

Recon 101:

Enrollment Reconciliation Fundamentals



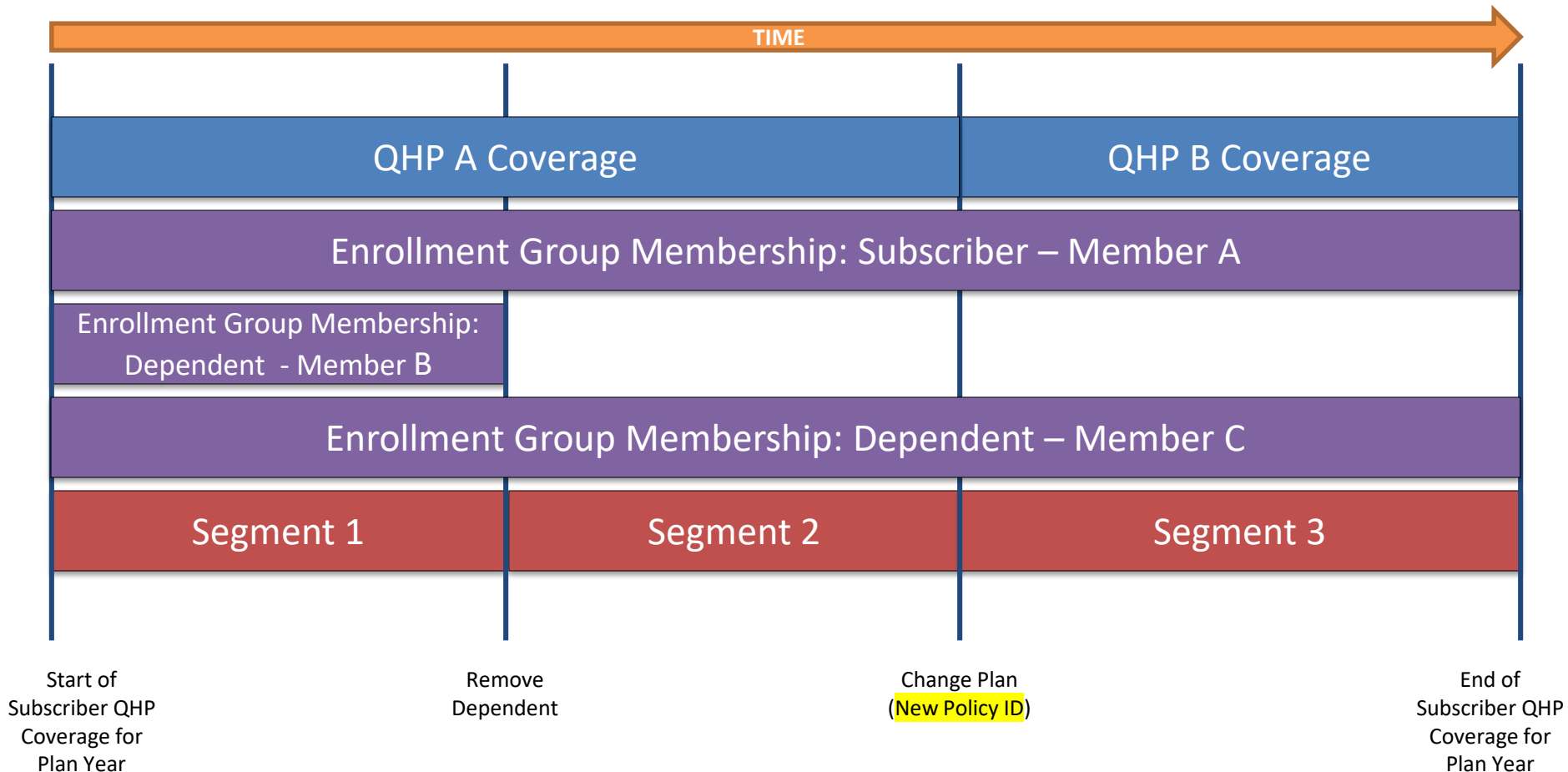
- ✓ *FFM Enrollment Data*
- ✓ *Pre-Audit Overview*
- ✓ *Reconciliation Concepts*
- ✓ *Process Overview*
- ✓ *Inbound Files*
- ✓ *Samples*
- ✓ *Reference Materials & Support*

