

Enrollment Reconciliation Education Suite

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Revision History

Date	Version	Changes	Author
1/9/2020	5.11	Corrected publication date and revision history for v5.1	J. Hase
1/6/2020	5.1	- Updated content to reflect sunseting of mass effectuation process in enrollment reconciliation - Updated reconciliation business rules - New content regarding FFM enrollment data, as shared in Recon 101 for PY2020 - Other general updates to ensure consistency	J. Hase M. Gleason
6/27/2019	5.0	- General updates throughout document for formatting and consistency - Added information regarding Overlaps Indicator, DOB Cleanup Indicator, New Policy ID Indicator for the Pre-Audit File - Added information regarding Footnotes on the RCNO File - Added section on FFM Policies and Policy Segments - Added section on Cancellation and Termination Reason Codes	J. Hase
3/4/2019	4.5	- Added valid values to Field 89 Overlaps Indicator in the Pre-Audit file - Added Date of Birth Indicator field 101 instructions on use of Pre-Audit Files	M. Gleason
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Date	Version	Changes	Author
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8/8/2017	4.1	• Updated business rules to reflect changes effective August 2017 • Revised section on Paid Through Date to indicate that data element will not be reported to IRS for the foreseeable future • Replaced content in <i>Issuer Use of Pre-Audit and Supplemental Files</i> section with a reference to the same information in the Standard Enrollment Data Files document • Various minor edits to ensure consistent terminology	J. Hase
5/22/2017	4.0	• Changed name of the <i>Orphan Finder Files</i> to <i>Missing Outbound 834 Finder Files</i> • Added Appendix H with details of September 2017 changes to the Pre-Audit File • Updated Appendix A with links to Version 4.0 of the Inbound and Outbound Recon File specs effective September 2017	D. Mitchell M. Gleason
4/10/2017	3.2	• Aligned descriptions of <i>E</i> and <i>P</i> record-level flags to descriptions in RCNO file specifications • Modified description of <i>F</i>, <i>G</i>, <i>I</i>, and <i>R</i> record-level flags • Clarified business rules for Initial Premium Paid Indicator • Added scenario for removal of dependent as never effective via M834	M. Gleason
3/15/2017	3.1	• Updated links to Enrollment Reconciliation area in zONE	M. Gleason

Date	Version	Changes	Author
3/7/2017	3.0	- Added the following sections: - Paid Through Date Common Issues and General Guidelines - Tips for Successful Enrollment Reconciliation - Reinstatement of Cancelled Enrollments - End of Year Termination Indicator - Changes and Viewing Enrollment Data by Coverage /Financial Span - Reporting Newborn Free Coverage Period - HICS Case to Change Termination Date for Member Leaving Policy - Moved the Change in Circumstance (CiC) Scenarios section to Appendix G - Changed the Issuer Use of Pre-Audit File section to Issuer Use of Pre-Audit and Supplemental Files - Added reference to the Standard Issuer Enrollment Data Files document and communication process - Added descriptions of record level findings from Recon 103 - Updated Appendix A: Reference Materials on zONE	M. Gleason
12/1/2016	2.1	- Expanded instructions for Issuer Use of Pre-Audit File - Deleted Table of Key RCNI Data Elements as duplicate information - Updated Record Level Flags table to reflect latest logic - Updated Field Level Flags tables to reflect latest logic - Updated links to Reference Materials in Appendix A	R. Tabak A. Carter M. Gleason
9/15/2016	2.0	- Updated field level business rules - Added business rules for new fields in RCNO files Removed references to Pre-Audit Data Issues Template - Moved CiC Scenarios to Appendix F - Added CiC Examples pre-M834 and post M834 - Updated RCNO record and field level flag descriptions to match RCNO file specs Updated Acronyms list - Added M834 clarifications in the Change In Circumstance (CiC) section - Modified descriptions of E and P record-level flags	M. Gleason
3/9/2016	1.1	Initial published version	T. alSalaam

Contents

Introduction	1
Reconciliation Basics	1
Pre-Audit Extract and File	4
Pre-Audit File Naming Convention.....	4
Pre-Audit File Specifications	5
Policies and Policy Segments on the Pre-Audit File	5
Issuer Use of Pre-Audit Files	6
Overlaps Indicator – Field 89	6
New Policy ID Indicator – Field 100	7
Date of Birth Cleanup Indicator – Field 101.....	8
Missing Outbound 834 Indicator – Field 102.....	10
Outbound 834 Retransmission Indicator – Field 103	10
Outbound 834 Transaction History – Field 104	11
Examples of Pre-Audit File Fields.....	12
Enrollment Reconciliation Process Overview	15
Enrollment Reconciliation Process Diagram	15
RCNI File Format	15
RCNI Filename Validation Checkpoint (1)	15
RCNI File Naming Convention	15
RCNI File-Level Validation Checkpoint (2).....	16
Common Causes of File-Level Validation Failure	16
Enrollment Reconciliation Technical Contacts.....	17
Statistical Analysis Checkpoint (3)	17
Enrollment Reconciliation Data & Key Concepts	18
RCNI Data Entities and Attributes.....	18
FFM Enrollment Data Structure	19
Change to QHP ID.....	20
Change to Financials	20
Change to Enrollment Group Composition.....	20
Change to Demographics	21

Change to Exchange-Assigned Policy ID	21
Alignment of Records between Issuer and FFM Data	22
Removal of Dependent as Never Effective via M834	22
Change to Financial Eligibility, No Change to Financials	22
Historical and Non-Historical Data Rules	23
Initial Premium Paid Status Rules	24
Cancellation Rules	24
Cancellation and Termination Reason Codes	25
Reinstatement of Cancelled Enrollments	27
Reinstatement of Terminated Enrollments	27
Agent/Broker Information	27
Issuer-Assigned IDs Guidelines	28
Paid Through Date Requirements	29
End of Year Termination Indicator	29
Reporting Newborn Free Coverage Period	29
HICS Case to Move Termination Date for Member Leaving Policy	30
Enrollment Reconciliation Logic	31
Record Matching Logic	31
Record Level Flags	32
Field-Level Comparison and Flags	34
Sample field-level comparison results	34
Field-Level Resolution Rules	35
SSA Matching Rules for Names	43
Footnotes	43
#GAP	43
#OVERLAP	43
#SPANSHORT	44
#NLE	44
Tips for Successful Enrollment Reconciliation	45
Statistical Analysis	46
Common Field-Level Matching Issues	46
FFM Updates Based on Results of Statistical Analysis	47

Communication of Results of Statistical Validation	47
RCNO Files	49
File Naming Convention	49
File Format	49
File Structure and Row Attributes	50
ER&R (Enrollment Resolution and Reconciliation) Contractor	50
Enrollment Dispute Process	51
FFM Updates via ER&R Dispute Process	51
ER&R Contacts	51
Appendices	53
A. Reference Materials on CMS zONE	53
B. Checklist for Successful Reconciliation Data Submission	54
C. Overall Best Practices	54
D. Key Terms and Acronyms	55
E. Handling Personally Identifiable Information (PII)	56

Introduction

The intent of this document is to provide Issuers with an overview of the Enrollment Reconciliation processes on the Federally-Facilitated Marketplace (FFM), a description of their roles and responsibilities, and resources for successful completion of Enrollment Reconciliation with CMS on a monthly basis.

The information contained in this document pertains to the Enrollment Reconciliation process for the FFM Individual Market only. SHOP and State Based Marketplace (SBM) Enrollment Reconciliation processes are separate and distinct from the FFM Individual Market process and are not addressed in this document.

This document is organized to follow the Enrollment Reconciliation process. Hyperlinks in the table of contents can be used to jump to a section of interest. In addition, hyperlinks within the document link to materials in other sections of the document and in the appendices.

Information in this document is current as of the latest revision date. Please note: changes to Enrollment Reconciliation processes made after this date are not reflected in this document.

Reconciliation Basics

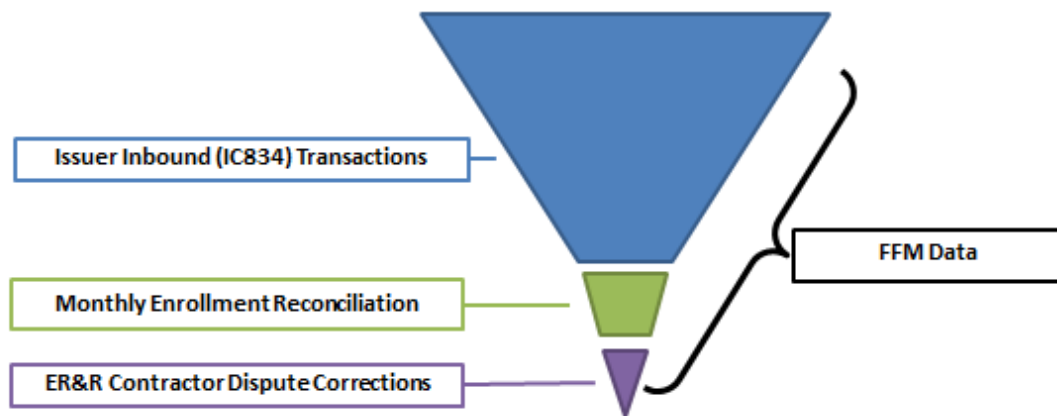
It is critical that Issuers maintain and persist certain key data elements in their systems associated with enrollments received from the FFM; likewise, the FFM will persist identifiers supplied by the Issuer.

Key data elements include:

- **Exchange-Assigned Member ID:** Constitutes a unique identifier for a specific individual when used in conjunction with the HIOS ID associated with the enrollment
- **Exchange-Assigned Subscriber ID:** The Exchange-Assigned Member ID of the subscriber of the individual's enrollment group
- **Exchange-Assigned Policy Number:** Unique identifier for the enrollment group's policy
- **Issuer-Assigned Member ID:** Identifier for the individual as provided by the Issuer
- **Issuer-Assigned Subscriber ID:** Identifier for the subscriber of the enrollment group as provided by the Issuer
- **Issuer-Assigned Policy Number:** Identifier for the enrollment group's policy as provided by the Issuer
 - **Please Note:** This value should be unique to the enrollment group, and not a higher-level identifier such as a Group Number

Enrollment data alignment between CMS and Issuers is maintained by IC834 Transactions, Enrollment Reconciliation, and the Dispute Resolution process.

The diagram below represents the volume of policy updates performed by each component of enrollment in the Federally-Facilitated Marketplace (FFM).



- Inbound IC834 transactions are used to make basic updates to the status of an enrollment such as effectuation, cancellation or termination. IC834 transactions should also be used to update Issuer assigned IDs (Subscriber, Member, Policy) if a change is required after the policy has been effectuated. Issuers are able to reinstate policies through the IC834 process under certain circumstances. These transactions must pass stringent data quality checks and do not allow Issuers the flexibility to change certain data elements, such as the Benefit Start Date. Additional information about Inbound 834 transactions is available on zONE at <https://zone.cms.gov/document/inbound-834>.
- Monthly Enrollment Reconciliation is an analytical process with greater flexibility in updating policies. Approved policy updates are then run against FFM via the Batch Update Utility (BUU). Issuers may also be required to update their enrollment data based upon the results of reconciliation.
- Enrollment Resolution & Reconciliation (ER&R) Contractor Dispute Corrections may involve manual inspection of a policy and direct contact with Issuers, and should represent the smallest contingent of enrollment updates applied to the FFM. Prior year disputes typically also require CMS Account Manager approval. Additional information about the ER&R Contractor and the dispute process is available on zONE at <https://zone.cms.gov/document/enrollment-resolution-and-reconciliation>.

Monthly participation in Enrollment Reconciliation is essential for data alignment and to maintain proper policy-based payments. **All FFM Individual Market Issuers are required to submit Enrollment Reconciliation Files for each monthly reconciliation cycle.**

Even if Issuers are diligent and proficient in submitting IC834 transactions to update enrollment status, Enrollment Reconciliation is critical to ensure all appropriate updates have been applied to

the FFM and highlight any updates that may be required on the Issuer's side. This alignment of enrollment data ensures that Issuers and consumers have accurate enrollment information and that proper subsidies and payments can be applied to each policy.

During each monthly reconciliation cycle, Issuers will submit an Inbound Enrollment Reconciliation (RCNI) File for each Trading Partner ID. CMS will perform an initial validation on the Issuer file and then match Issuer enrollment records to FFM records based on certain identifying information. Results of record matching and field-by-field comparison are sent to Issuers via the Outbound Enrollment Reconciliation (RCNO) File. The FFM is updated accordingly based on the results of reconciliation as documented in the RCNO File. Any remaining discrepancies not resolved via reconciliation must be handled by the Enrollment Reconciliation & Resolution (ER&R) contractor.

CMS provides several files to Issuers monthly as part of the Enrollment Pre-Audit and Reconciliation processes. A list of the files including background information and instructions for Issuer handling of the files is included in the Standard Issuer Enrollment Data Files document available on zONE. CMS also publishes a Pre-Audit and Reconciliation Calendar on zONE which includes due dates for Issuer-submitted files and target delivery dates for CMS-provided files.

All filenames for these files include standard EFT (Electronic File Transfer) function codes which reflect the plan year and function or use of the data in the files. The Pre-Audit and Reconciliation Calendar includes a list of the EFT function codes for any files related to Enrollment Reconciliation.

See [Appendix A](#) for links to the Standard Issuer Enrollment Data Files document and Pre-Audit and Reconciliation Calendar.

Files will be delivered to Issuers during a standard delivery window and should typically be available no later than 6PM Eastern on the scheduled date. A reminder will be added to CMS Issuer Communications morning e-mail blast on the scheduled delivery date. If file delivery is delayed for any reason, an e-mail will be sent by CMS Issuer Communications and will provide an updated delivery estimate. To add yourself to the distribution list for the morning emails, send an email to CMS_Issuer_Communications@cms.hhs.gov with the subject line: "Add POC to Distribution List."

Pre-Audit Extract and File

The monthly Enrollment Reconciliation process begins with the FFM Pre-Audit extract.

