



Centers for Medicare & Medicaid Services

CMS Enrollment Processing System – SBM Issuers Interface Control Document

**Version 1.2
August 21, 2017**

Contents

Contents

1	Purpose.....	3
2	Preliminary Payment Report (PPR) for SBM Issuers	4
2.1	Overview	4
2.2	Timeline.....	5
2.3	File Naming Convention	5
2.4	PPR Data Elements.....	5
3	EPS Extract.....	6
3.1	Overview	6
3.2	Timeline.....	7
3.3	File Naming Convention	7
3.4	Record Layout.....	8
3.5	Financial Node Information Representation	13
3.6	XML Schema Definition	14
3.7	Example file.....	14
	Appendix A - Acronyms and Abbreviations	15
	Appendix B - Referenced Documents	16
	Appendix C - Record of Changes.....	17
	Appendix D – Enrollment Processing Summary	18

List of Figures

Figure 1 : SBM Issuer PPR Timeline.....	5
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List of Tables

Table 1 : EPS Extract naming convention	7
Table 3 : EPS Extract record layout	8
Table 4 : Referenced Documents.....	16

1 Purpose

This Interface Control Document (ICD) defines the common set of specifications, rules, formats, methods, and protocols required to implement the policy-level enrollment data exchange interface between the Centers for Medicare & Medicaid Services (CMS) and State-Based Marketplace (SBM) Issuers. The ICD specifies the interface requirements each participating system must meet, describes the concept of operations for the interface, and defines the message structure and protocols that govern the interchange of data.

This document establishes the standard rules, requirements and policies that will govern the interface implementation.

SBM Issuer's (referred to as Issuer) technical and management personnel responsible for the planning, design, development, testing, integration and implementation of the data exchange interface, are the primary target audience of this document.

The topics covered in this document include outbound interface files provided by CMS to Issuers to help with payment reconciliation and dispute resolution.

The following documents are covered:

- Preliminary Payment Report (PPR) (Pipe separated variables format)
- Enrollment and Processing System (EPS) Extract (XML format)

2 Preliminary Payment Report (PPR) for SBM Issuers

2.1 Overview

CMS will deliver a monthly PPR to each of the SBM's Issuer payees. The PPR is provided as an informational artifact to the Issuers. The PPR provides payment information for the Issuers to use to consult with CMS during payment dispute resolution and with SBMs during enrollment reconciliation.

The PPR is a pipe-delimited text artifact that CMS delivers during a monthly payment cycle ahead of the actual payment and delivery of the Payment Remittance Advice (HIX 820). During a payment cycle, CMS performs several calculations, adjustments, and aggregations using the latest approved policy-level enrollment data submitted by SBMs, and determines payments to be made to each issuer. The PPR was developed in response to Issuers requiring the payment information earlier in the payment cycle in order to provide enough time for Issuers to review data for disputes and timing issues with effectuated enrollments. A PPR for the Issuer is transmitted to their Payee and is similar to their HIX 820 transactions as it provides all the policy-level details as well as any applicable program-level payment information in one (1) transaction. The Issuer PPR estimates the expected payment, while the HIX 820 transaction provides the actual payment or charge. The actual payment or charge is calculated by taking the aggregated current month payment and charges and offset them with any prior period accounts receivable and/or any Treasury offsets. All Payees will receive one (1) PPR near the middle of the month that corresponds to HIX 820 transaction(s) provided near the end of the same month.

Issuers are advised to report any discrepancies observed in the payments reported in the PPR as a payment dispute.

As payments are made directly to Issuers, only an Issuer may dispute a payment. Upon receipt and processing of disputes, CMS will provide the Issuer with a disposition report that describes CMS's assessment of the disputes. If the dispute reflects a discrepancy between the data provided by the SBM and the Issuer's data, the dispute details will be provided to the SBM to facilitate communication between the SBM and the Issuer. In rare instances, a calculation error in EPS may have caused a payment discrepancy, and in such cases, CMS will advise remediation strategies.