September 25, 2019

FFM Enrollment Data Structure

- 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**
- 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

Example 2020 QHP Policy w/Changes Throughout the Year



Policy and Segment Relationship

Application 12345

Policy 123

Subscriber: Member A

QHP ID: 12345TX0010001

Status: Active/Effectuated

Policy 145

Subscriber: Member A

QHP ID: 12345TX0020005

Status: Active/Effectuated

Segment 234

Start Date: 1/1/2020

End Date: 3/31/2020

CSR Variant: 01

Total Premium Amount:
\$1200

APTC Amount: \$800

Dependent B

Dependent C

Segment 345

Start Date: 4/1/2020

End Date: 7/31/2020

CSR Variant: 01

Total Premium Amount:
\$900

APTC Amount: \$700

Dependent C

Segment 456

Start Date: 8/1/2020

End Date: 12/31/2020

CSR Variant: 01

Total Premium Amount:
\$1100

APTC Amount: \$850

Dependent C

When is a New Policy Created?

- The FFM will create a new policy any time one of the following is updated:
 - Subscriber
 - 14-Character QHP ID
 - Tobacco Status
- **Rule of Thumb:** If a change is conveyed by a CIC Cancel/Term + Initial transaction pair, a new policy has been created
- A new policy is also created any time there is a gap in coverage for the enrollment group

When is a New Segment Created?

- 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
 - Member demographics related to eligibility/rating
- **Rule of Thumb:** If a change is conveyed by a M834 with a new effective date, a new segment has been created
- **Please Note:** 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 (no change in Segment ID)

Overview of Enrollment Pre-Audit

- The Enrollment Pre-Audit process is designed to provide Issuers with a comprehensive view of enrollment data from the FFM perspective
- CMS will produce and distribute these files on a monthly basis throughout Plan Year 2019
- The Pre-Audit file ***is not*** in the EDI 834 format; it is a **pipe-delimited flat file**
- All Pre-Audit Files are year-specific; Pre-Audit Files for 2019 will only contain data pertaining to enrollments effective 1/1/2019 – 12/31/2019
 - This includes effectuated, uneffectuated, terminated and cancelled enrollment records

CMS Activities: Enrollment Pre-Audit File

- As part of each iteration of the Enrollment Pre-Audit, CMS will:
 - Extract all enrollment records for the plan year from the FFM policy folder
 - This extract is done in alignment with the extract supporting the payment process and occurs on the 15th of each month at 6PM ET
 - Confirm correct file format and contents
 - Aggregate enrollment records by Trading Partner ID
 - Distribute files to Issuers via EFT
 - Issuers will receive these files in the same manner that EDI 834 traffic is received
 - 2020 Enrollment Pre-Audit Files will be identified by the function code **AUD0** in the filename (e.g. [TPID].**AUD0**.D181115.T010000000.P.OUT)

Supplemental Information on the Pre-Audit File

- ***Missing Outbound 834 Indicator***

- FFM processes capture any enrollment transactions that do not successfully convey to the Issuer via 834 due to a technical issue
 - Typically there is a very low volume of missing outbound 834s each month
- The **Missing Outbound 834 Indicator** identifies any records in the Pre-Audit File where a related transaction failed to convey since the last Pre-Audit File received by Issuers
- Issuers should carefully review these enrollment records in the Pre-Audit File and ensure that:
 - For a new initial enrollment, the enrollment group is loaded into the Issuer's system and appropriate new member outreach performed
 - For a cancellation, the affected policy is cancelled in the Issuer's system
 - For a termination, the affected policy is 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 is made to the enrollment in the Issuer's system