- A Pre-Audit extract is taken from the FFM and used to create Enrollment Pre-Audit Files that convey all enrollments in the FFM (including cancellations and terminations) ascribed to a particular Issuer for a single plan year.
 - This extract is done in alignment with the extract supporting the payment process and occurs on the 15th of each month at 6PM ET.
- Each Pre-Audit File is distinctly defined by Plan Year. For example, 2020 Pre-Audit Files will only contain data pertaining to enrollments effective 1/1/2020 – 12/31/2020.
- As part of each iteration of the Enrollment Pre-Audit, CMS will:
 - Extract all policy records from the FFM policy folder
 - Confirm correct file format and contents
 - Aggregate extracted enrollment data by Trading Partner ID
 - Distribute files to Issuers via EFT
- Pre-Audit Files will be delivered to Issuers in the same location as daily EDI 834 traffic
 - Enrollment Pre-Audit Files will be identified by the function code AUDYY or AUDY in the filename, where Y is the 1 or 2-digit year (e.g. [TPID].**AUDY**.D200117.T010000000.P.OUT or [TPID].**AUDYY**.D200117.T010000000.P.OUT)
 - Plan years prior to 2018 use a 2-digit year in the function code (i.e. AUD17 for 2017); plan years 2018 and later use a single digit year identifier in the function code (i.e. AUD8 for 2018)
- Enrollment Pre-Audit Files are **not** in the EDI 834 format; they are pipe-delimited files which Issuers will need to ingest and process or convert into a readable format (such as Excel).
- Enrollment Pre-Audit Files do **not** stop, interrupt, or replace the ongoing process of Issuers receiving 834 transactions at 6PM ET daily.
- In some cases, Issuers will **not** receive regenerated 834s for enrollment transactions that fail to convey via standard 834; these members should be enrolled or have their enrollment records updated using the information in the Pre-Audit File. Enrollments with transactions that failed to convey via 834 are indicated in field 102, Missing Outbound 834 Indicator, in the subscriber record on the Pre-Audit file.
- The date and time of the Pre-Audit extract are published so that Issuers can align their own extract for the RCNI File to transactions received from the FFM through that day.

Pre-Audit File Naming Convention

Pre-Audit Files have the following file naming convention:

- *TPID.AUDY.DYYMMDD.THHMMSSmmm.P.OUT*, where:
- *TPID* – Trading Partner Identifier
- *AUDY* – function code including 1-digit Plan Year identifier*
- *DYYMMDD* – date with 2-digit year, month and day
- *THHMMSSmmm* – timestamp with 2-digit hour, minute, seconds and 3-digit milliseconds

- **P** – environment (P = production)
- **OUT** – outbound from CMS to the Issuer

*Prior to Plan Year 2018, the function code contains a 2-digit year identifier, **AUDYY**, (i.e., AUD17).

Pre-Audit File Specifications

Specifications for the Pre-Audit File are available on zONE in the Enrollment Reconciliation area. See [Appendix A](#) for a link to the document on zONE.

Pre-Audit Files are in pipe-delimited format, which can be easily imported into Excel.

Policies and Policy Segments on the Pre-Audit File

Upon implementation of Maintenance 834 transactions in late 2016, the FFM maintains the same Exchange-Assigned Policy ID across multiple coverage spans when a change is made that does not require creation of a new policy. Internally, the FFM refers to these coverage spans associated with the same Exchange-Assigned Policy ID as **segments**, each with its own Policy Segment ID (or Segment ID).

Each segment has a start date and end date and its own coverage and financial attributes, and its own version of the enrollment group composition.



The FFM will create a new policy any time one of the following is updated:

- Subscriber
- 14-Character QHP ID
- Tobacco Status

For Issuers, a good rule of thumb is if a change is conveyed by a CIC Cancel/Termination with a new Initial transaction, a new policy has been created. A new policy is also created any time there is a gap

in coverage for the enrollment group. Currently, a gap in coverage can only be created through the dispute process and the new Exchange-Assigned Policy ID would be conveyed on the Pre-Audit File.

The FFM will create a new segment under a policy any time one of the following is updated:

- Enrollment group composition (i.e. addition or removal of any dependents)
- CSR Variant
- Maximum and/or Applied APTC Amount
- Residential Address (with rating change)
- Member demographics that change eligibility/rating, such as Date of Birth

If a change is conveyed by a M834 with a new effective date, a new segment has been created. If any of these values are changed prior to the effective date of a segment, and do not require a later effective date for the change, the segment will be “versioned” and the change applied to the existing segment – with no change in Segment ID.

It is important to understand that Inbound 834s (IC834s) operate at the policy level; Issuers are not able to cancel, effectuate, or terminate individual segments – any updates submitted via IC834 will automatically update the appropriate segment(s) of the submitted policy.

Also, Exchange-Assigned Policy ID and Policy Segment ID have the same format; it is possible that the exact same value is used for a Policy ID and a Segment ID that are completely unrelated. This would likely happen across different Issuers, but it is possible within the same HIOS ID.

Likewise, the Policy ID and Segment ID are not interchangeable; the Policy ID will never be the same as an underlying Segment ID for that policy for any policy created after the implementation of Maintenance 834s.

Issuer Use of Pre-Audit Files

In general, Issuers should consider the Pre-Audit File to be the authoritative source of FFM data *as of the date and time of the extract*; if the Issuer has received information via a HICS Case they believe conflicts with what is seen on Pre-Audit they should take the proper steps to update the FFM.

In addition, Issuers should review Pre-Audit files each month and take appropriate actions based on data in the following fields:

Overlaps Indicator – Field 89

CMS conducts a monthly overlapping enrollment cleanup as part of the effort to eliminate duplicate and/or overlapping coverage on the FFM. Duplicate and/or overlapping coverage may arise when a consumer uses multiple applications and/or accounts to enroll in coverage on the FFM; in this case, prior enrollment records are not cancelled or terminated as appropriate in the course of the new enrollment. This cleanup will apply the appropriate cancellation or termination to eliminate the

duplicate or overlapping coverage. **There are no EDI 834 transactions generated as a result of this cleanup process.**

The results of this cleanup are reflected on the Pre-Audit File by an indicator in field 89 on the subscriber record only. Only records modified by the cleanup since the last Pre-Audit File will have an indicator. Overlap indicators are:

- 1 - Record was modified to resolve a within-HIOS overlap
- 2 - Record was modified to resolve across-HIOS overlap
- 3 – Record was modified to resolve a within-HIOS overlap with one or more members losing coverage
- 4 – Record was modified to resolve across-HIOS overlap with one or more members losing coverage

The field will be empty if the record was not modified by the overlaps cleanup.

Issuer Actions:

Apply the cancellations and terminations reflected in the Pre-Audit file to the corresponding enrollments in your system.

To identify the type of transaction that needs to be applied, Issuers should first check the value in Field 11: Transaction Type Code.

- Terminations applied on the FFM will be identified by the presence of an end date later than the start date and a Transaction Type Code of 1.
- Cancellations applied on the FFM will be identified by a Transaction Type Code of 3.

New Policy ID Indicator – Field 100

Certain processes, such as Data Cleanups or Enrollment Disputes, can result in the creation of a new Exchange-Assigned Policy ID and/or new Marketplace Policy Segment ID in very limited circumstances; in these cases, the new Policy ID and/or Segment ID is only sent to the Issuer via the Pre-Audit File. Enrollments that have had a new Policy ID and/or Segment ID created in such a fashion will be flagged on the Pre-Audit File in Field 100, New Policy ID Indicator with one of the following values:

- 1 – New Policy ID and new Segment ID generated
 - Typically, a new Policy ID is generated to enforce a Marketplace business rule; the two most common scenarios are the creation of a gap in coverage under a single Policy ID or a change in tobacco use status that only affects certain segments within a single Policy ID
 - Any time a new Policy ID is generated, a new Segment ID will be generated as well
- 2 – New Segment ID only generated
 - Typically, a new Segment ID is generated when a new coverage segment must be created on the FFM to account for a change submitted through the dispute process

- Issuers should ensure their data reflects the distinct segments as shown on the Pre-Audit File

Issuers should review any enrollment flagged in this field and ensure the new Policy ID and/or Segment ID is captured in their system along with the appropriate start and end dates.

Date of Birth Cleanup Indicator – Field 101

CMS conducts a monthly Date of Birth cleanup process. When a Date of Birth (DOB) change is entered in the FFM, the DOB and premium are adjusted as needed going forward, but no update is made to the historical records for that plan year. The DOB cleanup process rolls back the changes to prior policies and policy segments on the same application.

- If the DOB change on the historical update would cause a change in premium, the premium adjustment and DOB will be applied to historical records.
- If the premium on the historical record had been previously updated through reconciliation, a DOB change will be made but no update to the premium will be applied.

CSR amounts will be adjusted along with any premium changes, as appropriate

Note: APTC will only be adjusted by this cleanup if the new Total EHB Premium would be lower than the Applied APTC Amount; in that case the Applied APTC Amount would be lowered to match the new Total EHB Premium.

If the record was impacted by the DOB cleanup in the prior month, it will be flagged on the Pre-Audit File in Field 101, DOB Cleanup Indicator with one of the following values:

- 1 – Enrollment Impacted by DOB Cleanup; Change to DOB for one or more members of enrollment group
 - In this scenario the consumer has made a change to their enrollment, using their existing application, which includes a change to the DOB for one or more members of the enrollment group
 - Any prior segments for the same policy, and any other prior policies on the same application, will have the DOB changed to match what is on the latest segment
 - There is no financial change associated with the DOB change on the flagged coverage segment
 - **Example:** Member A enrolls in coverage January 1st with DOB 1/2/1990; on March 3rd she returns to the FFM to update her residential address and corrects her birthday to 2/2/1990
 - The first coverage segment starting 1/1/2019 will have the DOB updated to 2/2/1990 but there is no rerating; that segment will be flagged **1**
- 2 – Change to DOB and rerating for one or more members of enrollment group
 - In this scenario the consumer has made a change to their enrollment, using their existing application, which includes a change to the DOB for one or more members of the enrollment group

- Any prior segments for the same policy, and any other prior policies on the same application, will have the DOB changed to match what is on the latest segment
- On the flagged segment, the DOB change has also resulted in a change to the member's age rating, leading to a change in the Total Premium Amount
- In some cases, if the prior Applied APTC Amount exceeds the new Total Premium Amount, the APTC Amount will also be adjusted downward to align with the new EHB Premium on the policy
- **Example:** Member B enrolls in coverage January 1st with DOB 3/1/1980; on April 10th he returns to the FFM to corrects his birthday to 3/1/1970 and updates his income resulting in a new Applied APTC Amount
- The first coverage segment starting 1/1/2019 will have the DOB updated to 3/1/1970 and will be rerated with a new Total Premium Amount based on the updated DOB; that segment will be flagged **2**
 - This record would not qualify for collapsing as seen below due to the change in Applied APTC Amount
- **3 – Change to DOB for one or more members of enrollment group applied retroactively by collapsing segments**
 - In this scenario the consumer has made a change to their enrollment, using their existing application, in which there was a change to the DOB for one or more members of the enrollment group and no changes were made that would typically require creation of a new coverage segment (i.e. residential address change, APTC eligibility change, QHP change, etc.)
 - This would include a scenario where the consumer was rerated but the financials would now be identical on the different segments after the cleanup was applied
 - In this case, as updating the prior segment(s) would lead to financially identical contiguous records, the records are “collapsed” into a single segment on the FFM side using the DOB from the latest segment
 - Issuers should align the data in their systems to the data provided for the continuous segment flagged on the Pre-Audit File
 - **Example:** Member C enrolls in coverage January 1st with DOB 4/5/1976; on May 1st she returns to the FFM to update her mailing address and corrects her birthday to 4/15/1976
 - As updating this information on the first segment would make it financially identical to the new segment, the first segment is *cancelled* on the FFM and the start date of the new segment rolled back to January 1st and flagged **3**

This field will be empty if the record was not modified by the Date of Birth cleanup in the prior month.

Note: This flag on the Pre-Audit file replaces the MISCx files CMS previously sent to Issuer to convey Date of Birth cleanup records.

Issuer Actions:

Issuers should apply the Date of Birth and any financial changes reflected in the Pre-Audit file to the corresponding enrollments in their system.

Missing Outbound 834 Indicator – Field 102

Field 102 on the Pre-Audit file will be populated if an outbound 834 transaction failed to convey to the Issuer in the prior month (since the last Pre-Audit File). The indicator signals that the record had at least one outbound 834 that failed to convey during the month (excluding retransmissions or I834RTs). The indicator will be populated only on impacted subscriber records.

The indicator will be 1 to indicate at least one failed outbound 834 during the prior month. The field will be empty if all outbound 834s were successful.

Issuer Actions:

Issuers should first check the value in Field 11: Transaction Type Code

- Transaction Type Code 1 (Active)
 - If the Exchange-Assigned Policy ID (Field 68) on the record does not exist in the Issuer system, this record represents a new **initial enrollment**
 - If the Exchange-Assigned Policy ID on the record already exists in the Issuer system
 - If the end date is earlier than the current end date in the Issuer system, this record represents a **termination** transaction
 - Otherwise, this record represents a **maintenance** transaction
- Transaction Type Code 3 (Cancelled)
 - This record represents a **cancellation** transaction

Issuers should then use the information in the Pre-Audit file to make appropriate updates to their data stores.

- For a new initial enrollment, the enrollment group should be loaded into the Issuer's system and appropriate new member outreach performed.
- For a cancellation, the affected policy should be cancelled in the Issuer's system.
- For a termination, the affected policy should be terminated in the Issuer's system in alignment with the end date reflected in the Pre-Audit File.
- For a maintenance transaction, the appropriate update should be made to the enrollment in the Issuer's system.

Outbound 834 Retransmission Indicator – Field 103

For informational and research purposes, CMS populates field 103 on the Pre-Audit File with an indicator of whether an outbound 834 was retransmitted (via I834RT File) since the last Pre-Audit File.

This indicator signals that the record had at least one retransmitted outbound 834 during the prior month. It will be 1 to indicate at least one retransmitted outbound 834. The field will be empty if all outbound 834s were successful.

I834RTs will not be indicated as Missing Outbound 834 Transactions in field 102; rather they are flagged only in field 103.

Note: Action is only required if the Issuer believes they did not receive and/or load the retransmitted 834 transaction.

Outbound 834 Transaction History – Field 104

To provide additional information that may be useful to process any missing 834s, CMS populates field 104 with a history of the outbound 834 transactions for certain records.

The Outbound Transaction History field will be populated if the financial span had at least one outbound 834 that either failed to convey or was retransmitted (as indicated in Fields 102 or 103) for the month.

