renewed for the second year, cost-sharing reductions should be calculated and reconciled based on the year for which the accumulators for the cost-sharing would apply.

New FAQs (Continued)

Q6: If a member in a CSR plan is admitted to the hospital prior to a grace period, and is discharged after the 30-day grace period date, how should issuers handle these claims?

A: The issuer should pay, adjudicate, and re-adjudicate the portion of claims with cost-sharing incurred during the period the enrollee was covered, regardless of when the claim is presented for payment. CMS will not reimburse issuers for cost-sharing reductions provided during the second and third months of a 90-day grace period after which the enrollee is retroactively terminated. See also REGTAP FAQ 15103.

New FAQs (Continued)

Delayed Presentation of Claims

Q7: If a service was provided in September 2015, but the claim is lost or not presented until June 2016, in which benefit year reconciliation cycle should the issuer report the CSR provided? Is this a CSR provided in 2015, or in 2016?

A: This is a CSR provided in 2015 but which could not be re-adjudicated and reconciled with other 2015 claims on the same policy because the issuer did not get the bill for service until after the data submission deadline. In such a case, the issuer would adjudicate and re-adjudicate all claims on the 2015 policy again, and restate 2015 CSRs for that policy during the 2016 reconciliation cycle (April 2017). CMS intends to provide guidance on the CSR restatement process for previous year claims.

New FAQs (Continued)

Re-adjudication of claims

Q8: For the standard methodology, the natural order of claims was described as temporal order (i.e., when claims are received). Which is it, the date of service or the date that the claim was processed/paid/presented?

A: Claims for services provided in a particular benefit year must be re-adjudicated in the benefit year plan structure in which the cost-sharing was incurred regardless of when they are presented for payment. Therefore, issuers should adjudicate and re-adjudicate claims in the order that best approximates their natural order, e. g, when cost-sharing was incurred for a particular medical service. This may or may not coincide with the actual dates of service, for example, when coinsurance is assessed on a total bill rather than on a per-diem basis.

New FAQs (Continued)

Q9: If claims are pended during the plan year, should those claims be re-adjudicated in the original order they occurred during the plan year, or when resolved?

A: Pended claims should be re-adjudicated in the order that best approximates the initial adjudication of the claims. Thus, if the issuer's practice is to adjudicate a pended claim upon resolution (and not to retroactively adjudicate the pended claim as if it had occurred when originally incurred), the pended cost-sharing reduction reconciliation should similarly be re-adjudicated based on date of resolution.

New FAQs (Continued)

Q10: For the standard methodology, natural order – for claims from different sources, specifically pharmacy and medical claims – is there an order to processing for those received on the same day, or for those received on different days, or can they all be re-adjudicated in the order received regardless of claim type/source?

A: As discussed in November 2014 CMS guidance on re-adjudication of claims for the purpose of cost-sharing reduction reconciliation, all issuers must set all accumulators to zero and, if using a third party administrator (TPA), first re-process all medical claims in their natural order and then all pharmacy claims in their natural order. If not using a TPA, claims for any type of EHB service should be processed in the order received. https://www.regtap.info/uploads/library/APTC_Claims_Readjudication_Guidance_110314_5CR_111714.pdf

New FAQs (Continued)

Q11: Can you provide clarification on whether understating the CSR for a reported claim has any audit implications? We know that not reporting eligible claims doesn't have audit implications, but weren't sure about erring on the side of a conservative calculation.

A: CMS expects issuers to submit accurate data on cost-sharing reductions provided, and all amounts are subject to audit. However, in remedying any inaccuracies in a submission, CMS will consider the financial impact of the inaccuracy.

New FAQs (Continued)

Q12: If claims involving coordinated benefits cannot be properly handled before submission, is it acceptable to filter out COB claims and not include them for CSR reconciliation?

A: Issuers may wait to re-adjudicate complex claims until the complete cost of the benefit has been accounted for; however, in such a case, the issuer must re-state claims for the entire policy, including the complete COB claim, reducing total allowed costs for EHB by the amount paid by another issuer, as applicable, in both the standard plan and the plan variation, to ensure correct re-adjudication of CSR provided for that policy. See also REGTAP FAQ 15101 and 15106.

New FAQs (Continued)

Specification

Q13: I am an FFM issuer who is receiving errors in my summary/error report for having reported invalid Exchange Assigned Subscriber IDs. Why might I be getting this error?

A: For FFM plans, issuers need to report Exchange Assigned Subscriber IDs with any leading zeroes that the IDs originally had when generated by the FFM. Issuers will receive errors in their summary/error report if they report FFM generated Exchange Assigned Subscriber IDs without the leading zeroes.

Questions?