Supplementing the Pre-Audit File During OE

- ***Missing Outbound 834 Incremental Pre-Audit (MOIPA0) File***
 - ***Delivered Periodically During Open Enrollment only***
 - During Open Enrollment, CMS will periodically send a special Missing Outbound 834 IPA File distinct from distribution of a full Enrollment Pre-Audit File
 - This MOIPA0 File will contain the full Pre-Audit information for all enrollments with related transactions that failed to successfully convey to the Issuer via 834 during the period covered by the file
 - Upon receipt of the MOIPA0 File, Issuers should ensure that:
 - For a new initial enrollment, the enrollment group is loaded into the Issuer's system and appropriate new member outreach performed
 - For a cancellation, the affected policy is cancelled in the Issuer's system
 - For a maintenance transaction, the appropriate update is made to the enrollment in the Issuer's system

Supplemental Information on the Pre-Audit File

- ***Retransmitted Outbound 834 Indicator***
 - On occasion, when 834s fail to convey initially to Issuers, CMS is able to regenerate the 834s
 - In these cases, the transactions will be sent on a special I834RT File to distinguish them from the standard daily 834 traffic
 - The **Retransmitted Outbound 834 Indicator** identifies any records in the Pre-Audit File where a related transaction was sent on an I834RT File since the last Pre-Audit File received by Issuers
 - Issuers should carefully review these enrollment records in the Pre-Audit File and verify that they have applied the appropriate updates based on the retransmitted transaction:
 - For a new initial enrollment, the enrollment group is loaded into the Issuer's system and appropriate new member outreach performed
 - For a cancellation, the affected policy is cancelled in the Issuer's system
 - For a termination, the affected policy is 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 is made to the enrollment in the Issuer's system

Supplemental Information on the Pre-Audit File

- ***Overlaps Cleanup Indicator***

- In cases where a consumer uses multiple accounts that are not detected as duplicative and prevented by the FFM, new enrollment activity will not result in the appropriate cancellation or termination of any prior enrollments
- Each month, prior to generation of the Pre-Audit File, CMS applies ***cancellations or terminations*** to records that have overlapping or duplicate coverage for the same member
 - In these cases, the most recent enrollment action by the member would be kept active, and the cancellation or termination applied to records associated with any earlier activity
 - Is it important to understand that the overlapping or duplicate coverage may be with another Issuer

Supplemental Information on the Pre-Audit File

- **Overlaps Cleanup Indicator**

- The Overlaps Indicator identifies records in the Pre-Audit File that have been terminated or cancelled via this process since the last Pre-Audit File
 - The Overlaps Indicator will also show whether the conflicting coverage is within the same HIOS ID or with a different HIOS ID
 - Value **1** = Overlap corrected in same HIOS ID
 - Value **2** = Overlap corrected due to coverage in a different HIOS ID
 - Value **3** = Overlap corrected in same HIOS ID with loss of coverage
 - Value **4** = Overlap corrected due to coverage in a different HIOS ID with loss of coverage
 - For additional details on the Overlaps Cleanup, please refer to the Enrollment Reconciliation Education Suite, available on zONE at:
<https://zone.cms.gov/document/enrollment-data-reconciliation>

Supplemental Information on the Pre-Audit File

- **Overlaps Cleanup Indicator**

- For records marked with an Overlaps Cleanup Indicator, Issuers should:
 - **For Cancellations**, if the duplicate coverage is within the same HIOS ID, the Issuer should have another enrollment transaction (with a different Exchange-Assigned Policy ID) for the same member resulting in some period of active coverage
 - If such a record exists, that coverage should not be impacted by the cancellation of the duplicate enrollment record
 - If no such record exists or the duplicate coverage is with another carrier, coverage for the member should be cancelled
 - **For Terminations**, if the overlapping coverage is within the same HIOS ID, the Issuer should ensure that the coverage reflected in their system aligns to the configuration reflected in the Pre-Audit File
 - If the overlapping coverage is with another carrier, coverage should be terminated in alignment with the end date reflected in the Pre-Audit File

Supplemental Information on the Pre-Audit File

- ***DOB Cleanup Indicator***

- In cases where a consumer returns to the FFM to correct their Date of Birth, the FFM applies the change prospectively and an 834 is sent to the Issuer informing them of the change along with any financial changes due to the change in DOB or any other changes made during the update
 - The updated consumer DOB is **not** applied to prior segments or policies for that individual automatically
- Each month, prior to generation of the Pre-Audit File, CMS applies a cleanup to roll back the DOB changes to any earlier policies and/or segments **on the same application**
 - If necessary, this cleanup process will also adjust the Total Premium Amount if the change alters the consumer's age rating
 - Applied APTC will only be adjusted if for the new Total Premium Amount the current Applied APTC exceeds the Total EHB Premium; in those cases the Applied APTC will be reduced to align to 100% of the Total EHB Premium