In line with the CMS policy for delivering reports and artifacts to external partners, the PPR will be transmitted via Electronic File Transfer (EFT). An Issuer payee can request retransmission of a PPR file and CMS will be able to resend previously transmitted PPRs to requesting parties.

2.2 Timeline

A payment cycle spans two (2) months. Enrollment data submission and approvals occur during Month 1, the data is used for payment calculations between Months 1 and 2, and then the actual payments are made in Month 2. Below is an outline of a typical payment cycle between Months 1 and 2.

Month 2 Payment Cycle	Month/Day
First Monthly SBMI File Submission	Month 1 1 st
Last SBMI File Submission	Month 1 10 th
Freeze Period Begins (No New Record-Level File Processing)	Month 1 11 th
CMS Finalizes All SBMI File Approvals	Month 1 15 th
Payment Cycle Cutoff for Month 2 Payment Cycle	Month 1 15 th 6 p.m.
Freeze Period Closes	Month 1 16 th
Preliminary Payment Reports (PPR) for Month 2 Payment Cycle Sent to Issuers & SBMs	Month 2 14-18 th
Payment for Month 2 and Retroactive Payment Months Received by Issuers	Month 2 20-21 st
HIX 820 Transmitted Only to Issuers	Month 2 27-29 th

Figure 1 : SBM Issuer PPR Timeline

2.3 File Naming Convention

SBM Issuers' PPR files will be named according to the EFT file naming convention below.

File Name: SourceID.FuncCode.Date.Time.EnvCode.Direction

Table 1: EPS Extract naming convention

Section	Comments
Source ID	Source ID for destination (SBM and Issuers)
Function Code	I820
Date	DYYMMDD where the first character 'D' is static text and the rest is the date in 'YYMMDD' format
Time	THHMMSSmmm where the first character 'T' is a static text and the rest is the time in 'HHMMSSmmm' format
Environment Code	P for production, T for testing, R for production readiness
Direction	OUT

2.4 PPR Data Elements

The link to the latest version of the PPR template in the Registration for Technical Assistance Portal (REGTAP) Library is provided below.

https://www.regtap.info/reg_librarye.php?i=1282

3 EPS Extract

3.1 Overview

The EPS extract is a snapshot of EPS that will serve as the basis of payments for the upcoming payment cycle. After the payment cycle cutoff date, CMS will create an extract of all policy-level enrollment details in EPS and forward it to each of the SBM's Issuers and their corresponding SBMs. SBMs can use the extract to understand CMS data and payments to their respective issuers. SBMs update the data in EPS through the SBMI submission process and therefore, EPS represents a version of the SBM's enrollment data.

The EPS extract includes financial and demographic information about policies and members. The EPS extract will also include a subset of policy-level errors and warnings associated with the processing of SBMI file(s) since the previous EPS extract job execution. The subset is composed of any errors and warnings associated with policies that were not changed by a subsequent SBMI submission after the error or warning occurred. The extract will include a flag to indicate the presence or absence of any activity taking place for the SBM Issuer since the last EPS extract job execution. Activity is defined as any changes made to policies, any new policies created, or any new error or warning messages. It also includes the Trading Partner ID for the SBM and the Issuer who is to receive the extract.

EPS Extract Details:

- CMS Payment cycle cutoff date is on the 15th of every month at 6:00 p.m. Eastern Time (ET).
- The EPS extract will include the most recent SBM enrollment information from SBMI files that are submitted to and approved by CMS prior to the payment cycle cutoff date.
- If an enrollment group submitted by the SBM in the latest monthly submission is rejected, the EPS extract will include the enrollment group information from the last approved policy submission (if available).
- The EPS extract files are coverage year specific and include any enrollment that has or had at least one (1) day of coverage during the coverage year (effectuated, terminated and cancelled enrollments).
- A separate EPS extract will be created for each of the SBM's Issuers which will contain enrollment groups for that Issuer only.
- An EPS extract will be created for an Issuer irrespective of whether CMS has received a monthly SBMI submission for that Issuer for that month.
- The EPS extract will include a two (2)-character state code instead of a three (3)-character tenant ID.
- Policies that span coverage years will appear on multiple extracts.
- Issuers that are not yet transitioned to Policy Based Payment (PBP) will receive EPS extract.
- Cancelled policies will be included in EPS extract.
- Policy-level errors or warnings will only be included in EPS extract for matching policy if the policy version date in EPS predates the SBMI file processing that resulted in creation of that policy-level error or warning.
- Payee associated to the SBM Issuer in vendor management will be included in EPS extract.
- Trading partner ID for SBM state will be included in EPS extract.

