FM Payment Processing Series II:

2016 Restatement Information, Vendor Management Updates, Payment Dispute Updates, Payment Dispute FAQs

October 2, 2017

Division of Financial Transfers and Operations (DFTO)

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

WWW.REGTAP.INFO

Agenda

- 2016 Restatement Information
- Vendor Management Update
- Payment Dispute Guidance
- Payment Dispute FAQs

2016 Restatements

2016 Restatements

- 2016 Restatements for SBEs and SBE Issuers will be accepted during the November cycle using the manual workbook process
- The workbooks you receive in October for the November cycle will have editable 2016 tabs for you to populate
- The Final opportunity to restate your 2016 data will be in the Fall of 2018

Vendor Management Update

Vendor Management Update

The fax number for Bank Verification Letters (BVLs) has changed!

- Going forward, should you need to update your banking information, please have your Financial Institution use the NEW fax number, **(443) 380-5196,** to provide the required Bank Verification Letter (BVL)
- Please contact the Centers for Medicare & Medicaid Services (CMS) Vendor Management Team at Vendor_Management@cms.hhs.gov with any questions regarding this change

Payment Dispute Guidance

Payment Dispute Guidance

Presentation Outline:

- New Detail Codes:
  - PD598 & PY598
  - PD619 & PY619
- Detail Code Updates:
  - Additional Clarification: PD591 & PY591
- Process Reminders:
  - Disputes that Require HICS Cases
  - Rollover UIE Deadline

Submitting Payment Disputes

Please submit your Payment Disputes!

- Submit a Payment Dispute for any record perceived to be incorrect
- Issuers may submit large volumes of disputes without impeding processing time

Rejection for Incorrect or Missing Payments

- New Detail Codes: **PD598 & PY598**
- **PD598 & PY598** apply to disputes where the Issuer submitted an FFM Exchange Assigned Policy ID from a prior year, but start and end dates match coverage for the following year
  - **PD598 Issuer Action:** Review the policy that was on the submitted dispute. If the policy you intended to change is a 2017 policy, make corrections on the next RCNI submission. If the policy is from a prior year, resubmit the dispute with the correct FFM Exchange Assigned Policy ID.
  - **PY598 Issuer Action:** Review the dispute and resubmit it with the correct FFM Exchange Assigned Policy ID
- **PD598** results in Disposition Code: *R6 - Dispute Not Supported by RCNI*
- **PY598** results in Disposition Code: *R10 - Dispute Not Supported by RCNI - Prior Year*

Disputes after the End Date for the CMS/Issuer Contract

- New Detail Codes: **PD619 & PY619**
- **PD619 & PY619** apply to missing or incorrect Payment Disputes where the coverage period in question is after the Issuer's contract end date with CMS
  - **Issuer Action:** If there are any questions about the contract or other assistance required, contact the FMCC help desk at FMCC@cms.hhs.gov
- **PD619** results in Disposition Code: *R6 - Dispute Not Supported by RCNI*
- **PY619** results in Disposition Code: *R10 - Dispute Not Supported by RCNI - Prior Year*

Additional Clarification: PD591 & PY591

- **PD591 & PY591** apply to unexpected Payment Disputes where the Issuer submitted dates are invalid
  - As initially described, disputes will receive these disposition codes if the Benefit End Date is before the Benefit Start Date
  - A dispute may also receive these codes if the Benefit End date Field Flag is set to 'C' and the FFM and Issuer Benefit Start/End dates are different
- **Avoiding PD591 & PY591:** When an issuer believes there is only one span of coverage, they should only submit one coverage span and correctly cancel all others. If an issuer needs to submit two coverage spans, take care to correctly align the start and end dates.
- **PD591** results in Disposition Code: *R6 - Dispute Not Supported by RCNI*
- **PY591** results in Disposition Code: *R10 - Dispute Not Supported by RCNI - Prior Year*

Disputes that Require a HICS Case

Certain dispute types require an associated HICS case, these include:

- Applied APTC Amount
- Total Premium Amount (except in certain cases; see the next slide)

If a HICS case is not provided, the dispute is rejected by the automated system. Once the system determines the HICS case provided is a valid HICS case, APTC, QHP ID/Variant ID, and Total Premium disputes are manually reviewed.