Supplemental Information on the Pre-Audit File

- **DOB Cleanup Indicator**

- CMS will communicate the changes applied by the cleanup on the Pre-Audit File, and flag the impacted record(s) with a value in the DOB Cleanup Indicator field
- There are three potential values for the DOB Cleanup Indicator
 - 1 – Enrollment Impacted by DOB Cleanup; Change to DOB for one or more members of enrollment group
 - 2 – Change to DOB and rerating for one or more members of enrollment group
 - 3 – Change to DOB for one or more members of enrollment group applied retroactively by collapsing segments
- For additional details on the DOB Cleanup, please refer to the Enrollment Reconciliation Education Suite, available on zONE at:
<https://zone.cms.gov/document/enrollment-data-reconciliation>

Supplemental Information on the Pre-Audit File

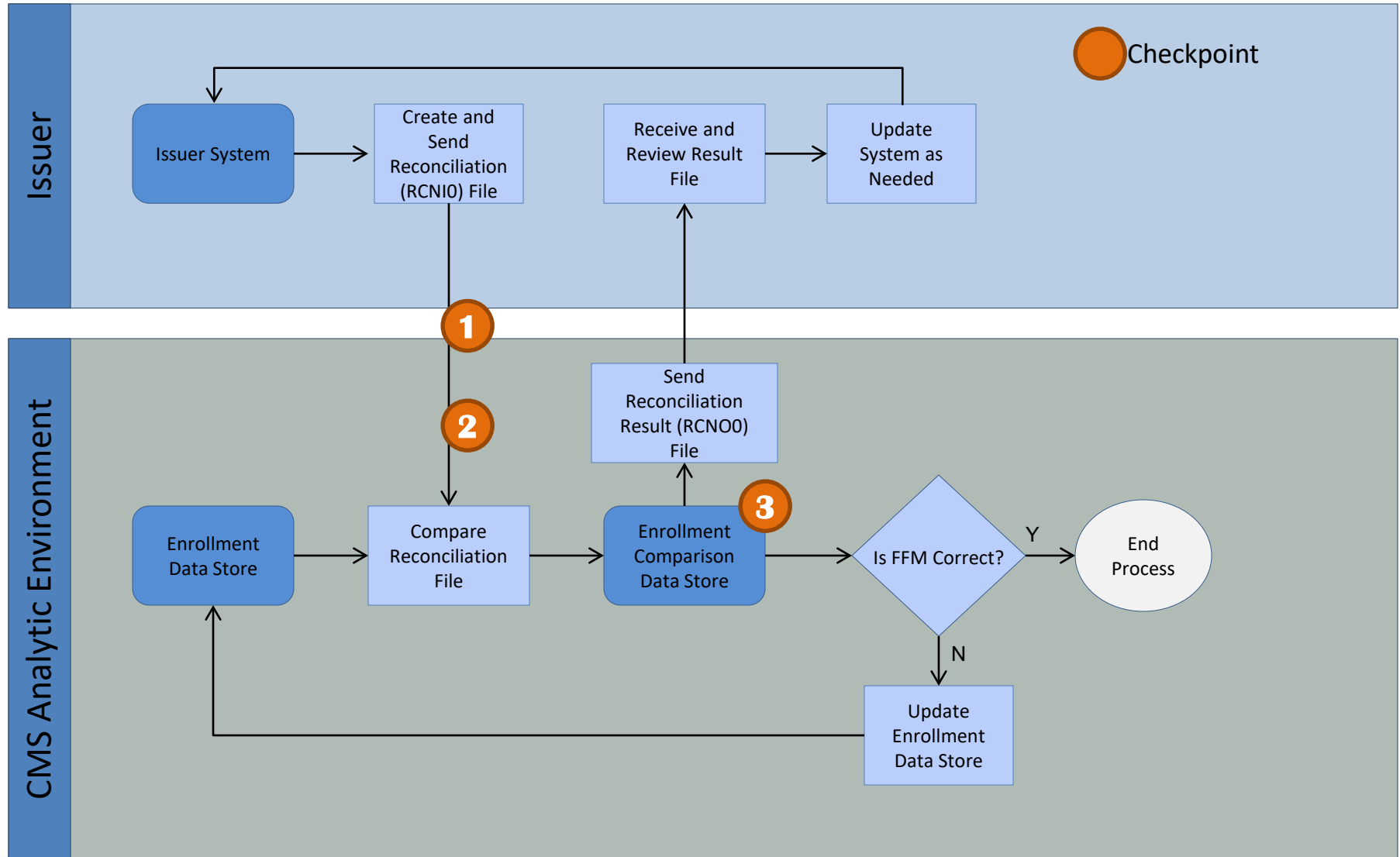
- ***New Policy ID Indicator***

- In very limited circumstances, 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 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 are flagged on the Pre-Audit File in the New Policy ID Indicator field with one of the following values:
 - 1 – New Policy ID and new Segment ID generated
 - 2 – New Segment ID only generated
 - 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

Enrollment Reconciliation Concepts

- To ensure consistency between FFM and Issuer enrollment data throughout Plan Year 2020, CMS plans to initiate monthly reconciliation of 2020 enrollment data in December 2020
- Per regulatory requirement, Issuers must reconcile enrollment data with CMS ***on a monthly basis***
- Issuers will submit an Inbound Enrollment Reconciliation (RCNIO) file for each Trading Partner ID during each monthly cycle
 - Issuer organizations with multiple HIOS IDs under the same Trading Partner ID may submit individual files for each HIOS ID, or one file containing all HIOS IDs for that Trading Partner ID
- CMS will perform an initial validation on the Issuer file, match Issuer enrollment records to FFM records, and compare on a field-by-field basis for matched records
 - Results of matching and field-by-field comparison are sent to Issuers via the outbound Reconciliation (RCNOO) File