3.2 Timeline

EPS extracts will be generated once per month after the payment cycle cut off date and sent to the SBM and each Issuer via EFT.

Source	Destination	Timeline	Mode of transmission
CMS	SBM	Around 18 th of a month	EFT
CMS	Issuer		EFT

3.3 File Naming Convention

EPS Extract files will be named according to the EFT file naming convention below.

File Name : SourceID.FuncCode.Date.Time.EnvCode.Direction

Table 2 : EPS Extract naming convention

Section	Comments
Source ID	Source ID for destination (SBM and Issuers)
Function Code	EPSEXT (EPS Extract)
Date	DYYMMDD where the first character 'D' is static text and the rest is the date in 'YYMMDD' format
Time	THHMMSSmmm where the first character 'T' is a static text and the rest is the time in 'HHMMSSmmm' format
Environment Code	P for production, T for testing, R for production readiness
Direction	OUT

3.4 Record Layout

The record layout for EPS extract is provided below:

Table 3 : EPS Extract Record Layout

No	XSD Element Name	Defintion	Data	Min	Max	Min	Max	Required?	Format / Valid values
			Type	Length	Length	Occ	Occ		
1	EPSExtract					1	1		
2	FileInformation					1	1	Y	
3	FileId	Unique CMS File ID	Text	1	50	1	1	Y	
4	FileCreateDateTime	Date and Time Extract File Created by CMS	DateTime			1	1	Y	YYYY-MM-DDThh:mm:ss
5	StateCd	Two Character State Code	Text	2	2	1	1	Y	
6	CoverageYear	Specified Year of coverage for policies in the file. Those with either a PolicyStart or PolicyEnd in the Coverage Year.	Int	4	4	1	1	Y	2016-2999
6a	PayeeID	Payee ID for the SBM issuer	Text	4	8	1	1	Y	
6b	StateTPID	Trading partner ID for SBM state	Text	1	10	1	1	Y	
7	IssuerId	Five (5)-digit Health Insurance Oversight System (HIOS) ID for the issuer extract file generated by CMS	Text	5	5	1	1	Y	
8	FileNumber	This field is to be used when splitting EPS extract due to size limitation in multiple files	Text	1	50	0	1	N	File 1 of 2 / File 2 of 2
9	Policy					0	Unbounded	N	
10	OriginalSBMIFileId	File ID of SBMI file provided by SBM to CMS	Text	1	50	1	1	Y	
11	OriginalSBMIExtractDateTime	Extract date and time of original SBMI file provided by SBM to CMS	DateTime			1	1	Y	YYYY-MM-DDThh:mm:ss
12	CMSPolicyVersionDateTime	Date and Time Policy record inserted into CMS Payment System	DateTime			1	1	Y	YYYY-MM-DDThh:mm:ss