To submit questions by phone:

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

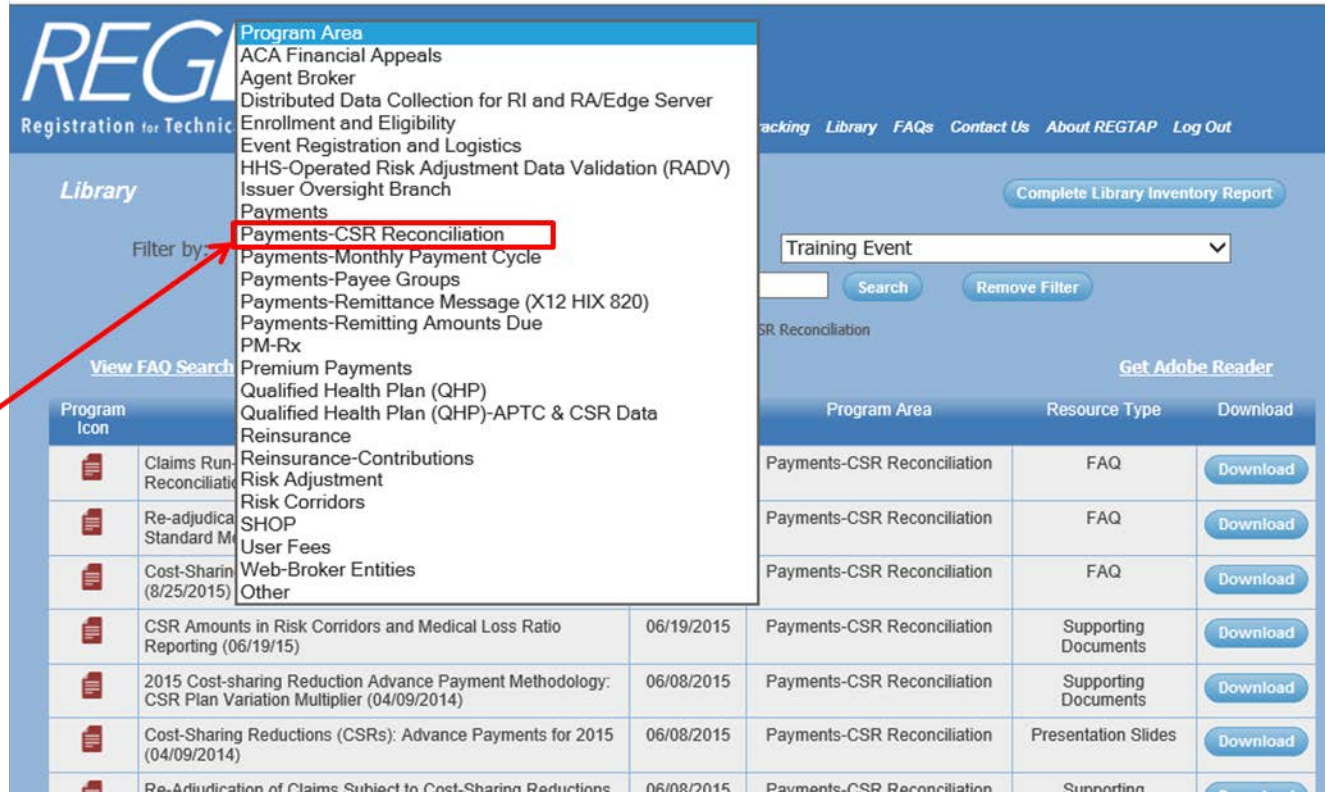
To submit questions by webinar:

- *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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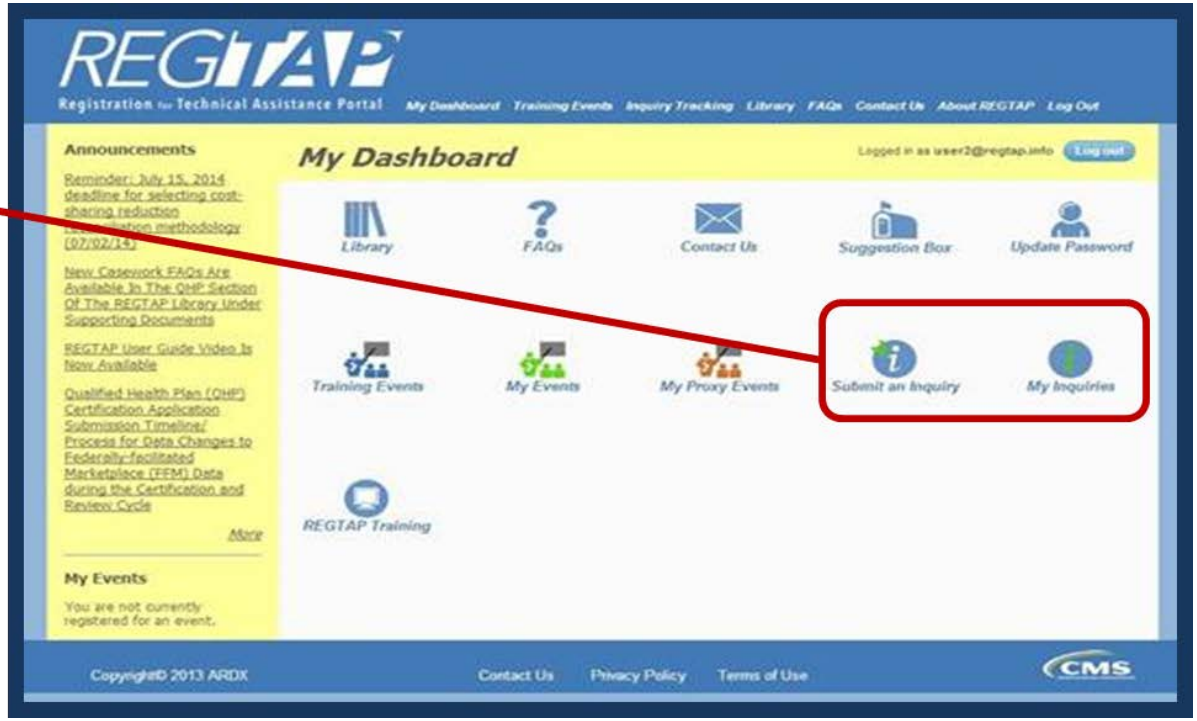
Resources