High-Level Reconciliation Approach



Key Data Elements

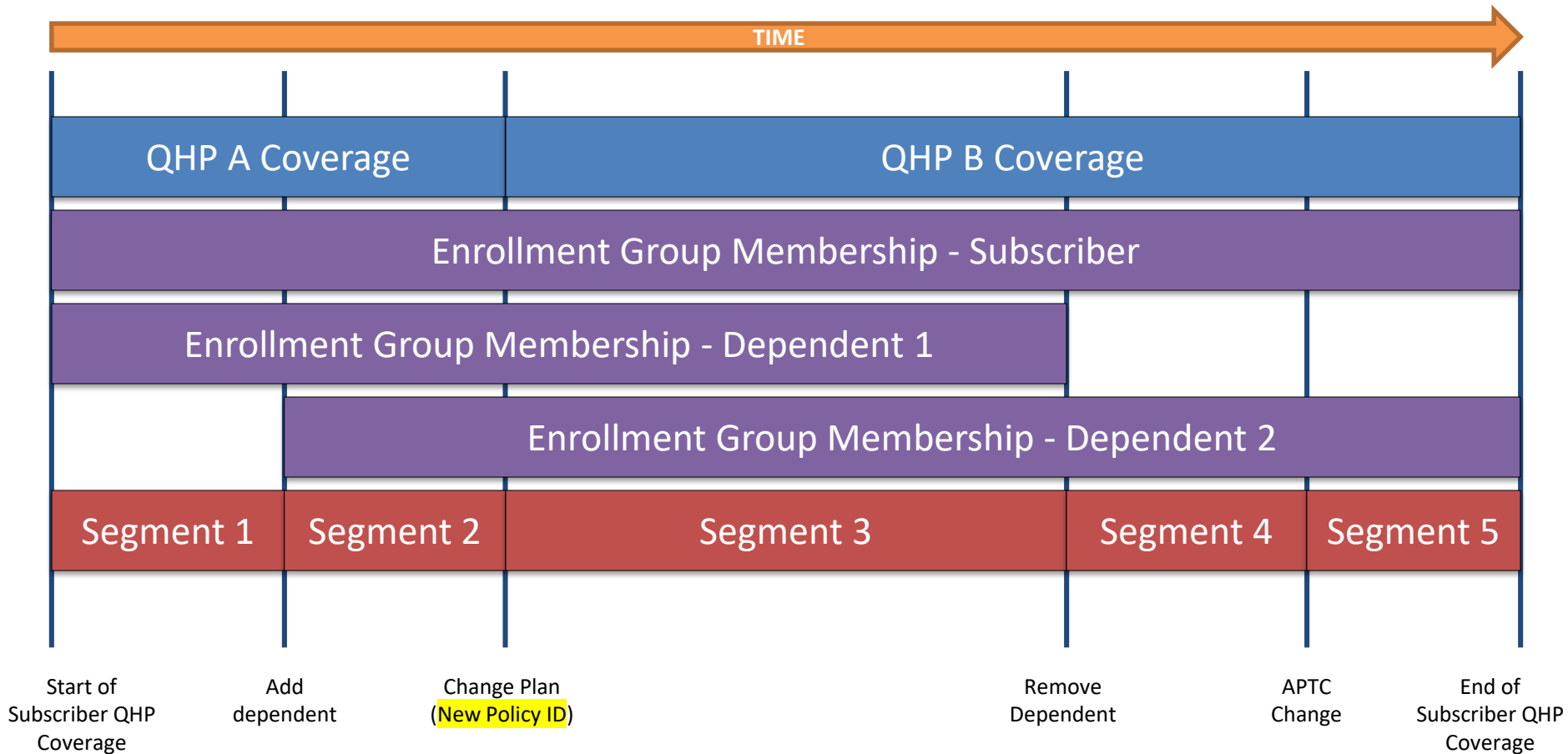
Member Attributes	Coverage Attributes	Financial Attributes
First Name	QHP ID	Tobacco Status
Last Name	Benefit Start Date	Applied APTC Amount
DOB	Benefit End Date	APTC Effective / End Dates
Gender	Effectuation Status	CSR Advance Payment Amount
SSN	Exchange-Assigned Policy ID	CSR Effective / End Dates
Subscriber Indicator	Exchange-Assigned Subscriber ID	Total Premium Amount
Residential Address	Exchange-Assigned Member ID	Total Premium Effective / End Dates
Mailing Address	Issuer-Assigned Policy ID	
	Issuer-Assigned Subscriber ID	
	Issuer-Assigned Member ID	
	Agent/Broker Information	
	Cancellation/Termination Reason*	

* Cancellation Reason and Termination Reason were added to reconciliation in August 2019

Enrollment Data Reconciliation Approach

- Many source systems for Issuer enrollment data
 - There are a wide variety of Issuer system database designs across 100+ Issuer organizations
- One target format for the Issuer Reconciliation file
 - CMS will centrally consume the files from each Issuer to compare and reconcile enrollment data
 - File Function Code: **RCN10**
- In the RCN10 file, various attributes of the enrollment information must be effective/end dated
 - Visual example follows...

Example 2020 QHP Policy w/Changes Throughout the Year



Historical and Non-Historical Data Rules

- Historical values are provided only for fields that have related effective dates, i.e., all financial values plus QHP ID, which is associated with the Benefit Start and Benefit End Dates
- ***Files that do not adhere to these rules will not process correctly in reconciliation, and CMS will be unable to apply updates to the FFM based on the results***
- All records (subscriber or dependent) must contain a QHP ID and Benefit Start/End Dates
 - Any member that changes QHP ID during the year must have multiple records in the file, with distinct Benefit Start and End Dates corresponding to the dates in which they were enrolled in each QHP ID

Historical and Non-Historical Data Rules

- Subscriber records carry all financial values: Total Premium, Individual Member Premium, Applied APTC Amount, and CSR Amount
 - Total Premium and associated effective dates should be populated for all subscriber lines 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)
- Dependent (non-subscriber) member records should not have the Total Premium Amount, Applied APTC Amount, or CSR Amount nor the associated dates populated