CMS SBM_Issuers Interface Control Document

No	XSD Element Name	Defintion	Data	Min	Max	Min	Max	Required?	Format / Valid values
			Type	Length	Length	Occ	Occ		
13	QHPIId	First 14 characters of the 16 digit Qualified Health Plan ID - does not include the last two digits which is the CSR Variant ID (captured in a subsequent loop).	Text	14	14	1	1	Y	
14	ExchangeAssignedPolicyId	This ID is generated by the Exchange and uniquely identifies the enrollment group specific to the 14 digit QHP ID.	Text	1	50	1	1	Y	
15	ExchangeAssignedSubscriberId	This ID is generated by the Exchange and uniquely identifies the subscriber of the policy. If the member is the subscriber, generally the member and subscriber IDs should be the same.	Text	1	50	1	1	Y	
16	IssuerAssignedPolicyId	This ID is generated by the issuer to represent the policy.	Text	1	50	0	1	N	
17	IssuerAssignedSubscriberId	This ID is generated by the issuer to represent the subscriber.	Text	1	50	0	1	N	
18	PolicyStartDate	Day Coverage Begins	Date			1	1	Y	YYYY-MM-DD
19	PolicyEndDate	Day Coverage Ends	Date			1	1	Y	YYYY-MM-DD
20	EffectuationInd	Indicates that the policy is in an effectuated status	Text	1	1	1	1	Y	Valid values 'Y' or 'N'
21	InsuranceLineCode	Type of coverage (HLT for Medical or DEN for dental)	Text	3	3	1	1	Y	Valid values 'HLT' or 'DEN'
22	MemberInformation	Contains demographics on all members including subscriber				1	Unbounded	Y	
23	ExchangeAssignedMemberId	This ID is generated by the Exchange and uniquely identifies the member within the Exchange.	Text	1	50	1	1	Y	
24	SubscriberIndicator	Indicates whether the member is the subscriber.	Text	1	1	1	1	Y	Valid values 'Y' or 'N'
25	IssuerAssignedMemberId	This ID is generated by the issuer to represent the member.	Text	1	50	0	1	N	
26	NamePrefix	Name prefix (Example : Mr., Mrs.)	Text	1	10	0	1	N	
27	MemberLastName	The last name of the member	Text	1	60	1	1	Y	
28	MemberFirstName	The first name of the member	Text	1	35	0	1	N	
29	MemberMiddleName	The middle name of the member	Text	1	25	0	1	N	
30	NameSuffix	Name suffix (Example: Sr., Jr.)	Text	1	10	0	1	N	

CMS SBM_Issuers Interface Control Document

No	XSD Element Name	Defintion	Data	Min	Max	Min	Max	Required?	Format / Valid values
			Type	Length	Length	Occ	Occ		
31	BirthDate	Date of birth	<i>Date</i>			1	1	Y	YYYY-MM-DD
32	SocialSecurityNumber	Social Security Number, should be sent if available.	<i>Text</i>	9	9	0	1	N	
33	PostalCode	Zip code of the residence address	<i>Text</i>	3	15	1	1	Y	
34	LanguageQualifierCode	Language qualifier code as specified in the 834 TR3*	<i>Text</i>	2	25	0	1	N	LD or LE
		LD – NISO Z39.53 Language Codes							
		LE – ISO 639 Language Codes							
35	LanguageCode	Language - CMS will accept any type although spoken is preferred.	<i>Text</i>	1	25	0	1	N	
36	GenderCode	Gender Indicator (F - Female, M - Male, U - Unknown)	<i>Text</i>	1	25	0	1	N	Valid values – F, M, U
37	RaceEthnicityCode	Race and Ethnicity Code list as provided in the 834 TR3* (2100A DMG05-1)	<i>Text</i>	1	25	0	1	N	
38	TobaccoUseCode	Tobacco use indicator (T - Tobacco use, N - None, U - Unknown)	<i>Text</i>	1	25	0	1	N	Valid values – T, N, U
39	NonCoveredSubscriberInd	Individual identified as the subscriber of the policy yet does not receive coverage.	<i>Text</i>	1	1	0	1	N	Valid value - Y
40	MemberDates	CoverageDates for the Member- Multiple nodes may exist				0	Unbounded	N	
41	MemberStartDate	Member coverage start date.	<i>Date</i>			1	1	Y	YYYY-MM-DD
42	MemberEndDate	Member coverage end date.	<i>Date</i>			1	1	Y	YYYY-MM-DD
43	FinancialInformation	Contains financial information for the policy- multiple nodes for time periods may exist				1	Unbounded	Y	
44	FinancialEffectiveStartDate	Start date for all financial information provided in the financial information node.	<i>Date</i>			1	1	Y	YYYY-MM-DD
45	FinancialEffectiveEndDate	End date for all financial information provided in the financial information node.	<i>Date</i>			1	1	Y	YYYY-MM-DD
46	MonthlyTotalPremiumAmount	Monthly total premium amount.	<i>Decimal</i>	1	99999999.99	1	1	Y	
47	MonthlyTotalIndividualResponsibilityAmount	The amount in which the enrollment group is responsible to pay toward the monthly total premium amount.	<i>Decimal</i>	1	99999999.99	1	1	Y	