With the addition of the HICS Direct Dispute process, Issuers may now submit these and some other case types directly to ER&R through HICS, completely bypassing the need to submit an Enrollment or Payment dispute.

For more information, see the *HICS Direct Dispute Master Guidance* on zONE:

- https://zone.cms.gov/document/enrollment-resolution-and-reconciliation

Total Premium Exceptions for Requiring HICS Cases

Total Premium Disputes do NOT require a HICS case if one of these conditions is met:

- The update is required for a Stand Alone Dental Plan
- The Benefit Start Date was updated
- The Tobacco Status changed on an adult within acceptable ranges
- A non-subscriber on a previous policy became the subscriber on a new policy linked by CIC
- If the enrollment group is in the same QHP, but there was a gap in coverage or a cancelled record prior to the new initial/effectuated coverage span and no change to the FFM Total Premium Amount between the prior record and the new record
- If the enrollment group is in the same QHP, and all of the following applies:
  - There was a new enrollment without a gap in coverage and no change to the enrollment group size
  - The FFM Total Premium Amount is higher in the new initial/effectuated coverage span than the prior record
  - The Issuer's value is less than the new premium amount

Handling of Rollover UIEs after 09/30/2017

- Rollover UIEs are assigned the Prior Year category in the UIR reports
  - This category is assigned to UIE records for members that had coverage with the same HIOS in 2016 but do not have a 2017 enrollment
  - Rollover UIEs are eligible for an Enrollment Error Technical SEP that will allow the member to complete a 2017 enrollment
- Rollover UIEs will not be eligible for payment after 09/30/2017 unless the consumer completes a 2017 enrollment
- If a 2017 enrollment is completed after 9/30, a payment correction will be made after the policy is corrected on the subsequent RCNI File
- The previously published *Manual Payment Process for 2017 Unaffiliated Issuer Enrollments* is included as an appendix in the UIR Master Guidance

https://zone.cms.gov/system/files/documents/uir_2017_master_guidance_v1.4.pptx

Payment Dispute FAQs

Payment Dispute FAQs

Q: What happens if Issuers receive new detail codes that are not listed in the published version of the Payment Dispute Disposition and Detail Code List? When will the latest disposition list be published?

A: Issuers will receive an email notification from FMCC with the publication date of new Payment Dispute Disposition and Detail Code List once posted on REGTAP and zONE. The email will include an attachment of the newest version of the document.

If Issuers do receive a detail code not in the current published disposition/detail code list, they can contact FMCC to obtain information about the new code in the interim.

Payment Dispute FAQs

Q: If Issuers receive a response file and notice several disputes received rejected error codes, does this mean that all records on the payment dispute file were rejected and a new file should be submitted for all records?

A: All records in the file do not need to be resubmitted. Only records that were rejected with an "R1 - R3" or "R6 – R11" disposition would need to be reviewed and/or corrected. "R4 - R5" indicate duplicates and not rejections that need to be corrected. Prior year disputes with an R10 or R11 disposition should be resubmitted as an Enrollment Dispute. Records flagged with a "Cx" are complete and do not require further action and records flagged with an "Ix" are currently in process and an updated disposition code will be reflected for these records in your semi-monthly reports. Please reference the Payment Dispute Disposition and Detail Code List for more information and full instructions.

Payment Dispute FAQs

Q: How long does it take to receive a response file from ER&R?

A: Issuers should expect a response file from ER&R within 48 hours of submitting a payment dispute file.

Q: How do Issuers know which RCNI/RCNO files their payment disputes are being processed against?