The Outbound Transaction History will be populated only on the subscriber record and will represent **only outbound transactions that occurred in the past month.**

The transaction history will be sent as a delimited string consisting of:

Enrollment Action Date:Enrollment Action Time:Type of Transaction:Successful Conveyance (Y/N/R):AMRC:SEP Code

- Enrollment Action date and time fields reflect consumer activity that caused the change in the FFM
- Type of transaction: initial, termination, cancellation, maintenance
- Successful conveyance:
 - Y – successfully conveyed
 - N – missing outbound 834
 - R – retransmitted 834
- 'NA' will be populated if AMRC and/or SEP Code is not available

Issuer Action:

Issuers should review this information for help in determining appropriate actions to take, in conjunction with all other information in the enrollment record.

Examples of Pre-Audit File Fields

Example 1: Added Dependent via M834, Missing Outbound 834

- Jane and John Doe add their son to their policy on 3/14/19, effective 4/1/19
- M834 to add the dependent is not successfully conveyed, resulting in the Missing 834 Indicator and Outbound Transaction History being populated on Jane's (the subscriber's) new financial span

Member Name	Subscriber Indicator	APTC	FFM Ben Begin Date	FFM Ben End Date	Missing 834 Indicator	Retransmitted 834 Indicator	Outbound Transaction History*
Jane Doe	Y	\$100	1/1/19	3/31/19			
John Doe	N		1/1/19	3/31/19			
Jane Doe	Y	\$150	4/1/19	12/31/19	1		190314:HHMMSSmmm: MAINTENANCE:N: FINANCIAL CHANGE:02
John Doe	N		4/1/19	12/31/19			
Son Doe	N		4/1/19	12/31/19			

Example 2: 834RT for Maintenance 834 to Indicate Financial Change

- Jane and John Doe update their income, resulting in a change to Applied APTC.
- M834 to indicate change to Applied APTC fails to convey successfully but is successfully retransmitted to the Issuer, resulting in the Retransmitted 834 Indicator and Outbound Transaction History being populated on Jane's (the subscriber's) new financial span.

Member Name	Subscriber Indicator	APTC	FFM Ben Begin Date	FFM Ben End Date	Missing 834 Indicator	Retransmitted 834 Indicator	Outbound Transaction History*
Jane Doe	Y	\$100	1/1/19	3/31/19			
John Doe	N		1/1/19	3/31/19			
Jane Doe	Y	\$150	4/1/19	12/31/19		1	190314:HHMMSSmmm: MAINTENANCE:R: FINANCIAL CHANGE:FC
John Doe	N		4/1/19	12/31/19			

Example 3: Duplicate Coverage within Same HIOS

- In December, Jane and John Doe enroll in Policy ID 234, effective 1/1/19.
- In early January, they create a new application and enroll in Policy ID 345 (with the same HIOS), effective 2/1/19.
- Prior to the January Pre-Audit File, the Overlaps Cleanup terminates Policy ID 234 with a 1/31/19 Plan Benefit End Date to eliminate overlapping coverage on the FFM.
- Both initial 834s conveyed successfully, so Missing Outbound 834 Indicator, Retransmitted 834 Indicator, and Outbound Transaction History will all be null.
- The Overlaps Indicator is populated with “1” on Jane’s (the subscriber’s) row, indicating that the record was affected by the Overlaps Cleanup to resolve a within-HIOS overlap.

Member Name	Subscriber Indicator	HIOS	Policy ID	APTC	FFM Ben Begin Date	FFM Ben End Date	Overlaps Indicator
Jane Doe	Y	123	234	\$100	1/1/19	1/31/19	1
John Doe	N	123	234		1/1/19	1/31/19	
Jane Doe	Y	123	345	\$105	2/1/19	12/31/19	
John Doe	N	123	345		2/1/19	12/31/19	

Example 4: Duplicate Coverage Across Different HIOS

- In December, Jane and John Doe enroll in Policy 234, effective 1/1/19.
- In early January, they create a new application and enroll in Policy 456 in a different HIOS, effective 2/1/19.
- Prior to the January Pre-Audit File, the Overlaps Cleanup process terminates Policy 234 with a 1/31/19 Plan Benefit End Date to eliminate overlapping coverage on the FFM.
- Both initial 834s conveyed successfully, so Missing Outbound 834 Indicator, Retransmitted 834 Indicator, and Outbound Transaction History will all be null.
- The Overlaps Indicator is populated with “2” on Jane’s (the subscriber’s) row in HIOS 123, indicating that the record was affected by the Overlaps Cleanup to resolve an across-HIOS overlap.

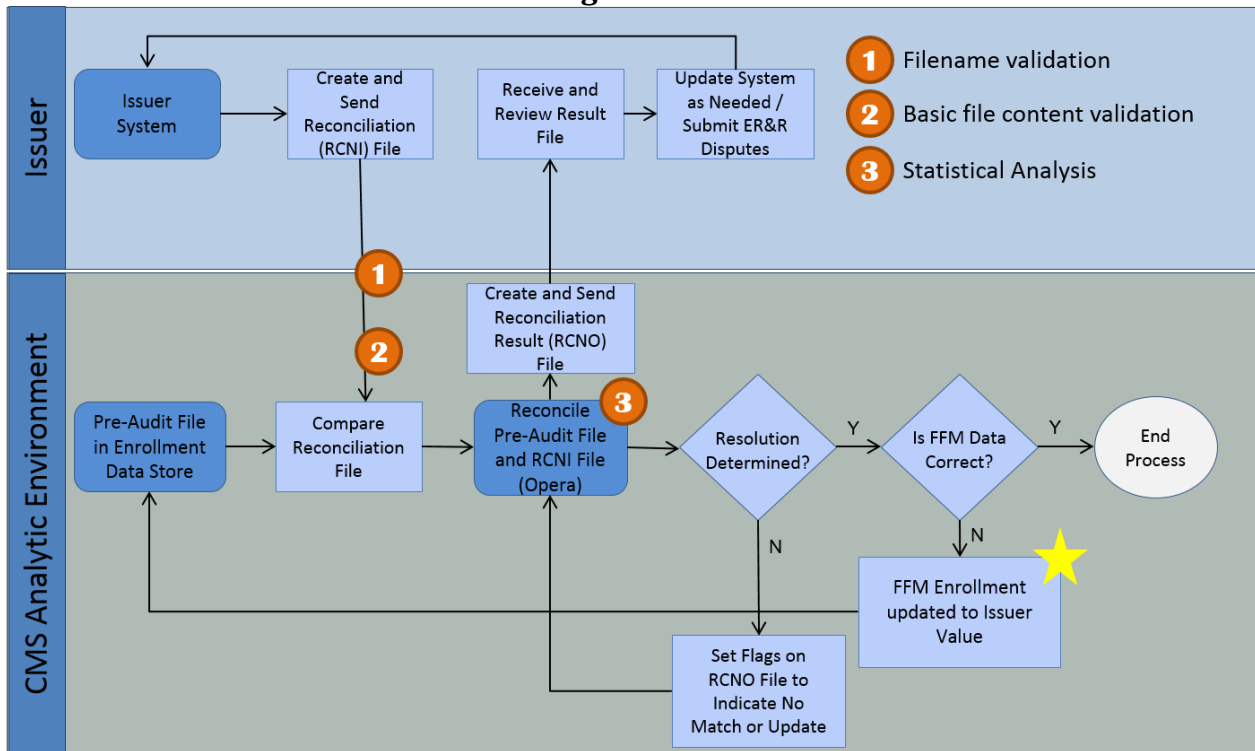
Member Name	Subscriber Indicator	HIOS	Policy ID	APTC	FFM Ben Begin Date	FFM Ben End Date	Overlaps Indicator
Jane Doe	Y	123	234	\$100	1/1/19	1/31/19	2
John Doe	N	123	234		1/1/19	1/31/19	

- HIOS 345 would not have the Overlaps Indicator populated because no change was made to the policy.

Member Name	Subscriber Indicator	HIOS	Policy ID	APTC	FFM Ben Begin Date	FFM Ben End Date	Overlaps Indicator
Jane Doe	Y	345	456	\$105	2/1/19	12/31/19	
John Doe	N	345	456		2/1/19	12/31/19	

Enrollment Reconciliation Process Overview

Enrollment Reconciliation Process Diagram



RCNI File Format

The RCNI file must be in pipe-delimited format. See [Appendix A](#) for a link to the RCNI File Specification document available on CMS zONE.

RCNI Filename Validation Checkpoint (1)

Upon submission of an RCNI File by the Issuer, the CMS EFT process will validate the RCNI filename and route the file accordingly. EFT only validates the filename and it must comply exactly with the naming convention.

RCNI File Naming Convention

File naming convention for RCNI files is: *TPID.RCR.RCNIY.DYYMMDD.THHMMSSmmm.P.IN*, where:

- **TPID** – Trading Partner Identifier
- **RCR** – target application
- **RCNIY** – function code including 1-digit year identifier*
- **DYYMMDD** – date with 2-digit year, month and day
- **THHMMSSmmm** – timestamp with 2-digit hour, minutes, seconds and 3-digit milliseconds
- **P** – environment (P = Production)

- **IN** – file direction (Inbound from Issuer to CMS)

*Prior to 2018 the function code contained a 2-digit year identifier, **RCNIYY** (i.e., RCNI17, RCNI16, etc.)

- If the RCNI filename is not compliant the file will be rejected; the rejection will be placed in the Outbound Error EFT folder.
 - Issuers should check their Error folder after submitting their files and confirm successful transmission.
- Common issues causing rejection include:
 - Incorrect function code
 - Incorrect/invalid TPID
 - Incorrect/invalid date/time format
- Note: If you put a T in the environment position (next to last node), the file will not be processed and you may not receive a notification as the file will not be routed to the proper destination for verification or acknowledgment.

RCNI File-Level Validation Checkpoint (2)

Upon successful receipt of the RCNI file via EFT, CMS will perform initial file-level validation.

Please note that if you submit a file with an identical filename to a previously submitted file, that file will automatically be rejected at this step in the validation process. All RCNI files submitted must have a unique filename to be processed.

Common Causes of File-Level Validation Failure

Below is a list of common reasons that a file might fail front end file-level validation.

- File unreadable
- File structure not pipe-delimited
 - All 01 and 02 records must be pipe-delimited
- All 01 detail records and 02 total records must be terminated with a carriage return line feed
 - Ensure that EBCDIC (hex 0d25) or ASCII (hex 0d0a) is used for the carriage return line feed; EBCDIC (hex 0d) will cause file rejection
- File does not contain both 01 and 02 record type
- 01 or 02 records do not have the correct number of fields per the specification
 - 01 records must have 63 fields
 - 02 records must have 12 fields
- Counts and sums in 02 Record do not match corresponding 01 Records
 - Summary records are to be reported by HIOS ID (not QHPID Lookup Key)
 - Each HIOS ID in the file must have a corresponding 02 record
- Null values in administrative fields:
 - Record Code
 - Trading Partner ID

- HIOS ID
- QHP ID Lookup Key
- Issuer Extract Date
- Issuer Extract Time
- HIOS ID mismatch to first 5 characters of the QHP ID
- QHP ID does not exist in HIOS reference data
- Invalid QHP ID Lookup Key to Trading Partner ID relationship
 - Files must only contain valid QHP IDs associated with the Trading Partner ID for the file
- Invalid characters received in Exchange-Assigned Member/Subscriber ID

Files that pass this validation will be staged for reconciliation processing and a success acknowledgment e-mail will be sent to the Issuer's designated technical contacts.

Files that fail this validation will **not** be processed further; a replacement file must be sent. A failure notification e-mail with details on the error(s) encountered will be sent to the Issuer's designated technical contact(s).

Issuers are encouraged to submit RCNI files at least a day or two ahead of the monthly deadline to allow time to resubmit in the event issues are encountered. Resubmitted files must be given a new, distinct filename with a later date/timestamp. As mentioned above, duplicate filenames will not be processed.

Enrollment Reconciliation Technical Contacts

Reconciliation Technical Contacts for your organization will be contacted by CMS resources regarding any technical issues identified in the Issuer-submitted Reconciliation (RCNI) File. 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 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
 - Please include the Trading Partner ID(s) and HIOS ID(s) represented by the technical contacts

Statistical Analysis Checkpoint (3)

Upon completion of full reconciliation processing between the Issuer RCNI files and FFM data, the record and field-level matching results are analyzed for each Issuer and compared to established

statistical baselines. Results of statistical validation are communicated to the Issuers and updates are made, as appropriate, to FFM data. Details on [Statistical Analysis](#) are covered later in this document.