Cancellations

- Cancellations **must** be sent on the RCN10 File when the Issuer cancelled the policy
 - Issuers may, but are not required to, echo back cancellations received from the FFM
- Cancellations should only be sent for consumers that had no period of effectuated coverage, made no payment, or had any payment refunded
 - No APTC payments will be applied to these enrollments
- Issuers should include all typically required data elements on cancelled records and must include a Cancellation Reason, at least on the subscriber record, for any policy cancelled by the Issuer
- Cancellations are to be sent with all end dates equal to the start date, or one day prior to the start date for proper processing

Explaining Initial Premium Paid Status

- 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 active coverage *or* terminated coverage, a **Y** should be sent for Initial Premium Paid Status
 - Any enrollment span that represents 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
 - **Please Note:** No updates will be applied to the FFM for any record submitted with Initial Premium Paid Status **N**

Additional Reconciliation Fundamentals

- For proper record matching, the following elements must be included on each record:
 - Exchange-Assigned Member ID
 - Exchange-Assigned Subscriber ID
 - Exchange-Assigned Policy ID
 - Full 16-character QHP ID
 - Demographic information for the individual
- All financial amounts should always reflect full monthly amounts
 - Do not send amounts billed or paid (i.e. “Total Responsibility Amount”)
 - ***Do not send prorated amounts for partial coverage months***
 - **Please Note:** Any necessary proration to support payments is done separately from the enrollment reconciliation process

Reconciliation Process Checkpoints

- **EFT Filename Validation**

- The CMS EFT process will validate the filename submitted on the reconciliation file and route the file accordingly
- If the filename is not compliant the file will be rejected; the rejection will be placed in the Outbound Error EFT folder
- **Note:** If the filename submitted duplicates a prior filename, the file will not be processed

- **Initial File-Level Validation**

- Upon successful receipt of the file, CMS will perform initial file-level validation
- Validation criteria are included later in this presentation
- Files that pass this validation will be staged for reconciliation processing – a success acknowledgment e-mail will be sent to the Issuer's designated 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 contacts

- **Statistical Validation**

- Upon completion of full reconciliation processing, the record and field-level matching results are analyzed for each Issuer
- Further details on statistical validation will be shared in a future education session

Inbound File-Level Validations

- Issues Causing File Rejection:
 - File unreadable
 - 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
 - Null values in administrative fields:
 - Record Code
 - Trading Partner ID
 - Tenant ID
 - HIOS ID
 - QHP ID Lookup Key
 - Issuer Extract Date
 - Issuer Extract Time
 - Invalid QHP ID Lookup Key to Trading Partner ID relationship
 - HIOS ID mismatch to first 5 characters of the QHP ID
 - QHP ID does not exist in HIOS reference data
 - Counts and sums in 02 Record do not match corresponding 01 Records
 - Invalid characters received in Exchange-Assigned Member/Subscriber ID or Initial Premium Paid Status fields

Enrollment Reconciliation: Reference Materials & Support

- Reference materials are available on CMS zONE at:
<https://zone.cms.gov/document/enrollment-data-reconciliation>
- Materials include:
 - Enrollment Reconciliation Education Suite
 - Standard Issuer Enrollment Data Files
 - Pre-Audit File Specification
 - Inbound Reconciliation File Specification
 - Outbound Reconciliation File Specification
- 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”

2020 Prep: Updated Recon Technical Contacts Needed

Enrollment Data Reconciliation Technical Contacts

- Reconciliation Technical Contacts for your organization will be contacted by CMS resources in regard to any technical issues identified in Issuer-submitted Inbound Reconciliation (RCNI) Files
- Please designate a primary and secondary contact or group e-mail address to ensure any issues can be addressed in a timely fashion
- To submit the Enrollment Data Reconciliation Technical Contacts to CMS:
 - Send an e-mail to the Help Desk (cms_feps@cms.hhs.gov) with the subject line “RECONCILIATION – TECHNICAL CONTACTS”
 - Please include the name, e-mail address, and business telephone number for each contact provided
- ***New Issuers should submit contacts no later than Wednesday, October 31st***

2019 Prep: Updated ER&R Contacts Needed

Enrollment Resolution & Reconciliation (ER&R) Contacts

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