A: Payment Disputes are always compared against the latest RCNI/RCNO files processed at the time of issuer submission of a payment dispute. For example, payment disputes submitted mid-month will be processed against the RCNI/RCNO submitted in the prior month.

Payment Dispute FAQs

Q: Will submitting a payment dispute result in a corrected payment?

A: A payment dispute will supply a disposition and detail code indicating whether a payment discrepancy has already or will be resolved, requires further investigation by ER&R or requires the issuer to take additional action via an RCNI or Enrollment dispute to correct an enrollment data error. In certain cases, a payment dispute may result in an enrollment update and corrected payment.

Questions?

To submit or withdraw questions by phone:

- Dial ***#** (star-pound) on your phone's keypad to ask a question
- Dial ***#** (star-pound) on your phone's keypad to withdraw your question

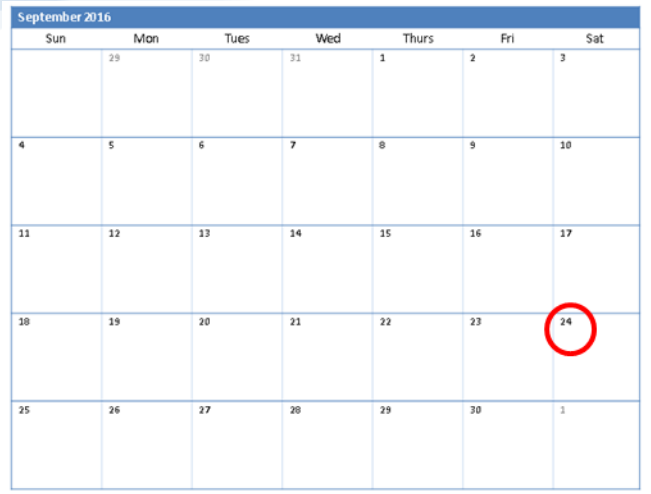
To submit questions by webinar:

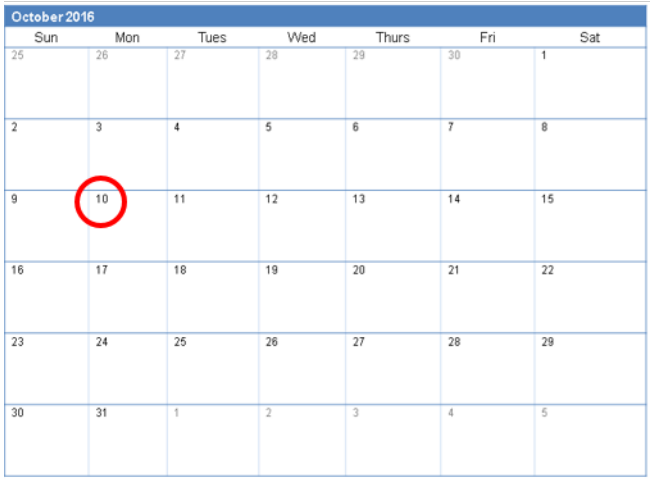
- Type your question in the text box under the 'Q&A' tab

APPENDIX

Vendor Management and Payment Activity Key Dates

Vendor Management Reminders





- Payee group information is used to direct program payments to your organization and provides the designated contact information in the event that CMS has a need to contact you. Maintaining your corporate billing address ensures that invoices will be delivered timely avoiding the accrual of interest and late fees.
- The Financial Management (FM) module is open from the 11th through the 24th of each month and closes on the 25th of each month through the 10th of the following month during the payment processing execution. All updates made to your payee group require internal approval from your organization prior to CMS having access to review and approve your record. To ensure that updates to your records are accepted and applied in the system, the updates need your approval two (2) business days prior to the 25th of the month.