Enrollment Reconciliation Data & Key Concepts

RCNI Data Entities and Attributes

Below is a list of key RCNI data entities and attributes as well as the field number of the data element (in parentheses)

- QHP Coverage (attributes about QHP policy)
 - Exchange-Assigned Policy ID (21)
 - Benefit Coverage Period: Benefit Start Date (38), Benefit End Date (39)
 - Issuer-Assigned Policy ID (22)
 - QHP ID (37), Initial Premium Paid Status (52)
 - Coverage Year (54)
 - Cancellation Reason Code (62), Termination Reason Code (63)
- Policy Membership (attributes about enrollees)
 - First Name (9), Middle Name (10), Last Name (11), DOB (12), Gender (13), SSN (14)
 - Addresses: Residential (23, 24, 25, 26, 27, 33), Mailing (28, 29, 30, 31, 32)
 - Subscriber Indicator (15), Relationship Code (16)
 - Exchange-Assigned Subscriber ID (17), Member ID (18)
 - Issuer-Assigned Subscriber ID (19), Member ID (20)
- Financial Information (attributes about financials or rating)
 - Tobacco Status (36)
 - Applied APTC Amount (40), CSR Amount (43)
 - Total Premium Amount (46)
 - Financial Period Start Dates (41, 44, 47, 50), End Dates (42, 45, 48, 51)
 - Agent/Broker Information (57-61)

Additional Notes on RCNI Key Data Elements

- For proper record matching, the following elements must be included on each record:
 - Last Name
 - Date of Birth
 - Exchange-Assigned Member ID
 - Exchange-Assigned Subscriber ID
 - Full 16-character QHP ID
- All financial amounts should always reflect **full monthly amounts**
 - Do not send amounts billed or paid (i.e. Individual Responsibility Amount)
 - ***Do not send pro-rated amounts for partial coverage months***
 - Any necessary proration to support payments is done separately from the Enrollment Reconciliation process

FFM Enrollment Data Structure

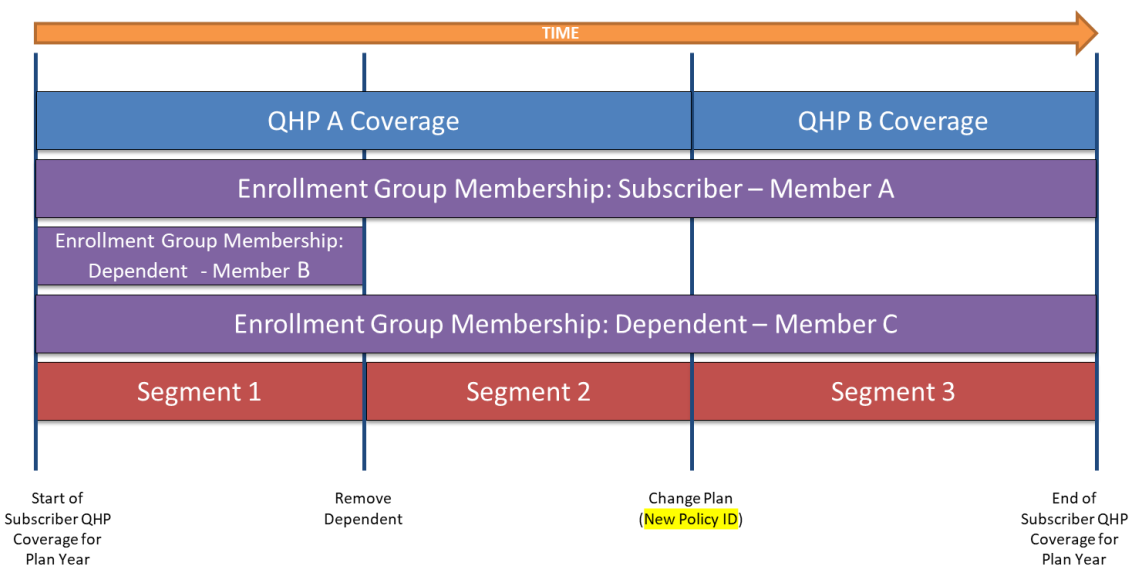
It is important to understand that enrollment reconciliation is **not a transactional process**, but rather reflects the structure of FFM enrollment data. FFM Enrollment Data is structured hierarchically and consists of **Applications**, **Policies**, and **Segments**.

During the enrollment process, an enrollee enters information into the eligibility application to determine their eligibility for benefit coverage and subsidy; much of this data is stored in the **Application**. Each Application can have one or more **Policies** associated with it.

Upon selection and enrollment in benefit coverage, a **Policy** is created with specific attributes about the enrollment including the subscriber, QHP ID, and status. Each policy will have one or more **Segments**. Each **Segment** will carry the detailed information about the enrollment, including the composition of the enrollment group, Total Premium Amount, CSR Variant, Applied APTC, etc. and will have a start and end date during which all these attributes are in effect.

If **any** of those elements changes as a result of a transaction from the FFM, a new, distinct segment is created and aligned to the effective date of the change. This new segment will apply to all members of the enrollment group and will have a new, unique Marketplace Policy Segment ID.

Below is a graphic representation of enrollment in QHP coverage with changes throughout the year:



Change Scenarios

The following scenarios describe changes that may take place on an enrollment and explain how data is to be conveyed in the RCNI file.

Change to QHP ID

Any time a member, whether subscriber or dependent, changes QHP enrollment (any change to the full 16-character QHP ID including CSR Variant) a new policy (and new Exchange-Assigned Policy ID) is created for the member(s) that have changed plans. Any member(s) remaining in the original plan will have a new segment created for their continuing coverage.

For example, if a member enrolls in QHP 55555TX001000101 effective January 1st, then granted a Special Enrollment Period switches to QHP 55555TX002000201 effective June 1st, **two distinct records** must be submitted on the RCNI File.

- The first record will have a Benefit Start Date of 1/1/2019 and a Benefit End Date of 5/31/2019
- The second record will have a Benefit Start Date of 6/1/2019 and a Benefit End Date of 12/31/2019
- Financial dates within each span should align to those start and end dates

Change to Financials

Any time there is a change in a financial element such as Total Premium Amount or Applied APTC Amount, a new segment is created applying to all members of the enrollment group; a change to Applied APTC Amount is possible with no other changes to the record if the member changes their election or updates their income on the FFM.

For example, if a member enrolls in QHP 55555TX001000101 effective January 1st with an Applied APTC Amount of \$350, then decides to only apply \$300 a month of APTC effective July 1st, **two distinct records** must be submitted on the RCNI File.

- The first record will have start dates of 1/1/2019 and end dates of 6/30/2019
- The second record will have start dates of 7/1/2019 and end dates of 12/31/2019

All financial dates should be aligned to these start and end dates whether there is a change to that particular financial amount or not.

Change to Enrollment Group Composition

Any time a member is added or removed from the enrollment group, a new segment is created **for all members remaining in the enrollment group**. This new segment will have a new Marketplace Policy Segment ID.

For example, if a member enrolls in QHP 55555TX001000101 effective January 1st, then gets married and adds a spouse effective March 1st, **two distinct records** must be submitted for the subscriber and a single record for the dependent spouse.

- The first record for the subscriber will have start dates of 1/1/2019 and an end dates of 2/28/2019 – financials on this record should reflect the original amounts prior to adding the spouse

- The second record for the subscriber will have start dates of 3/1/2019 and end dates of 12/31/2019 – financials on this record should reflect the amounts after the spouse was added
- The spouse's record must have a start date of 3/1/2019 and an end date of 12/31/2019

It is important to note that although financials may not change with the addition or removal of a dependent, a new segment must be created any time the enrollment group changes.

Change to Demographics

A change that only impacts the demographic information of a member (such as a correction to the address with no impact to rating area or an updated phone number) **will not result in creation of a new segment.**

For example, if a member enrolls in QHP 55555TX001000101 effective January 1st and corrects the phone number on record effective May 15th, **only one record** should be submitted on the RCNI File. This change would be conveyed to the Issuer via Maintenance 834 and would not result in creation of a new Marketplace Policy Segment ID.

- The latest demographic information should be included on the single record and there should be no alignment of start or end dates to the date of the demographic change

Change to Exchange-Assigned Policy ID

Although with the implementation of the Maintenance 834 transaction Exchange-Assigned Policy ID remains consistent across many change transactions, it is possible an Issuer would receive an update as a new initial enrollment with a new Exchange-Assigned Policy ID. This would typically occur if the member made the update via a new application rather than leveraging the existing application.

In this circumstance, a new record (or records) on RCNI is required **even if there is only a change to demographic information** aside from the change in Policy ID.

For example, if a member enrolls in QHP 55555TX001000101 effective January 1st, then opens a new application to update their address (with no other changes) effective February 1st, **two distinct records** must be submitted on the inbound Reconciliation File.

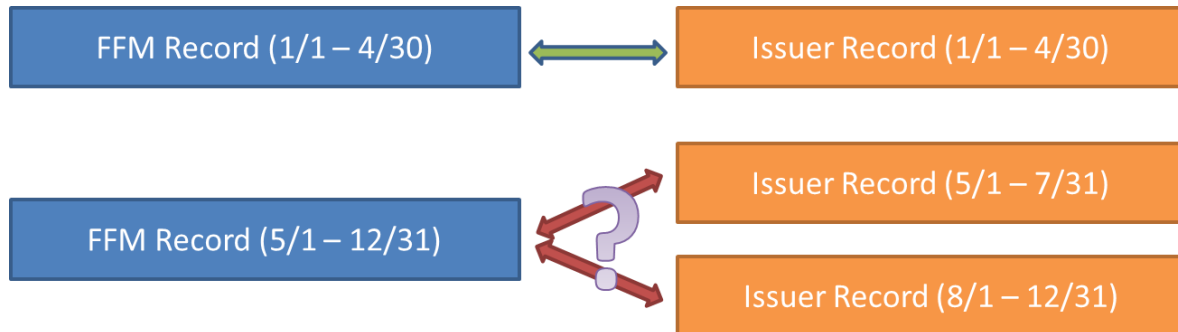
- The first record will have start dates of 1/1/2019 and end dates of 1/31/2019 with the original Policy ID
- The second record will have start dates of 2/1/2019 and end dates of 12/31/2019 with the new Policy ID
- Financial dates within each span should align to those start and end dates

Please note, in this example it is extremely likely that the termination of the initial policy would be done by the overlapping coverage cleanup process. Please see the section regarding the Overlaps

Indicator – Field 89 for additional information on this process and how this information is conveyed to Issuers on the Pre-Audit File.

Alignment of Records between Issuer and FFM Data

It is critical to align records between Issuer and FFM data.



- Where the Issuer and FFM have a different number of records for the same period of coverage, the reconciliation algorithms are unable to evenly match the records and updates cannot be made to FFM data
- Wherever possible, Issuers should work to resolve instances where their extract process generates a different number of records for a given policy than what is on the FFM side
- If an Issuer has a HICS Case or other legitimate business reason to have a mismatching number of spans, the appropriate action – typically an Enrollment Dispute or HICS Direct Dispute – should be taken to ensure a successful even-sided match in future cycles

Removal of Dependent as Never Effective via M834

A common scenario is removal of a dependent as **never effective** from an enrollment group via Maintenance 834 (M834) transaction.

For example, a subscriber enrolls with spouse and adult child effective January 1. Prior to January 1, the adult child receives employer-sponsored coverage and is removed from the enrollment group via a M834 transaction.

Once the dependent is removed from the enrollment group as **never effective**, they no longer appear on the FFM side on the Pre-Audit or RCNO files.

On the RCNI file, the Issuer **should not** send the removed dependent member as part of the enrollment group. Only the members that remain active in the enrollment group as of the effective date should be included. If the Issuer does send the dependent member, the record will be flagged 'I' and contribute to uneven-sided matching, which prevents updates from being applied to the FFM via reconciliation.

Change to Financial Eligibility, No Change to Financials

When a consumer returns to the Marketplace and makes an update that results in a change to financial eligibility, a new coverage span is created on FFM. If there is no change to Applied APTC or other financial attributes associated with the enrollment, the Issuer will **not** receive an 834 transaction and will not reflect distinct segments in their system.

In this scenario, CMS will “merge” the multiple records on the FFM side into a single record on the RCNO file for better matching to Issuer records. As a result:

- The merged record is tagged on the RCNO file in the Footnotes field to indicate the FFM record actually represents two or more records
- The merged record is counted as a single record in terms of determination of ‘sidedness’, allowing for full field level updates on an even-sided match
- This does not guarantee records will be even-sided, but it will eliminate the suppression of updates due *solely* to this data condition on FFM

There is no change to the way the records are conveyed on the Pre-Audit file. Each distinct coverage span continues to appear on the Pre-Audit file.

In the example below the merged records appear on the RCNO file as a single row with #MERGE in the Footnotes field.

FFM Benefit Start Date	Issuer Benefit Start Date	FFM Benefit End Date	Issuer Benefit End Date	FFM Applied APTC	Issuer Applied APTC	Footnotes	Record Flag
1/1/2018	1/1/2018	12/31/2018	12/31/2018	\$550	\$550	#MERGE	Z

On the Pre-Audit file they continue to appear as separate records:

Exchange-Assigned Member ID	Exchange-Assigned Policy ID	Benefit Start Date	Benefit End Date	Applied APTC
0000000123	5551234	1/1/2018	3/31/2018	\$550
0000000123	5551234	4/1/2018	12/31/2018	\$550

Historical and Non-Historical Data Rules

RCNI files should include all active, cancelled and terminated enrollments, regardless of whether updates have already been applied to FFM.

- Historical values are provided only for fields that have related effective dates, i.e., all financial values, plus QHP ID and tobacco use indicator, which are associated with the Benefit Start and Benefit End Dates
- All records must contain a QHP ID and Benefit Start/End Dates. However, Benefit End Date may be left blank for members with active, open-ended coverage

- Subscriber records carry all financial values: Total Premium, Individual Member Premium, APTC, and CSR
 - Total Premium, Individual Member Premium and the associated effective dates should be populated for all subscriber records in the file
 - For any period in which a policy has no APTC or CSR, the Issuer may:
 - Leave the APTC and/or CSR blank along with the associated effective dates
 - Or populate the amount explicitly with 0.00 and provide the effective dates
 - Financial dates should always be in alignment within any given record (i.e. Total Premium, APTC, and CSR Start and End Dates should all be the same, if provided)
- Non-subscriber (dependent) member records will contain only the financial value for the Individual Member Premium and its associated effective dates
 - Non-subscriber records should not have the Total Premium Amount, APTC, or CSR Amount nor corresponding dates populated

Initial Premium Paid Status Rules

The effectuation status of each enrollment record will be determined by the value submitted in the **Initial Premium Paid Status** field for the subscriber of the enrollment group.

- For cancellations (no effectuated coverage), a **C** should be sent for Initial Premium Paid Status
 - For cancellations, Benefit End Date should be set to the same date or one day prior to the Benefit Start Date; the Benefit End Date may also be sent as blank for cancellations
- For active coverage or terminated coverage, a **Y** should be sent for Initial Premium Paid Status
 - An enrollment record that reflects any period of active coverage should have a **Y**
- For new enrollments that have not yet been effectuated and are still in the initial waiting period prior to cancellation for non-payment, an **N** should be sent for Initial Premium Paid Status
 - Following Open Enrollment, it is expected that a very low percentage of records will be submitted with N status; as the Issuer will know if the binder payment has been made, the records should reflect Y or C status, depending on whether the enrollment was effectuated or cancelled
 - **Please Note:** No updates will be applied to the FFM based upon a record submitted with an **N** value for Initial Premium Paid Status

Cancellation Rules

Cancellations must always be sent on the RCNI File when the Issuer has cancelled the policy.