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)

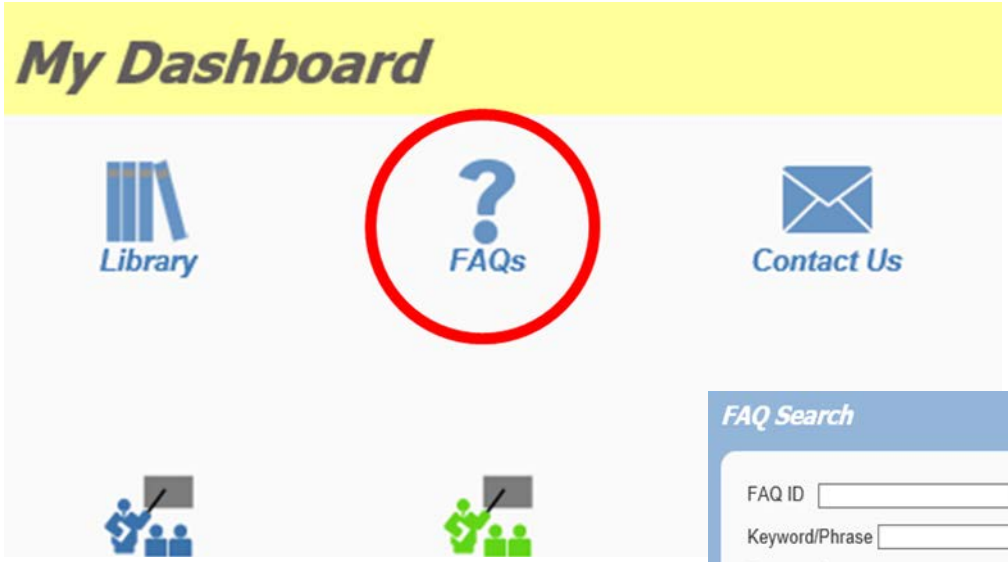
Stakeholders can submit inquiries to https://www.REGTAP.info through ITMS.

Select ‘Submit an Inquiry’ from My Dashboard.

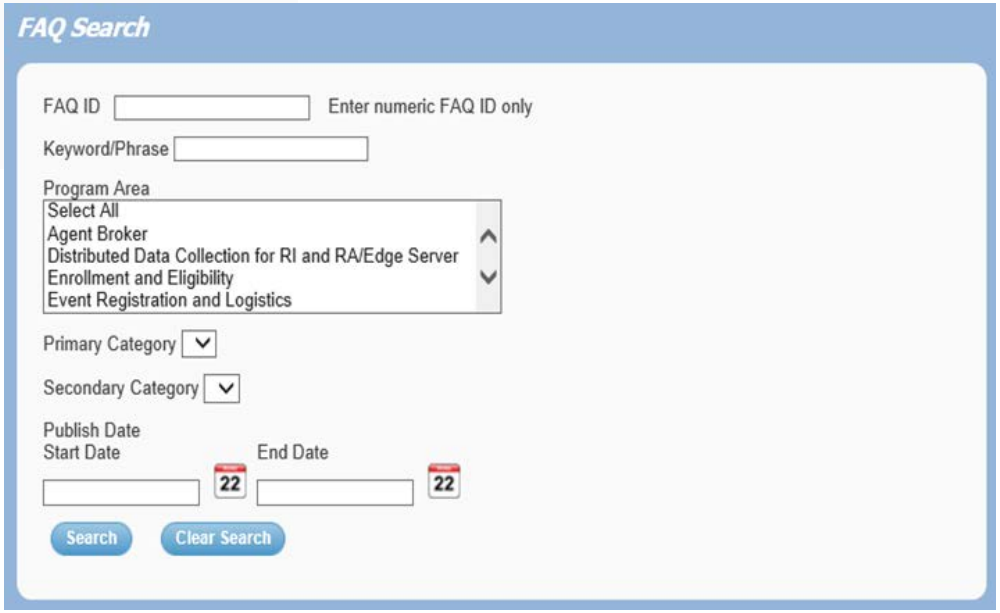


Note: Enter only one (1) question per submission.

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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