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Vendor Management Reminders
(continued)

Records that are not approved or remain in an incomplete status, at the time of module closing, jeopardize ACA program payments for that cycle

- If your edits include changes to your banking information, your financial institution is required to fax a Bank Verification Letter (BVL) directly to CMS at 443-380-5196 to allow CMS to approve these updates. In the interim, payments will be processed using the most recent **approved** banking information
- You can reach the CMS Vendor Management Team at Vendor_Management@cms.hhs.gov

Payment Activity Key Dates

Key Payment Activities	October	November	December
SBE Issuer Workbooks Submission Window	September 18th-22nd	October 16th-20th	November 16th-21st
Vendor Management Module Open	September 25th-October 10th	October 25th-November 10th	November 25th-December 10th
Initial Invoice sent to Issuers	October 11th-13th	November 9th-14th	December 11th-13th
Preliminary Payment and Payee Information Reports sent to Issuers	October 11th-13th	November 13th-15th	December 13th-15th
Treasury issues payments to Issuers	October 20th	November 21st	December 20th
HIX 820 Payment transactions sent to Issuers	October 31st	November 30th	December 29th

Resources

- Inbound 834 Process (CMS zOne Dedicated Page):
  - Production Overview, Technical Specifications, Reporting
  - For further assistance, please contact: Inbound834@bah.com
- Enrollment Reconciliation:
  - Educational Materials, Technical Specifications
    - https://zone.cms.gov/document/2016-enrollment-data-reconciliation
  - For further assistance, please contact: recon_issuer_support@bah.com
- Dispute submission:
  - Resources
    - Enrollment dispute form: https://zone.cms.gov/document/enrollment-resolution-and-reconciliation-dispute-form
    - Payment dispute form: https://zone.cms.gov/document/enrollment-resolution-and-reconciliation-dispute-form
    - Payment dispute Technical Reference Guide: https://zone.cms.gov/document/ppr-820-disputes-page
  - For further assistance, please contact the ER&R Support Center at errsupportcenter@cognosante.com or (855) 591-7113

Points of Contact

- CMS directs Issuers to contact the Federal Enrollment and Payment System (FEPS) Helpdesk with technical questions or issues. Issuers can contact the FEPS Helpdesk at the CMS_FEPS@cms.hhs.gov email address.
- CMS directs Issuers to contact the Exchange Payments Team with questions related to the Manual Payment Process. Issuers can contact Exchange Payments at the Exchangepayments@cms.hhs.gov email address.
- CMS directs Issuers to contact the Financial Management Coordination Center (FMCC) with questions regarding the PBP process. Issuers can contact the FMCC at the FMCC@cms.hhs.gov email address.
- CMS directs Issuers to contact the Enrollment Reconciliation and Resolution (ER&R) contractor with questions regarding the discrepancy reporting process, as well with dispute form submissions. Issuers can contact the ER&R contractor at the errsupportcenter@cognosante.com email address.

RA on Invoices, PPRs and HIX 820s

- Issuers with multiple RA payments or charges can distinguish between them by referring to the Invoice Number using the convention below.
- RA Invoice Number Example: I14VA160112345001
  - Digit 1: Program and Market Designator (I)
  - Digits 2-3: Program Year (14)
  - Digits 4-5: State Code (VA)
  - Digits 6-9: Year and Month (1601)
  - Digits 10-14: Issuer ID (12345)
  - Digits 15-17: Transaction Sequential Counter (001)

RA on Invoices, PPRs and HIX 820s
(continued)

- Program and Market Designator (Digit 1) Key:
  - Risk Adjustment Individual – I
  - Risk Adjustment Small Group – L
  - Risk Adjustment Catastrophic – T
  - Risk Adjustment Merged – M
  - Risk Adjustment Default Charge Individual – N
  - Risk Adjustment Default Charge Small Group – O
  - Risk Adjustment Default Charge Catastrophic – H
  - Risk Adjustment Default Charge Merged - B