- Issuers may, but are not required to, send cancellations received from the FFM on the RCNI File

- Cancellations should only be sent for enrollment records that reflect no period of effectuated coverage, where no payment was made/applied, or where the enrollee had any payment refunded
 - No APTC or CSR payments will be applied to these enrollments
- To ensure proper matching, Issuers should include all standard information on records to be cancelled, including the Cancellation Reason Code if the Issuer has cancelled the policy (see the subsequent section for further details on Cancellation Reason Codes)
 - Issuers should also include all members, whether subscriber or dependent, on cancelled records as well as records for all segments associated with a cancelled policy to ensure an even-sided match of records that will allow processing through reconciliation

Cancellation and Termination Reason Codes

Issuers are required to submit a Cancellation or Termination Reason Code, as appropriate, on cancelled or terminated records submitted on the RCNI File. Issuers should include a Cancellation Reason Code in Field 62 whenever the following conditions are true:

- The entire policy (as defined by Exchange-Assigned Policy ID) is **cancelled** in the Issuer's enrollment system
- The Issuer initiated the cancellation of the policy
 - Issuers may also include a Cancellation Reason Code when the cancellation was initiated on the FFM; in such cases, if the Issuer does not echo back the Cancellation Reason Code sent by the FFM the field should be left blank
- Issuers must include a Cancellation Reason Code on all segments submitted with the Exchange-Assigned Policy ID of the cancelled policy

Issuers **should not** populate the Cancellation Reason Code if any of the following is true:

- The Initial Premium Paid Indicator value submitted is either Y or N
- There is any period of effectuated coverage associated with that Exchange-Assigned Policy ID
- The coverage represented by the record is a reinstatement of previously cancelled coverage

Issuers should include a Termination Reason Code in Field 63 whenever the following conditions are true:

- The policy (as defined by Exchange-Assigned Policy ID) is **terminated** in the Issuer's enrollment system
- The Issuer initiated the termination of the policy
 - Issuers may also include a Termination Reason Code when the termination was initiated on the FFM; in such cases, if the Issuer does not echo back the Termination Reason Code sent by the FFM the field should be left blank
- The segment is the **final segment representing effectuated coverage** from the Issuer's perspective
 - Issuers may also include a Termination Reason Code on other segments for the same Exchange-Assigned Policy ID of the terminated policy

Issuers **should not** populate the Termination Reason Code if any of the following is true:

- The entire policy is **cancelled** in the Issuer's enrollment system
- The policy represents active, open-ended coverage (even if this coverage had previously been terminated)

The example below illustrates how to submit Cancellation and Termination Reason Codes correctly. A member John enrolled effective 1/1/2019 and effectuated coverage in QHP A. John updated his financial eligibility leading to a new Applied APTC Amount effective 3/1/2019. Later, John moved and enrolled in QHP B with the same Issuer effective 5/1/2019.

- John did not pay for any coverage after March
- After honoring the grace period, the Issuer terminates John's coverage effective 4/30/2019

Benefit Start Date	Benefit End Date	Applied APTC	QHP ID	Exchange-Assigned Policy ID	Initial Prm Paid Indicator	Cancellation Reason	Termination Reason
1/1/2019	2/28/2019	\$250	QHP A	12345	Y		
3/1/2019	4/30/2019	\$300	QHP A	12345	Y		6
5/1/2019	5/1/2019	\$300	QHP B	13456	C	6	

Because John enrolled in a new plan (QHP B) effective 5/1/2019, he has two **policies** for 2019. The first policy – 12345 – has two **segments** because of the financial change effective 3/1/2019. Because John did not pay for any coverage after March, the Issuer **terminates** his coverage in the first policy (coverage under QHP A) with an end date of 4/30/2019. Since the second segment carries the final period of coverage under that policy, it must have the Termination Reason Code populated. The second policy – 13456 – must be **cancelled** to reflect that John never effectuated coverage under QHP B, therefore the single record for that policy carries the Cancellation Reason Code.

In the next example, a consumer Jane enrolls in coverage effective 1/1/2019. Prior to making binder payment, Jane updates her financial eligibility resulting a new Applied APTC Amount effective 2/1/2019 under the same policy.

- Jane never makes her binder payment
- The Issuer cancels Jane's enrollment due to non-payment

Benefit Start Date	Benefit End Date	Applied APTC	QHP ID	Exchange-Assigned Policy ID	Initial Prm Paid Indicator	Cancellation Reason	Termination Reason
1/1/2019	1/1/2019	\$400	QHP A	34567	C	6	
2/1/2019	2/1/2019	\$350	QHP A	34567	C	6	

Because of the financial change made on the FFM while the policy was still in active, uneffectuated

status, there are two **segments** associated with the single **policy**. In this case, if the Issuer submits both segments as records on the RCNI File, the Cancellation Reason must be included on both records. Alternately, the Issuer could send only the first segment associated with that Exchange-Assigned Policy ID and have that carry the cancellation (as indicated by an Initial Premium Paid Status of **C**) and the Cancellation Reason.

Reinstatement of Cancelled Enrollments

Under certain circumstances, CMS will attempt to reinstate cancelled enrollments via the automated Enrollment Reconciliation process.

Policies cancelled on the FFM with a value of **2** (IC834) or **4** (Reconciliation) in Field 86, Cancellation Source, on the Pre-Audit file, may be eligible for reinstatement and effectuation through automated reconciliation.

Issuers should ensure a Cancellation Reason Code is not populated on records to be reinstated.

Note: Issuers should submit these records as active and effectuated on their RCNI file. Issuer should also submit these to the ER&R Contractor to ensure they are reinstated and effectuated on FFM. Downstream processes may prevent application of the reinstatement through Enrollment Reconciliation in certain circumstances.

Reinstatement of Terminated Enrollments

Under certain circumstances, CMS will attempt to reinstate or extend the end date of previously terminated enrollments via the automated Enrollment Reconciliation process.

Policies terminated on the FFM with a value of **2** (IC834) or **4** (Reconciliation) in Field 87, Termination Source, on the Pre-Audit file, may be eligible for reinstatement and effectuation through automated reconciliation.

If the reinstatement would restore the enrollment to active, open-ended coverage, Issuers should ensure the Termination Reason Code is not populated on records to be reinstated.

Note: Issuers should submit these records as active and effectuated on their RCNI file, with the Benefit and Financial End Dates set appropriately. Issuer should also submit these to the ER&R Contractor to ensure the proper end date is reflected on the FFM. Certain business rules or downstream processes may prevent application of the reinstatement or extension of the end date through Enrollment Reconciliation.

Agent/Broker Information

Enrollment Reconciliation is the proper method for Issuers to ensure the FFM has the correct Agent/Broker attribution for their enrollments. This is necessary so that proper attribution is

reflected on any FFM enrollment channel and carries forward to any future enrollment actions including auto-renewal for the following plan year.

Issuers should send the proper NPN and name of the Agent/Broker on each enrollment record on the RCNI File. Records sent with only an NPN or name but not both will not be updated. If the information submitted by the Issuer is different from the information currently stored on the FFM for that enrollment it will be changed on the FFM, with the following caveats:

- The record match must be even-sided (i.e. the same number of records for the enrollment group on both the Issuer and FFM side)
- Agent/Broker information cannot be removed entirely (i.e. changing from an Agent/Broker attribution on a policy to no Agent/Broker) through automated reconciliation; removal of this information must be done via an ER&R Enrollment Dispute
 - **Please Note:** Issuers must use the ER&R process to remove agent/broker information and should not attempt to circumvent this requirement by submitting dummy agent/broker information on the RCNI File

There is a current limitation that only one Agent/Broker can be attributed to an FFM policy, as defined by Exchange-Assigned Policy ID; sending different Agent/Broker information on different records for the same policy will prohibit any update to that information via automated reconciliation.

Issuer-Assigned IDs Guidelines

It is important for Issuers to maintain accurate and consistent Issuer-Assigned Policy, Subscriber and Member Identifiers. They are required in IC834 transactions and Enrollment Reconciliation (RCNI) files. In addition, Issuers must ensure the IDs are consistent when sent in IC834s and in RCNI files. Failure to submit consistent IDs could result in failure of IC834 transactions.

Below are guidelines for Issuer-Assigned IDs:

- Issuer-Assigned Member ID
 - This value should be unique for **each member** within that Issuer HIOS ID
- Issuer-Assigned Subscriber ID
 - This value should be unique for **each enrollment group** within that Issuer HIOS ID
 - All members within the same enrollment group should have the same value for the Issuer-Assigned Subscriber ID
- Issuer-Assigned Policy ID
 - This value should be unique for **each enrollment group** within that Issuer HIOS ID
 - All members within the same enrollment group should have the same value for the Issuer-Assigned Policy ID
 - If Issuers do not assign a Policy ID, the Exchange-Assigned or Issuer-Assigned Subscriber ID can be entered in this field as a proxy, as this value is unique to the Enrollment Group – **any proxy value should be consistently used on both IC834 and RCNI submissions**

Paid Through Date Requirements

Through discussion with the Internal Revenue Service (IRS), it has been determined that Paid Through Date will **not** be reported for the foreseeable future. As such, reference information regarding use of that field has been removed from this document.

Issuers may submit a value in that field in the RCNI File or leave the field blank for all records. If the Issuer populates the value, it will be given a field-level flag of **D** indicating it was not compared or **M** if both the FFM and Issuer values are blank.

If a decision is made to require population of the Paid Through Date field in the future, full requirements will be communicated to all FFM Issuers with significant advance notice.

End of Year Termination Indicator

Reference information regarding use of this field has been removed from this document because FFM is not updating this field with Issuer information at this time. Issuers may submit a value in their RCNI file or leave the field blank. If a decision is made to require population of this field in the future, requirements will be communicated to all FFM Issuers with significant advance notice.

Reporting Newborn Free Coverage Period

CMS has outlined the process for Issuers in states where a newborn baby is to receive a month of free coverage on the mother's plan to update the FFM to account for this coverage. This is done through the ER&R Dispute process.

For proper processing of the disputes, Issuers must submit data in their RCNI file that aligns to the dispute.

The following examples illustrate how this should be reflected on the RCNI file.

Example 1: No Plan Change, APTC Does Not Exceed Premium

A mother and father enroll in coverage on the FFM effective 1/1/2017 and have a baby on 3/16; the baby is added to the policy and is to receive a month of free coverage.

- Prior to the child's birth the family has a monthly premium of \$850 and an APTC of \$450
- After the child's birth, the family is re-rated to a total premium of \$1100 and an APTC of \$650

Member	QHP ID	Benefit Start Date	Benefit End Date	Financial Start Dates	Financial End Dates	Total Premium	APTC
Mom	QHP A	1/1/2020	3/15/2020	1/1/2020	3/15/2020	850	450
Dad	QHP A	1/1/2020	3/15/2020				
Mom	QHP A	3/16/2020	4/15/2020	3/16/2020	4/15/2020	850	650
Dad	QHP A	3/16/2020	4/15/2020				
Baby	QHP A	3/16/2020	4/15/2020				
Mom	QHP A	4/16/2020	12/31/2020	4/16/2020	12/31/2020	1100	650
Dad	QHP A	4/16/2020	12/31/2020				
Baby	QHP A	4/16/2020	12/31/2020				

Example 2: APTC Exceeds Free Newborn Coverage Period Premium

A mother and father enroll in coverage on the FFM effective 1/1/2017 and have a baby on 3/16; the baby is added to the policy and is to receive a month of free coverage.

- Prior to the child's birth the family has a monthly premium of \$850 and an APTC of \$750
- After the child's birth, the family is re-rated to a total premium of \$1100 and an APTC of \$950
- In this case, since the new APTC is higher than the Total EHB Premium for the month of free coverage for the newborn, the APTC must be adjusted down to \$850 for that month

Member	QHP ID	Benefit Start Date	Benefit End Date	Financial Start Dates	Financial End Dates	Total Premium	APTC
Mom	QHP A	1/1/2020	3/15/2020	1/1/2020	3/15/2020	850	750
Dad	QHP A	1/1/2020	3/15/2020				
Mom	QHP A	3/16/2020	4/15/2020	3/16/2020	4/15/2020	850	850
Dad	QHP A	3/16/2020	4/15/2020				
Baby	QHP A	3/16/2020	4/15/2020				
Mom	QHP A	4/16/2020	12/31/2020	4/16/2020	12/31/2020	1100	950
Dad	QHP A	4/16/2020	12/31/2020				
Baby	QHP A	4/16/2020	12/31/2020				

HICS Case to Move Termination Date for Member Leaving Policy

Ending coverage for some but not all members on an application can at times create an unpredictable date of last coverage for the member(s) being removed. The system may not assign the desired termination date for the individual whose coverage is ending.

In such cases, the individual can request a change to the termination date via HICS case. The Issuer would process the HICS ticket and use automated reconciliation to report the changed end date. The Issuer should check the next Pre-Audit File to ensure that the FFM changed the member end date.

The following example illustrates how an Issuer can report this and make the adjustment to FFM data via the reconciliation process:

- Jane and John Doe enroll in coverage on 1/1/2017; on 3/10 they request termination of John's coverage and are given a termination date of 4/30 by the FFM
- John requests termination of coverage effective 3/31 rather than 4/30, which is sent to the Issuer via HICS

As reconciliation business rules accept changes to start dates from Issuers **and** earlier end dates from Issuers, the combination sent here will realign the date of the member termination appropriately.

Member Name	FFM Ben Start Date	Issuer Ben Start Date	Ben Start Date Flag	FFM Ben End Date	Issuer Ben End Date	Ben End Date Flag
Jane Doe	1/1/2017	1/1/2017	M	4/30/2017	3/31/2017	F
John Doe	1/1/2017	1/1/2017	M	4/30/2017	3/31/2017	F
Jane Doe	5/1/2017	4/1/2017	F	12/31/2017	12/31/2017	M

Enrollment Reconciliation Logic

CMS compares Issuer data submitted via RCNI files to FFM data extracted for the Pre-Audit File, matches Issuer records to FFM records, assigns record and field-level flags, conducts statistical validation, and communicates results of statistical validation to the Issuers. Contingent on statistical results, CMS makes updates to the FFM data based on results of Enrollment Reconciliation processing. The entire process, from generation of the Pre-Audit extract to completion of updates to FFM data takes approximately 4 weeks, beginning on the 15th of the month and ending on the 15th of the following month.

Record Matching Logic

The CMS Enrollment Reconciliation algorithms use the following process to match Issuer enrollment records to FFM enrollment records.