CMS SBM_Issuers Interface Control Document

No	XSD Element Name	Defintion	Data	Min	Max	Min	Max	Required?	Format / Valid values
			Type	Length	Length	Occ	Occ		
48	MonthlyAPTCAmount	The monthly advance payment of the premium tax credit amount applied toward the monthly total premium amount for a qualifying individual.	<i>Decimal</i>	1	99999999.99	0	1	N	
49	MonthlyOtherPaymentAmount1	The amount an issuer can expect to be paid by a tribe as a portion of total premium amount.	<i>Decimal</i>	1	99999999.99	0	1	N	
50	MonthlyOtherPaymentAmount2	The amount an issuer can expect to be paid by the state as a portion of total premium amount.	<i>Decimal</i>	1	99999999.99	0	1	N	
51	MonthlyCSRAmount	The monthly advance cost-sharing reduction amount for a qualifying individual.	<i>Decimal</i>	1	99999999.99	0	1	N	
52	CSRVariantId	The last two digits of the 16 digit Qualified Health Plan (QHP) ID.	<i>Text</i>	2	2	1	1	Y	
53	RatingArea	Rating area in which the enrollment group receives coverage	<i>Text</i>	7	7	0	1	N	R-[A-Z][A-Z][0-9][0-9][0-9]
54	PartialMonthPremiumAmount	Premium amount for partial month of coverage	<i>Decimal</i>	1	99999999.99	0	1	N	
55	PartialMonthAPTCAmount	Advance premium tax credit amount for partial month of coverage.	<i>Decimal</i>	1	99999999.99	0	1	N	
56	PartialMonthCSRAmount	Advance cost-sharing reduction amount for partial month of coverage.	<i>Decimal</i>	1	99999999.99	0	1	N	
57	RecentErrorReporting					0	1	N	
58	ActivityInd	Indicates if there are errors, warnings, new policies or policy updates since last EPSExtract. N means no new activity/rejects since last EPS extract.	<i>Text</i>	1	1	1	1	Y	'Y' or 'N'
59	PolicyError	Identifies the Issuer Policies with error/warnings recorded since last time the EPS Extract was generated.				0	Unbounded	N	
s60	SourceFileId	Most recent unique SBMI File ID	<i>Text</i>	1	50	1	1	Y	
61	SourceFileCreateDateTime	Date and Time inside the most recent source file (SBMI)	<i>DateTime</i>			1	1	Y	YYYY-MM-DDThh:mm:ss
62	RecordControlNumber	Control number that identifies a record in a SBMI file uniquely	<i>Int</i>	1	9	0	1	N	
63	ExchangeAssignedPolicyId	Exchange policy ID submitted by the SBM	<i>Text</i>	1	50	0	1	N	

CMS SBM_Issuers Interface Control Document

No	XSD Element Name	Defintion	Data	Min	Max	Min	Max	Required?	Format / Valid values
			Type	Length	Length	Occ	Occ		
64	QHPId	14 character Qualified Health Plan (QHP) ID - does not include variant code - submitted on SBMI	<i>Text</i>	14	14	0	1	N	
65	ExchangeAssignedSubscriberId	Exchange subscriber ID submitted by the SBM	<i>Text</i>	1	50	0	1	N	
66	Error					1	Unbounded	Y	
67	ErrorCode	Error or warning code	<i>Text</i>	6	6	1	1	Y	
68	ErrorDescription	Error description	<i>Text</i>	1	255	1	1	Y	
69	ElementInError	XML elements in error	<i>Text</i>	1	255	0	1	N	
70	AdditionalErrorInfo	Expected element value	<i>Text</i>	1	2000	0	10	N	
71	ExchangeAssignedMemberId	Exchange member ID being submitted by the SBM	<i>Text</i>	1	50	0	1	N	