Additional Information

- Additional information related to the PBP transition is available in the Registration for Technical Assistance Portal (REGTAP) Library at the following links:
  - PBP Temporary Adjustment Reconciliation Methodology
  - May 2, 2016 Payment Bulletin
  - PBP May Payment Back-out Example Workbook

Documents Available on REGTAP

- The ***Managed File Transfers (MFT) Thin Client Help Guide*** and ***Manual Payment and Enrollment Data Workbook User Guide*** are currently available in the REGTAP Library at the following links:
  - https://www.regtap.info/uploads/library/FT_MFTHelpGuide_081016_v1_5CR_081016.pdf
  - https://www.regtap.info/uploads/library/FT_AutoTemplateUserGuide_5CR_081016.pdf

Acronyms

Acronym	Definition
DSH	Data Services Hub
EDI	Electronic Data Interchange
EPS	Enrollment and Payment System
FFE	Federally-facilitated Exchange
FMCC	Financial Management Coordination Center
HIOS	Health Insurance Oversight System
HIX	Health Insurance Exchange
PBP	Policy-based Payments
PPR	Preliminary Payment Report
PSV	Pipe-separated value
SBE	State-based Exchange
SHOP	Small Business Health Options Program

Resources

Financial Management Coordination Center

- The Financial Management Coordination Center (FMCC) help desk at fmcc@cms.hhs.gov assists Issuers with:
  - Questions or concerns regarding the Payment Dispute process.
  - Technical assistance.
  - File submission.

Contacting FMCC



When contacting the FMCC, Issuers should include their five (5)-digit Health Insurance Oversight System (HIOS) ID and their seven (7)-character Payee ID, along with their request.

Technical Reference Guide

- The Payment Dispute Technical Reference Guide (TRG) provides guidelines for Issuers regarding how to submit Payment Disputes.

- Issuers can access the TRG at the following links:
  - https://www.regtap.info/uploads/library/FT_TRG_v1_5CR_101416.pdf
  - https://zone.cms.gov/document/ppr-820-disputes-page