- Establish Pairs of Records between FFM and Issuer data using:
 - Demographic matching including last name, date of birth, HIOS ID, and Line of Business, OR
 - Exchange-Assigned Subscriber ID, Exchange-Assigned Member ID, HIOS ID, and Line of Business
 - Line of Business is derived from the 16-character QHP ID
- Execute simple one-to-one matches
 - One-to-one matches occur when only one record for a member exists on the Issuer side and one record exists for the same member on the FFM side
- Resolve complex or uneven-sided matches

- If more than one record for a member is present on one or both sides, the matching algorithm considers other elements, such as Benefit Start Date, QHP ID and Total Premium Amount to find the best match for each record
- If there are an unequal number of records between the FFM and the Issuer file, the matching algorithm will select the best match and the remaining unmatched records will be conveyed as “leftover” records on the RCNO file; uneven matches limit the ability to update records through reconciliation

Record Level Flags

Upon completion of record-level matching (and field-level matching where applicable), a record-level flag will be assigned as follows. The *Field-Level Flags* column indicates whether each field will be compared and a field-level flag set on the RCNO File.

Flag	Description	Field-Level Flags?
M	1:1 Record Match and all fields that are compared match between the Issuer and FFM record; may contain field-level discrepancies flagged ‘D’ – Did Not Compare	Yes
E	Uneven Match with Issuer Action Required to resolve; additionally, one or more field-level discrepancies flagged for Issuer update and one or more fields flagged for FFM update, however due to uneven matching of records within the enrollment group no FFM updates will be applied in this cycle Note: Issuers should review records flagged ‘E’ and ‘P’ and, where possible, align extract logic to match the coverage spans represented on the FFM; this is necessary to ensure proper updates are applied to FFM	Yes
N	1:1 Match with Issuer Action Required; at least one field flagged for Issuer action; one or more fields may also be flagged for FFM update	Yes
P	Uneven Match with Issuer Action Required to resolve; no field-level discrepancies flagged for Issuer update but one or more fields flagged for FFM update, however due to uneven matching of records within the enrollment group no FFM updates will be applied in this cycle Note: Issuers should review records flagged ‘E’ and ‘P’, and, where possible, align extract logic to match the spans represented on the FFM; this is necessary to ensure proper updates are applied to FFM	Yes
Z	1:1 Match with no Issuer Action required; no field-level discrepancies flagged for Issuer update, but one or more fields flagged for FFM update Note: if there is a value in Footnotes (field 144) updates may not be applied on FFM	Yes

Flag	Description	Field-Level Flags?
Q	1:1 Match with Issuer Action Required to resolve; may have one or more fields flagged for Issuer and/or FFM update, however due to data conditions highlighted in the Footnotes field, no FFM updates will be applied in this cycle Note: To resolve, Issuers must update their internal records to reflect the FFM dates on the RCNO File or submit the appropriate dispute(s) to the ER&R Contractor to resolve the data condition blocking the update	Yes
C	Cancellation; the enrollment record has been cancelled in the FFM and/or has been marked for cancellation by the Issuer	No
U	Unprocessable Record with Issuer Action Required to resolve: Significant data issues have caused removal of the record from the matching process; such issues include, but are not limited to, poorly formed date or financial values, or dates in the incorrect plan year	No

Record-level flags listed below indicate lack of a good one-to-one match; a high number of any of these flags may result in statistical validation failure of your Enrollment Reconciliation File.

Flag	Description	Field-Level Flags?
F	Unmatched FFM Enrollment: No matching Issuer record found for this FFM enrollment	No
G	“Leftover” FFM Enrollment: After determining the best match for all records for the individual, one or more FFM records remain that cannot be matched to an Issuer record	No
I	Unmatched Issuer Enrollment: No matching FFM record found for this Issuer enrollment	No
R	“Leftover” Issuer Enrollment: After determining the best match for all records for the individual, one or more Issuer records remain that cannot be matched to an FFM record	No
W	Non-Match – Many to Many: The best match cannot be found for multiple records for the same individual on both the FFM and Issuer side, all records remain unmatched	No
L	Non-Match – Many to One/One to Many: The best match cannot be found for multiple records on either the FFM or Issuer side to a single record on the other side for the same member, all records remain unmatched	No
D	Duplicate Issuer Record (all duplicates flagged with D)	No
S	FFM Data Artifact Due to Financial Eligibility Change (No Issuer Action Required); record is associated with another matched record on the file, but due to a financial eligibility change not conveyed to the Issuer, more spans exist on the FFM side; coverage represented on the S record(s) will be considered in conjunction with any matched records for the same Exchange-Assigned Policy ID when applying updates to FFM Note: this flag applied only from January 2018 to July 2018	No

Flag	Description	Field-Level Flags?
V	Coverage Span to be Cancelled on FFM; record is active on FFM but exists outside the bounds of active coverage submitted by the Issuer on the RCNI file. Note: Although no further Issuer action is required, Issuers are encouraged to review V records to ensure the cancellation of the coverage span is appropriate and not due to a technical problem with the Issuer's extract	No

Field-Level Comparison and Flags

Once a one-to-one match is found for an Issuer and FFM record, a field-level comparison is done to identify discrepancies and determine required updates to FFM and/or Issuer data.

- Field-level matching is done for any record with a Record-Level Flag value of M, E, N, P, Q or Z
 - No other records will have field-level flags assigned
 - Canceled records will have field-level flags of D (did not compare)
- Based on established CMS business rules, field-level discrepancies are assigned a flag to indicate the appropriate action required to resolve the discrepancy

Flag	Definition
M	Exact match, no action
I	Non-match, Issuer to update to FFM value
F	Non-match, FFM to update to Issuer value
L	Non-match, FFM and Issuer to update to value listed in the FFM field based on automated business rule
U	Unprocessable, Issuer to correct file
C	Match due to Change in Circumstance or maintenance transaction, no action
D	Did not compare, no action

Sample field-level comparison results

Initial Premium Paid Status

FFM Initial Premium Paid Status	Issuer Initial Premium Paid Status	Initial Premium Paid Status Flag
N	Y	F

APTC Amount

FFM APTC Amount	Issuer APTC Amount	APTC Amount Flag
830.20	0.00	I

QHP ID

FFM QHP ID	Issuer QHP ID	QHP ID Flag
12345TX001000101	12345TX001000401	I

Field-Level Resolution Rules

The following table provides field-level discrepancy resolution rules applied in Enrollment Reconciliation and reflected in RCNO Files.

Field Name	Business Rule
Initial Premium Paid Status	Subscriber values roll down to dependent members on policy If match, M If Issuer value null for subscriber, U If non-match and: • FFM Subscriber Indicator = N, D • Issuer value = Y and FFM value = N, F • Issuer value = N and FFM value = Y, D • Issuer value = Y and FFM value = C with Cancellation Source 1, 3, or 5, I • Issuer value = Y and FFM value = C with Cancellation Source 2 or 4, F • Issuer value = N, FFM value = C and governing Benefit Start Date over 30 days old, will be translated to C Please Note: Presence of an NLE on the policy may cause CMS to reject a value of Y for Initial Premium Paid Status and set the flag to I
Member Name	If exact match, M If SSA match, M If non-match, D
Member DOB	If match, M If non-match, I If Issuer DOB invalid, U
Member Gender	If match, M If populated by Issuer and non-match, F If Issuer value invalid, U

Field Name	Business Rule
Member SSN	If match, M If non-match and: - FFM is not blank, I - FFM blank or invalid format, D
Subscriber Indicator	If match, M If Issuer value is blank, I If non-match, I If Issuer value not blank and <> Y or N, U
Relationship to Subscriber	If exact match, M If non-match, D
Exchange-Assigned Subscriber ID	If match, M If non-match, I
Exchange-Assigned Member ID	If match, M If non-match, I
Issuer-Assigned Subscriber ID	If match, M If non-match: • And Issuer value valid and ≠ null, F • And Issuer value = null or invalid and Initial Premium Paid Status = Y, U • And Issuer value = null or invalid and Initial Premium Paid Status = N, D *Invalid = non-ASCII characters
Issuer-Assigned Member ID	If match, M If non-match: • And Issuer value valid and ≠ null, F • And Issuer value = null or invalid and Initial Premium Paid Status = Y, U • And Issuer value = null or invalid and Initial Premium Paid Status = N, D *Invalid = non-ASCII characters
Issuer-Assigned Policy ID	If match, M If non-match: • And Issuer value valid and ≠ null, F • And Issuer value = null or invalid and Initial Premium Paid Status = Y, U • And Issuer value = null or invalid and Initial Premium Paid Status = N, D *Invalid = non-ASCII characters
Exchange-Assigned Policy ID	If Match, M If non-match, D

Field Name	Business Rule
Residential Address	If match, M If non-match, D
Residential County Code	If match, M If non-match, D
Rating Area	If match, M If non-match, D
Telephone Number	If match, M If non-match: • and FFM value null or invalid and Issuer populated and valid, D • and FFM value and Issuer value ≠ null, D and Issuer value null and FFM populated with valid value, I
Mailing Address	Flags are applied to all five mailing address fields for subscriber and dependent records: If invalid state code, U If match, M* If Issuer data invalid per RCNI specifications or Issuer blank and FFM populated, D If not flagged U, M, or D per above rules, both Issuer and FFM addresses are submitted to address verification service for confirmation and standardization: • If Issuer address is undeliverable, U • If Issuer standardized address is deliverable and matches FFM standardized address, flagged in following order: ○ If BOTH addresses differ significantly** from the matched standardized address, all mailing address fields flagged L (standardized Issuer mailing address populated in FFM fields on RCNO) ○ If only Issuer address differs significantly from the matched standardized address (FFM address matches standardized address), I ○ If only FFM address differs significantly from the matched standardized address (Issuer address matches standardized address), F ○ If neither address differs significantly from the matched standardized address, M • If Issuer standardized address is deliverable and does not match FFM standardized address, flagged in following order: ○ If Issuer address differs significantly from Issuer standardized address, all mailing address fields flagged L (standardized Issuer mailing address populated in FFM fields on RCNO) ○ In all other cases, F * Match includes if FFM field length exceeds Issuer field length, but common characters match ** “Differing significantly” indicates there is a substantive difference between the standardized address and the original submitted for verification beyond a difference in abbreviation (i.e. Rd vs. Road); a misspelled street name or incorrect ZIP Code would result in a “significant” difference

Field Name	Business Rule
Tobacco Status	If match, M If non-match, F unless special condition below applies If Issuer set tobacco status = Y for member or subscriber <18 at time of extract, I (Issuer to update) If FFM previously set to tobacco status Y for member or subscriber <18 at time of extract, L (Issuer and FFM to update to N) If Issuer does not populate all rows with valid values for this field, ALL ROWS set to D
QHP ID	If Issuer value is null or ≠ 16 characters, U If CSR Variant is 00, U If Issuer value not alphanumeric (i.e., non-ASCII characters), U If match, M If non-match, and FFM Subscriber Indicator = Y, • And FFM value is null and Issuer value is not null and is valid, F • And FFM value is invalid, D • Otherwise, I If non-match, and FFM Subscriber Indicator = N, D
Applied APTC Amount	If match: • If FFM value = 0.00 and Issuer has 0.00 or blank, M • If FFM Subscriber = N and fields match, M If non-match: • and Issuer Null, FFM Not Null, I • and FFM Subscriber = N, D • and FFM Subscriber = Y and the Total Premium Amount flagged as I or M, I • and Total Premium Amount flagged as F: ○ and the FFM APTC is higher than the Issuer Total Premium Amount, F (set to Issuer Total Premium Amount) ○ and both FFM APTC and Issuer APTC are higher than Issuer Total Premium Amount, L (set to Issuer Total Premium Amount) ○ and Issuer APTC <> FFM APTC and FFM APTC equal to or less than Issuer Total Premium, I
CSR Amount	Compare for subscriber only and for CSR variants 02 - 06 Algorithm will recalculate CSR Amount and use this value to determine field flag* If calculated CSR amount matches both FFM and Issuer, M If calculated CSR amount matches FFM and not Issuer, I If calculated CSR amount matches Issuer and not FFM, F If calculated CSR amount matches neither, L * Calculated CSR includes ignoring de minimis difference of ≤\$0.01 from FFM value

Field Name	Business Rule
Individual Member Premium Amount	If match, M If non-match or Issuer sends null, D
Total Premium Amount	Compare for subscriber only If match, M If premium amount = \$0 or null, U If non-match and no special case applies, I If special case applies, F*: • FFM to update if tobacco status changes on adult, and Issuer premium within acceptable range (i.e. 2/3 of FFM Total Premium Amount) • FFM to update if Total Premium Effective Date is flagged F or L • FFM to update if Benefit Start Date is flagged F or L • FFM to update if Stand Alone Dental Plan • FFM to update if subscriber ID = non-subscriber member ID in prior policy, and prior and new policies linked by CiC • FFM to update if within the same Quattro Key and 14-digit QHP, and gap in coverage or cancelled record prior to new initial/effectuated coverage span, and no change to FFM premium between prior record and new record ○ FFM to update if for the same individual and 14-digit QHP, if no change in enrollment group size and no gap in coverage from prior record, and change in FFM premium amount is more in new record than prior record. Issuer's value must be less than new premium amount. • * When a special case applies and there is also a QHP ID discrepancy or a member added, FFM will not update

Field Name	Business Rule
Start Dates	<u>U rules:</u> If any Issuer Financial Start/Effective Date (APTC, CSR, Total Premium) is earlier than Issuer Benefit Start Date, U on Financial and Plan Benefit Dates If Issuer Plan Benefit Start Date later than the corresponding Plan Benefit End Date (i.e. inverted dates), U on entire row If any Issuer Financial Start/Effective Date is later than the corresponding associated/paired End Date (i.e. inverted dates), U on date pair If Issuer Plan Benefit Start Date is for a different benefit year (e.g., 2015 dates on the 2016 file) and all other Financial Effective Dates are null, U (exclude record entirely) Issuer Plan Benefit Start Date is earlier than DOB on each row, U If invalid data, U <u>D rules:</u> If invalid FFM values, D For CSR and APTC, if chosen Financial amounts = null, invalid or 0, set the corresponding Financial Start Date to D If ALL Member Premium Effective dates are null or non-match from Issuer, D If non-subscriber row and FFM value <> Issuer value, D <u>M, I, F, L rules:</u> Plan Benefit Start Date • If Issuer PB Start date = FFM Start date, M • If Issuer PB Start date <> FFM Start date and Issuer PB End date on prior period of coverage is flagged I, I, else F Financial Effective Dates Plan Benefit Start Date is compared to both the FFM Financial Effective Dates and the Issuer Financial Effective Dates: • If Plan Benefit Start Date = Issuer and FFM Financial Effective Dates, M • If Plan Benefit Start Date ≠ Issuer Financial Effective Dates, but = FFM Financial Effective Dates, I • If Plan Benefit Start Date = Issuer Financial Effective Date, but ≠ FFM Financial Effective Date, F • If Plan Benefit Start Date ≠ Issuer and FFM Financial Effective Dates, L ○ When L, the FFM Financial Effective Date will be updated with the chosen Plan Benefit Start Date. <u>C Rules:</u> If Issuer is sending same Plan Benefit Start/End Dates for each date span: Issuer PB Start dates except on row with earliest Financial Effective Dates, C Please Note: Presence of an NLE on the policy may cause CMS to reject date changes that would move the segment dates beyond the boundary of the NLE