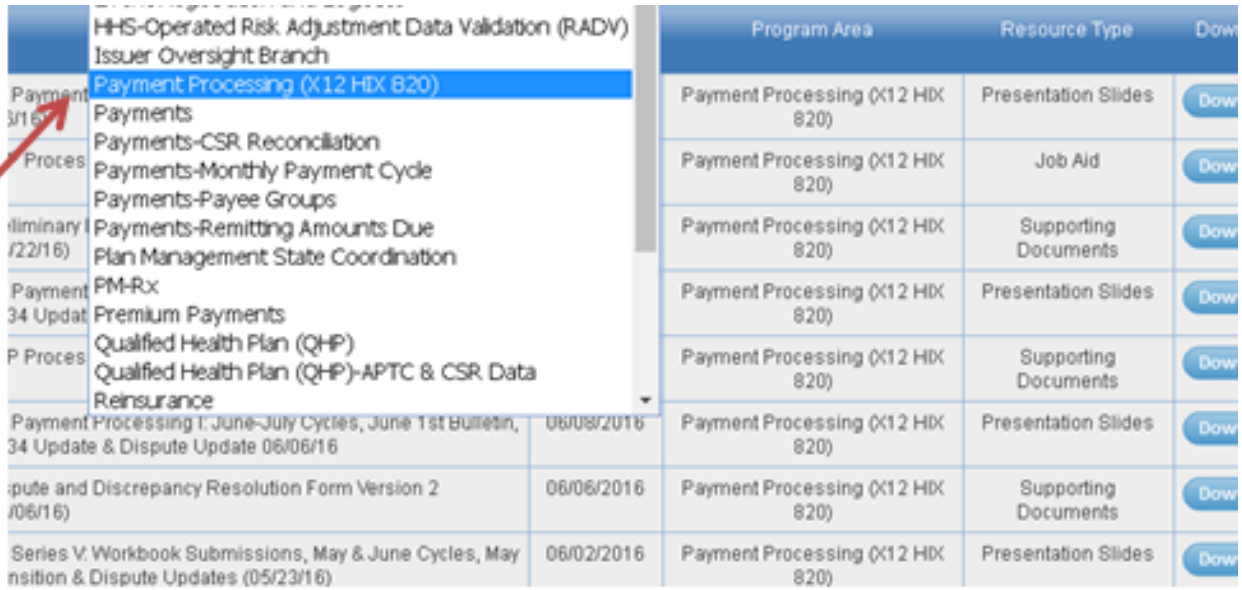
Resources

Resource	Resource Link
Centers for Medicare & Medicaid Services (CMS)	http://www.cms.gov/
U.S. Department of Health & Human Services (HHS)	http://www.hhs.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/
ASC X12 Store	http://store.x12.org/store/health-insurance-exchanges
Registration for Technical Assistance Portal (REGTAP) - presentations, FAQs	https://www.REGTAP.info

Document Location

Additional Materials for FM Payment Processing I are available in the REGTAP Library at https://www.REGTAP.info

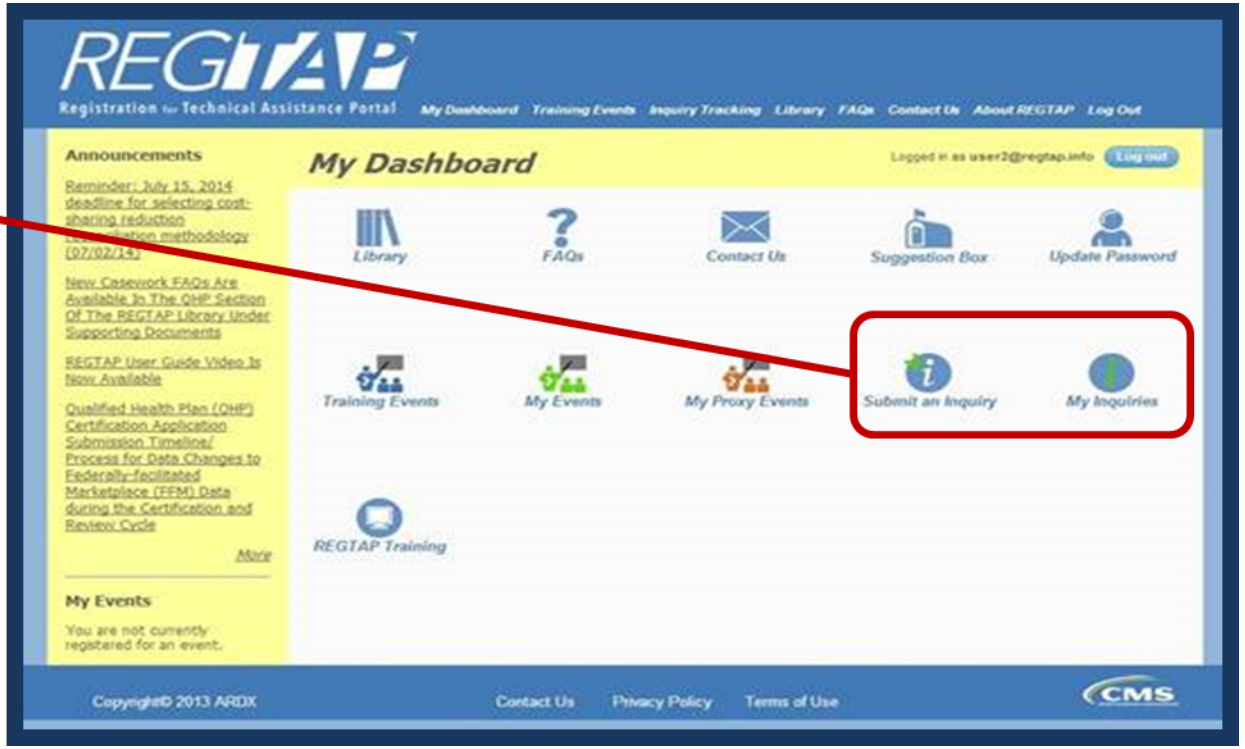
Under Program Area, select "Payment Processing (X12 HIX 820)"