Field Name	Business Rule
End Dates	See Start Dates for U and D rules <u>M, F, I, L Rules:</u> Plan Benefit End Dates • If Issuer Plan Benefit End date = FFM End date, M • If Issuer Plan Benefit End date ≠ FFM End date, F (unless I case below applies) ○ If Issuer Plan Benefit End date > FFM End date and Termination Source = 1 (Consumer), 3 (NLE), or 5 (FFM Cleanup), I ○ If Issuer Plan Benefit End date is not contiguous with Issuer Start Date on the subsequent period of coverage, I Financial End Dates Plan Benefit End Date is compared to both the FFM Financial End Date and Issuer Financial End Dates: • If Plan Benefit End Date = Issuer Financial End and FFM Financial End dates, M • If Plan Benefit End Date ≠ Issuer Financial End Date, but = FFM Financial End Date, I • If Plan Benefit End Date = Issuer Financial End Date and ≠ FFM Financial End Date, F • If Plan Benefit End Date ≠ Issuer Financial End Date and ≠ FFM Financial End Date, L ○ When L, the FFM Financial End Date will be updated with the chosen Plan Benefit End Date <u>C Rules:</u> If Issuer is sending same Plan Benefit Start/End Dates for each date span: • Issuer Plan Benefit End dates except on row with latest Financial End Dates, C Please Note: Presence of an NLE on the policy may cause CMS to reject date changes that would move the segment dates beyond the boundary of the NLE
End of Year (EOY) Termination Indicator	If match, M If non-match, D If Issuer EOY Termination Indicator not Y, N or blank, U
Paid Through Date	If match, M If non-match, D
Coverage Year	If match, M If FFM valid and Issuer null, I

Field Name	Business Rule
Agent/Broker Name	If valid* and match (and A/B NPN is valid on either FFM or Issuer), M If valid* and match, but A/B NPN is invalid on both, D If Issuer and FFM values are invalid, D If Issuer invalid, FFM valid but FFM A/B NPN is invalid, D If Issuer valid and ≠ FFM (including FFM invalid), F (unless U case below applies) - If Issuer A/B NPN is invalid, U If Issuer invalid, FFM valid (FFM name and valid A/B NPN), I (unless U case below applies) - If Issuer A/B NPN is valid and unmatched to FFM A/B NPN field, U If non-matched and non-subscriber, D * Field lengths defined in RCNI/RCNO file specifications * Valid values include letters, apostrophes, spaces, and hyphens; non-ASCII characters are not valid * For Middle Initial, only blank or a single alpha character are valid
Agent/Broker NPN	If match, M If Issuer not blank and <> FFM (including FFM blank or invalid), F* Issuer must also send populated and valid Agent/Broker Name field If Issuer blank, and FFM not blank and valid, I If non-matched and FFM Subscriber Indicator = N, D * Field length defined in RCNI/RCNO file specifications
Enrollment Group Size	If match, M If enrollment group size does not match, U IMPORTANT: Issuer enrollment group size is calculated as number of members with the same Issuer-Assigned Policy ID with same Issuer Benefit Start Date
Cancellation Reason Code	All records, D Detailed business rules will be published prior to CMS applying Issuer-submitted reason codes to the FFM
Termination Reason Code	All records, D Detailed business rules will be published prior to CMS applying Issuer-submitted reason codes to the FFM

SSA Matching Rules for Names

CMS applies two kinds of matching for names based on rules established by the Social Security Administration (SSA):

- If the first 7 positions of last name and first and middle initial match, consider the full name as a match. If the middle initial is blank, the first name initial must match; OR
- If the first 4 positions of last name and the first 4 positions of first name match, OR, if only the first initial is entered for first name, the first and middle initials must match.

CMS also accepts matches for some abbreviations of full name where the match value is a substring of full FFM value (ex: Kim is a match for Kimberly in FFM).

Footnotes

In 2018, CMS introduced the Footnotes field to the RCNO File to provide additional information regarding the enrollment record and results of reconciliation. Initially, this field was used to convey that FFM records had been “merged” in reconciliation, via the **#MERGE** tag. See the [Change to Financial Eligibility, No Change to Financials](#) section for additional information on merged records.

Additionally, this field is now used to convey the reason why data elements flagged for FFM update at the field level may not have those updates applied in that cycle.

#GAP

The **#GAP** value in the Footnotes field indicates that applying the update flagged on either the benefit coverage or financial dates on the RCNO record would result in a gap in coverage for that individual that does not already exist on the FFM. As gaps in coverage cannot be created through automated reconciliation, updates will be suppressed for all records associated with that member for that HIOS ID.

FFM Benefit Start Date	Issuer Benefit Start Date	FFM Benefit End Date	Issuer Benefit End Date	FFM Applied APTC	Issuer Applied APTC	Footnotes	Record Flag
1/1/2018	1/1/2018	6/30/2018	6/30/2018	\$550	\$550	#GAP	Z
7/1/2018	8/1/2018	12/31/2018	12/31/2018	\$400	\$400	#GAP	Z

In this example the Issuer is sending a change on the start date of the second coverage span which would create a gap in coverage from 7/1-7/31; due to this potential gap all updates for these records will be suppressed.

#OVERLAP

The **#OVERLAP** value in the Footnotes field indicates that applying the update flagged on the benefit coverage dates will result in overlapping or duplicate coverage for one or more members of the enrollment group on the FFM. This will happen if the Issuer file is requesting an earlier start date or later end date than is reflected on the FFM and coverage already exists with the same HIOS ID or a different HIOS ID that would create a duplicate or overlapping coverage scenario.

QHP ID	FFM Benefit Start Date	Issuer Benefit Start Date	FFM Benefit End Date	Issuer Benefit End Date	Footnotes	Record Flag
12345TX001000101	1/1/2018	1/1/2018	5/31/2018	5/31/2018	#OVERLAP	Z
12345TX004000401	6/1/2018	4/1/2018	12/31/2018	12/31/2018	#OVERLAP	Z

In this example, Issuer 12345 is sending a change on the start date to 4/1 for the second span which would cause an overlap from 4/1-5/31; full field-level updates will be suppressed for this member due to the potential overlap.

#SPANSHORT

The #SPANSHORT value in the Footnotes field indicates that applying the update flagged on either the benefit coverage or financial dates on the RCNO record would result in reducing coverage reflected on the FFM to less than the total coverage submitted by the Issuer on their RCNI file for the member. This scenario typically occurs when the Issuer submits multiple active records for a member where there is only one active on the FFM side, and one of the Issuer's active records is matched to an FFM cancel.

FFM Benefit Start Date	Issuer Benefit Start Date	FTI Start Date Flag	FFM Benefit End Date	Issuer Benefit End Date	FTI End Date Flag	FFM Prm Pd Ind	Issuer Prm Pd Ind	FTI Prm Pd Flag	Footnotes	Record Flag
1/1/2018	1/1/2018	M	12/31/2018	6/30/2018	F	Y	Y	M	#SPANSHORT	Z
7/1/2018	7/1/2018	M	7/1/2018	12/31/2018	D	C	Y	I	#SPANSHORT	C

In this example the Issuer is sending two periods of coverage where the FFM has only one 1/1-12/31; the end date flag on the first record suggests that coverage would be terminated on the FFM effective 6/30 – however as the Issuer is sending coverage for the full year that update will be suppressed to avoid removing a legitimate coverage span.

#NLE

The #NLE value in the Footnotes field is to further emphasize that a reinstatement or extension of an end date cannot be made due to an eligibility issue. Records that have been cancelled or terminated due to NLE where the Issuer provides an end date later than the FFM will be flagged #NLE in the Footnotes field.

Please be aware, the enrollee(s) may no longer be eligible for coverage due to the NLE, in which case the enrollment record will carry a Cancellation or Termination Source and Reason Code corresponding to the NLE. Alternately, the enrollee(s) may no longer be eligible for subsidized coverage due to the NLE, in which case there would likely be a later segment of coverage for the same policy that reflects the removal of the subsidy. As the policy itself was not cancelled or terminated due to the NLE, there will be no Cancellation or Termination Source and Reason Code associated with the NLE.

Tips for Successful Enrollment Reconciliation

Below are tips to successful Enrollment Reconciliation:

- Submit Inbound Reconciliation (RCNI) Files **every month** per the established Recon Calendar on zONE
 - Best practice is to submit a day or two prior to the deadline to ensure successful file transfer via EFT and address any issues identified by FFM front-end validation routines
- Review results of reconciliation as provided in the Outbound Reconciliation (RCNO) Files **every month**
- Review the matching rates of records found within your file
 - Record-Level Flags **M, E, N, P, Z, Q, C** indicate a successful match between Issuer and FFM records
 - Issuers highly proficient at reconciliation typically match at least 90-95% of records
 - Please note that enrollment groups with records flagged **E** or **P** should be reviewed as those indicate an uneven match with “leftover” records on the FFM and/or Issuer side; the uneven match will limit the updates than can be applied to the FFM for these records
 - Record-Level Flags **D, L, W, F, G, I, R, U, V** indicate an unmatched or erroneous record
- Review unmatched records to attempt to resolve mismatches if possible:
 - Unmatched FFM Enrollments (F): Review to determine if records should be added to Issuer enrollment system or are extraneous records that should be cancelled on FFM
 - Unmatched Issuer Enrollments (I): Review to determine if a matching FFM record exists in the file and update identifiers as needed to match to the FFM records; otherwise follow established Unaffiliated Issuer Record (UIR) guidance
 - Unmatched One:Many, Many:Many (L & W): Review to determine if extract process is creating the appropriate number of records to match FFM records and ensure that each record covers a distinct financial timespan
 - Duplicate Records (D): Review extract process to eliminate duplicate records
 - Unprocessable Records (U): Review to address data issues identified in the record that prevent processing
 - Leftover FFM Enrollments (G): Ensure that all coverage spans on FFM are reflected in Issuer data (or cancelled)
 - Leftover Issuer Enrollments (R): Ensure that Issuer records cover same total coverage spans reflected in FFM data
 - Review V records active on the FFM to ensure there was no active coverage for that span on the Issuer side that was not reflected on the RCNI File
 - Review Q records to determine the appropriate action to take to resolve, based upon the information provided in the Footnotes field

Statistical Analysis

Following each Enrollment Reconciliation processing cycle, CMS compiles and reviews statistics for all Issuers regarding record-level and field-level matching.

- These metrics are compared against established statistical baselines to identify outliers
- To avoid potentially updating the FFM data store with inaccurate data, certain updates may be “suppressed” based on the results of this statistical analysis
 - Any issues identified will be communicated to the designated Issuer technical contacts following distribution of the outbound files
- Issues identified in statistical analysis may require changes to an Issuer’s file creation process to ensure submission of accurate data; other issues may be resolved through verification of accuracy by the Issuer or discrepancy resolution through the ER&R Contractor

Preliminary analysis focuses on **record-level match rates** to ensure processing of the RCNI file resulted in a sufficient level of record matching to provide valid results.

Following analysis of record-level matching, a review of **field-level flag metrics** is completed to identify any unusual discrepancy rates on various elements.

- Extremely high discrepancy rates typically indicate an issue in the file extract process; Issuers will be asked to correct their extract prior to the next cycle
- In other cases, Issuers may be asked to review unusually high discrepancy rates and verify their accuracy in order to have the updates applied to the FFM

Common Field-Level Matching Issues

Common issues identified in field-level matching include:

- High rate of date mismatches caused by sending “paid through” dates rather than true coverage end dates
- QHP ID mismatches caused by mapping issues
- High rate of end date mismatches due to a high rate of terminations (Issuer to verify termination rate to resolve issue)

FFM Updates Based on Results of Statistical Analysis

The table below summarizes updates that may be made to FFM based on results of statistical analysis.

FFM Updates Based on Statistical Analysis

Updates Applied to the FFM Data Store	Issuer Inclusion Criteria (by HIOS ID)	Rules
Cancellations	HIOS ID must be within threshold for cancellation rate <i>or verify accuracy of cancellation rate above threshold</i>	Matched records submitted with Initial Premium Paid Status = C will be cancelled in the FFM; certain exceptions for cancellations of previously effectuated policies
Field-level updates on even-sided matched records	HIOS ID must fully pass statistical validation; no outstanding discrepancy rates identified <i>or accuracy of any outstanding rates verified</i>	Refer to the Field-Level Resolution Rules section for specific fields that are reconciled and updated in the FFM

Communication of Results of Statistical Validation

Following statistical analysis, and in conjunction with distribution of RCNO files to Issuers, messaging will be sent to Issuers indicating the success or suppression status of each HIOS ID.

This is followed by emails with details of all issues preventing full updates being applied to FFM for Issuers not fully successful in statistical validation.

Preliminary analysis focuses on record-level match rates to ensure processing of the RCNI file resulted in a sufficient level of record matching to provide valid results.