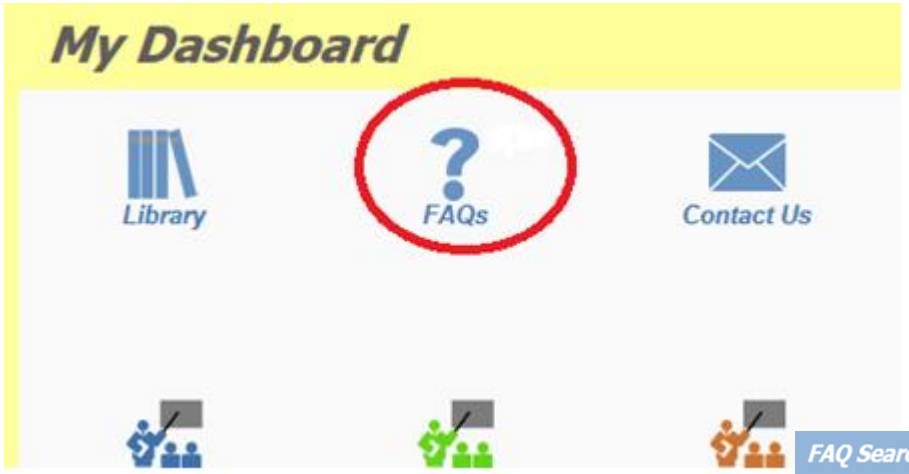
Inquiry Tracking and Management System (ITMS)

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

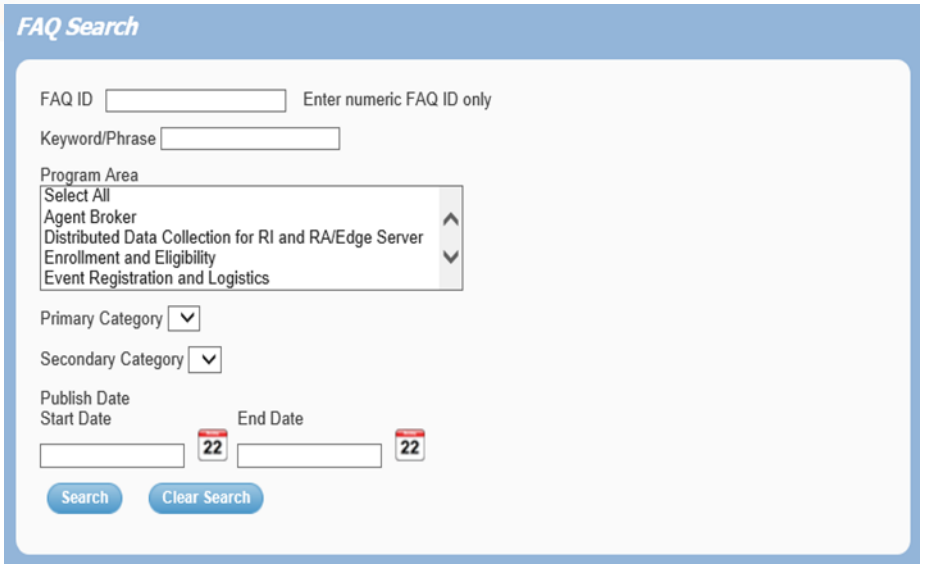
Select “Submit an Inquiry” from My Dashboard.



FAQ Database on REGTAP



The FAQ Database allows users to search FAQs by FAQ ID, Keyword/Phrase, Program Area, Primary and Secondary Categories, Benefit Year, Retired and Current FAQs and Publish Date.



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

Closing Remarks