Sample record level statistics

HIOS ID	Issuer Name	LOB	Total	1:1 Matches + Cancels		Total Unmatched Issuer Enrollments: I+R		Total Unmatched FFM Enrollments: F+G		One-to-Many/ Many-to-Many: L + W		Unprocessable: U		Total Issuer Cancels		New Cancels: Issuer C <> FFM C	
				MEDIAN		MEDIAN		MEDIAN		MEDIAN		MEDIAN		MEDIAN		MEDIAN	
				93.7%		0.6%		3.4%		0.0%		0.0%		N/A		N/A	
HIOS ID	Issuer Name	LOB	Total	% of Total Records		% of Total Records		% of Total Records		% of Total Records		% of Total Records		% of Total Records		% of Total Records	
				Current Run	Prior Run	Current Run	Prior Run	Current Run	Prior Run	Current Run	Prior Run	Current Run	Prior Run	Current Run	Prior Run	Current Run	Prior Run
90000	ABC Insurance Co.	Dul	14,327	76.2%	72.0%	0.7%	4.5%	23%	23%	0.2%	0.0%	0.0%	0.0%	24.6%	0.0%	3.4%	2.2%

- **1:1 Matches + Cancels (M, E, N, P, Z, Q, C)** – This indicates the total percentage of “good matches” within the file; anything under 85% will cause full updates to be suppressed and high-matching Issuers are typically well above 90%
- **Unmatched Issuer Enrollments (I, R)** – A high rate of Unmatched Issuer Enrollments may be due to one of the following issues:

- Missing or incorrect Exchange-Assigned IDs; records without a valid Exchange-Assigned Member ID and Subscriber ID often result in an Unmatched Issuer Enrollment (**I**) record – this will also result in a corresponding Unmatched FFM Enrollment (**F**) for the unmatched record on the FFM side
- Multiple contiguous records for the same member without a change in QHP ID, financials or enrollment group; if the Issuer submits multiple records for the same member and one (or more) is matched, the others will become Leftover Unmatched Issuer Enrollments (**R**)
- High-matching Issuers typically have **less than 0.5%** total Unmatched Issuer Enrollments
- **Unmatched FFM Enrollments (F, G)** – A high rate of Unmatched FFM Enrollments indicates the Issuer may not be accounting for the full enrollment population sent by the FFM, or may not be reflecting changes to coverage or financials in their file submission
 - High-matching Issuers typically have **4%** or less Unmatched FFM Enrollments
- **One-to-Many/Many-to-Many (L, W)** – A high rate of unmatched one-to-many or many-to-many records indicates that Issuer file may have multiple records for a single member that are indistinguishable
 - High-matching Issuers typically have **less than 0.5%** unmatched one-to-many or many-to-many records.
- **Unprocessable (U)** – Unprocessable records are those with significant data anomalies that prevent processing of the record; this may be due to prior or future year financial dates, invalid characters in date or numeric fields, or dates that are not properly aligned (ex. Total Premium End Date greater than Benefit End Date)
 - High-matching Issuers will have a minimal number of unprocessable records
- **Total Issuer Cancells (C)** – the total volume of cancellations in the Issuer file
- **New Cancells (C)** - the volume of cancellations submitted by the Issuer that are not matched to a cancelled record on the FFM

Following analysis of record-level matching, a review of field-level flag metrics is completed to identify any unusual discrepancy rates on various elements.

Samples of field level metrics

- QHP Identifier (1.0% vs a median of 0.23%); **similar to prior run and a primary reason your file failed statistical validation.**
 - Please ensure the entire 16-character QHP ID, including CSR Variant, is being conveyed correctly in your file. If you believe you have the correct QHP ID and FFM needs to be updated, please send to the ER&R contractor using the Dispute Resolution form available on zONE.
- Benefit end date requiring FFM to update (25.24% vs a median of 5.56%); **new issue this run and a primary reason your file failed statistical validation.**
- Total Premium Effective Date requiring FFM to update (8.19% vs a median of 0.65%); **new issue this run and a primary reason your file failed statistical validation.**
- Total Premium End Date requiring FFM to update (25.24% vs a median of 5.84%); **new issue this run and a primary reason your file failed statistical validation.**
 - Extremely high discrepancy rates typically indicate an issue in the file extract process; Issuers will be asked to correct their extract prior to the next cycle
 - In other cases, Issuers may be asked to review unusually high discrepancy rates and verify their accuracy in order to have the updates applied to the FFM

RCNO Files

The RCNO echoes back the information submitted by the Issuer on the inbound RCNI file, plus:

- Record-level flags (FTI Issuer Overall Record Flag) to show the results of record and field-level matching (where applicable)
- FFM values used in comparison with Issuer values where records were successfully matched
- Field-level flags to show matching results and discrepancy resolution actions (on records that were successfully matched only)
- FFM administrative fields

File Naming Convention

RCNO files have the following naming convention: *TPID.RCNOY.DYYMMDD.THHMMSSmmm.P.OUT*, where:

- *TPID* – Trading Partner Identifier
- *RCNOY* – function code and 1-digit year*
- *DYYMMDD* – date with 2-digit year, month, and day
- *THHMMSSmmm* – timestamp with 2-digit hour, minutes, seconds, and 3-digit milliseconds
- *P* – environment (P = Production)
- *OUT* – outbound from FFM to Issuer

*Prior to 2018, the function code contained a 2-digit year, *RCNOYY* (i.e., RCNO17)

File Format

RCNO files are in pipe-delimited format, which can be imported to Excel.

The file specification for the Outbound Enrollment Reconciliation (RCNO) File is available on zONE.

See [Appendix A](#) for the link to the document.

File Structure and Row Attributes

FFM values and field-level flags are included only on records successfully matched; these will have a record-level flag of M, E, N, P, Q or Z.

For each enrollment data field submitted by the Issuer, the following three fields will be returned on the RCNO file:

- FFM [Field Name]
 - The FFM value for the field or the correct value as determined by application of business rules
- Issuer [Field Name]
 - The Issuer value as submitted on the RCNI file
- FTI [Field Name] Flag
 - The field-level flag indicating if the values match and providing resolution rules for those that do not
 - 'FTI' stands for FFM-to-Issuer

FFM Administrative Fields (a few commonly used fields are listed below)

- FFM Internal Inventory Record Number
 - Unique record identifier for each record in the RCNO file; can be used to identify a specific record requiring research/resolution
- Footnotes
 - Provides additional information regarding the record; may highlight data conditions that will prevent updates from being made to the FFM
- FTI Internal Batch ID
 - Identifies the specific reconciliation run in which the file was processed
- Enrollment Group Size
 - Shows the enrollment group size associated with the benefit coverage as calculated by the reconciliation process
 - For the FFM, the size is determined by the number of individual members with the same Exchange-Assigned Policy ID and start date
 - For the Issuer, the size is determined by the number of individual members with the same Issuer-Assigned Policy ID and start date
 - A mismatch identified in enrollment group size will limit the updates that can be made through automated reconciliation

ER&R (Enrollment Resolution and Reconciliation) Contractor

The Issuers' priority should be to submit quality data through the automated reconciliation process. ER&R should not be used to bypass reconciliation process for Issuers that have updates suppressed in the automated process due to data issues. However, for enrollment data discrepancies that cannot be resolved through the automated reconciliation process, Issuers should submit either an enrollment dispute or a payment dispute.

CMS will work with ER&R to review high volume dispute submissions to ensure they should be resolved through ER&R.

Enrollment Dispute Process

Issuers may submit an enrollment dispute to ER&R using the Dispute Resolution template available on zONE. See [Appendix A](#) for a link to the document.

- Instruction for completing and submitting the form are included in the first tab in the form
- Email address and telephone number for the ER&R Support Center are included in the instructions in the form if the Issuer has questions or needs help submitting a dispute
- Some types of Enrollment Disputes require HICS cases. Some types of HICS cases can be assigned directly to ER&R without having to fill out the form. For more information about submitting HICS cases directly to ER&R, Issuers should consult the HICS Direct Dispute Master Guidance on zONE

FFM Updates via ER&R Dispute Process

The following is a high-level overview of the dispute resolution process with the ER&R Contractor:

- Issuer submits Dispute Resolution form to ER&R following instructions in the form
- On the 1st and 16th of each month (or the following business day), ER&R will send Issuers that have submitted dispute forms a detailed report of the disputes that have been successfully resolved, the rejected disputes with codes as to why the update was unsuccessful, the disputes still being worked, and the disputes that have had their status changed since the previous report
- ER&R will update the FFM based on disputes processed successfully; ER&R submits all updates simultaneously to the FFM once a month to be coordinated with the monthly reconciliation process
- These updates will be included in the Pre-Audit File so Issuers can determine whether the update was included in that run or not
- It may take more than one cycle for the updates to be applied to the FFM from the time you are notified by ER&R that the dispute is closed

ER&R Contacts

The Marketplace 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 requests 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

Appendices

A. Reference Materials on CMS zONE

NOTE: zONE users will need to enter their user name and password. You may need to copy and paste the link into your browser once you are logged into zONE.

Reference Materials on CMS zONE

zONE Page	URL	Documents Available
Enrollment Reconciliation	https://zone.cms.gov/document/enrollment-data-reconciliation	• Enrollment Pre-Audit File Specifications • Inbound Enrollment Reconciliation File Specifications • Outbound Enrollment Reconciliation File Specifications • Standard Issuer Enrollment Data Files Document • Enrollment Reconciliation Education Suite
ER&R	https://zone.cms.gov/document/enrollment-resolution-and-reconciliation	• ER&R Dispute Resolution Templates
Pre-Audit & Reconciliation Calendar	https://zone.cms.gov/document/pre-audit-and-recon-calendar-and-file-specification	• Enrollment Pre-Audit & Reconciliation Operational Calendar • Enrollment Pre-Audit & Monthly Incremental Pre-Audit File Cadence Document
Inbound 834	https://zone.cms.gov/document/inbound-834	• Training and Reference materials related to IC834 transactions

If you have questions on Enrollment Reconciliation, please send them to the Help Desk (cms_feps@cms.hhs.gov) with the subject line “RECONCILIATION – QUESTION”

B. Checklist for Successful Reconciliation Data Submission

Below is a brief checklist of items to help ensure a successful reconciliation data submission.

Check for:	To avoid:
Correct filename including TPID and "RCNIY"	EFT failure
RNCIY includes 01 and 02 Records within the file	File-level validation failure
Both 01 and 02 records in the file and at least one 02 record per HIOS ID; 02 count/sums match 01 records	File-level validation failure
Correct HIOS ID, matches first five digits of QHPID	File-level validation failure
Records are terminated by Carriage Return Line Feed	File-level validation failure
Financial start/end dates are in reporting year only and financial start is not earlier than benefit start	'U' flag
All Exchange-Assigned Subscriber/Member IDs are correctly populated	Unmatched FFM and Issuer enrollments, or failure at file-level validation if not 10-digit numeric (incl. leading zeroes)
Only records that are intended to be <u>cancelled</u> have Initial Premium Paid indicator = C	Flagged for high cancellation rate and cancels not applied to FFM

C. Overall Best Practices

Below are some best practices to help ensure a success reconciliation data submission.

- Submit inbound Reconciliation Files (RCNI) early!
 - Deadlines are typically on Thursdays at 3PM ET
 - Issuers who wait until the last minute will not have sufficient time to resubmit to correct for validation errors (EFT or file-level)
 - Confirm successful transmission of your files
 - Check your outbound error folder for error messages
- Review Enrollment Reconciliation operational calendar posted on CMS zONE
- Be prepared to respond to CMS request to verify cancellation rates outside of statistical thresholds
 - Issuers must confirm they are submitting Initial Premium Paid Status = C for cancellations, not terminations that should have Initial Premium Paid Status = Y
- Reach out to Issuer outreach team for assistance understanding record-or field-level matching problems or to request testing opportunities; email CMS_FEPS@cms.hhs.gov with "Reconciliation Question" in the subject line
- Review outbound Reconciliation Files (RCNO) to determine data that should be updated in Issuer system, especially Exchange-assigned identification numbers

D. Key Terms and Acronyms

Selection of Key Terms and Acronyms

APTC	Advance Premium Tax Credit
AUDY	Function Code for Enrollment Pre-Audit Files
CSR	Cost-Sharing Reduction
ER&R Contractor	CMS Enrollment Resolution & Reconciliation Contractor
FFM	Federally-Facilitated Marketplace
LOB	Line of Business – type of coverage offered by an Issuer under a particular HIOS ID; may be QHP (Health), SADP (Dental), or Dual (both Health and Dental)
MISC	Function Code for miscellaneous files distributed via EFT
QHP	Qualified Health Plan
RCNIY	Function Code for Inbound (Issuer-to-FFM) Enrollment Reconciliation Files
RCNOY	Function Code for Outbound (FFM-to-Issuer) Enrollment Reconciliation Files
SADP	Stand-Alone Dental Plan

E. Handling Personally Identifiable Information (PII)

When communicating Enrollment Reconciliation issues with CMS, make sure you maintain compliance with HIPAA Privacy Act and CMS requirements for handling personally Identifiable Information (PII). The information below has been in effect for all FFM Issuers since June 18, 2014. The information below also applies to emails to any CMS or CMS contractor support staff.

- Acceptable Data in Help Desk Tickets:
 - Issuers can send Application ID or Exchange-Assigned Policy ID in the body of an e-mail to CMS_FEPS@cms.hhs.gov so long as it does not include any other PII (such as consumer's name, etc.) Otherwise, please follow the below procedures:
- Procedures for Issuers Sending PII via Standard E-mail:
 - Embed the PII in an encrypted attachment requiring a password
 - Input the subject line "Encrypted File – [MMdd-hhmm]"
 - Follow-up with a second e-mail containing password, using the same subject line.

Examples:

- This morning, at 11:07 a.m. Jane Doe sends first e-mail to MSD with subject line "Encrypted File – 0617-1107" with encrypted file and follows-up with a second e-mail containing the pw, using the same subject line
- Later this afternoon, around 3:10 p.m. Jane sends second e-mail to MSD with subject line "Encrypted File – 0617-1510" with encrypted file and follows-up with a second e-mail containing the pw, using the same subject line
- Issuers must not write "password" or "pw" in the subject line of the e-mail containing the password (i.e. simply repeat the subject line of the initial e-mail)
- **Note on Secure E-mail:** If your organization requires you to send e-mails via Secure, third-party e-mail service that already requires a password for the recipient to access, you do not need to add a separate encrypted attachment. (Otherwise please use the same procedures above for sending passwords via separate e-mail.)
 - If your Secure Email Provider does not allow sending an email using your individual email address, please make sure to include your individual email address along with your other identifying information (e.g. phone number, HIOS Issuer ID, company name, State) within the email.
 - If our teams encounter problems obtaining the required password to open your secure e-mail, we may need to work with you to obtain the information by other means (such as by having a Tier 2 entity contact you directly.)
- **Request on Sending Separate E-mails for Separate Issues:** Please do not combine separate, unrelated issues into the same Help Desk e-mail/ticket; doing so will slow down the response times as different issues are typically routed to different teams for proper troubleshooting and tracked separately.