FT EPS Extract with
Errors v1.xlsx

Notes on ActivityInd Field :

- This mandatory field is not at the policy-level but it is at the Issuer/file-level.
- Allowed values for this field are only 'Y' and 'N'.
- A value of 'Y' indicates one (1) or more of the following activities:
 - SBM submitted SBMI file - since last EPS extract was created - that may or may not have resulted in validation errors
 - CMS requested a rollback of previously applied changes to EPS.
- A value of 'N' indicates one (1) or more of the following activities:
 - SBM did not submit any policies for the Issuer.
 - SBM submitted SBMI file that is identical to SBMI submitted for previous payment cycle (or a subset of policies from SBMI submitted for previous payment cycle) that did not result in any validation errors or warnings.

3.5 Financial Node Information Representation

The EPS extract contains complete financial information for all the policies for a specific coverage year. This financial information will be represented using the following guidelines:

- There will be one (1) discrete node for every time period for each policy.
- Each financial info node will reflect both the full monthly amount and prorated amount, if applicable to the time period.



EPS Extract
Financial Node Rep

3.6 XML Schema Definition



EPSEExtractWithError
s_v1.xsd

3.7 Example file



SampleExtractWithError.xml

Appendix A - Acronyms and Abbreviations

Acronym / Abbreviation	Definition
APTC	Advanced Premium Tax Credit
CMS	Centers for Medicare & Medicaid Services
CONOP	Concept Of Operations
CSR	Cost Sharing Reduction
EFT	Electronic File Transfer
EPS	Enrollment and Processing System
FFM	Federally-facilitated Marketplace
HTTPS	Hypertext Transfer Protocol Secure
ICD	Interface Control Document
PBP	Policy Based Payment
PLR	Policy-level Reporting
PPACA	Patient Protection and Affordable Care Act
PPR	Preliminary Payment Report
QHP	Qualified Health Plan
SBM	State Based Marketplace
SBMI	SBM Inbound file
SBMR	SBM Response file
SBMS	SBM Status file
SDD	System Design Document
SERFF	System For Electronic Rate and Form Filing
SFTP	Secure File Transfer Protocol
SLA	Service Level Agreement
SPoE	Single Point of Entry
SSH	Secure Shell
TB	Terabyte
TP	Trading Partner
XML	eXtensible Markup Language

Appendix B - Referenced Documents

This section lists documents and standards this document references or that are applicable to the development of this document.

Table 4 : Referenced Documents

Document Name	Document Number and/or URL	Date
CMS XLC ICD Template	http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/XLC/Artifacts.html	April 30, 2012
Making Documents Section 508 Compliant	http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/Section508/index.html	April 26, 2012
Patient Protection and Affordable Care Act	http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf	March 23, 2010
Plain Writing Act of 2010	http://www.plainlanguage.gov/plLaw/law/index.cfm	April 13, 2011
File naming convention document link from CMS	https://zone.cms.gov/document/eft-file-naming-conventions	
U.S. Government Printing Office (GPO) Style Manual (30 th Edition)	https://www.gpo.gov/fdsys/pkg/GPO-STYLEMANUAL-2008/pdf/GPO-STYLEMANUAL-2008.pdf	2008

Appendix C - Record of Changes

Table 15 - Record of Changes

Version	Date	Author / Owner	Revision/Change Description
1.0	January 2017	CMS	Initial version
1.1	March 2017	CMS	Section 2.3 - Added section for PPR file naming convention Section 3.1 – Updated overview section for inclusion of new fields, payee ID and state TPID fields. Section 3.4 – Added payee ID and SBM TPID to EPS extract schema Section 3.5 – Revised example for financial node representation Included appendix D
1.2	June 2017	CMS	Appendix D – Addition of new error codes ER-065 and ER-066. Updated description for ER-046

Appendix D – Enrollment Processing Summary

This document covers the schema level and business validation errors and warning messages. The document may be revised if we find scenarios not covered at this time. CMS anticipates providing additional details about the data to be included in the AdditionalErrorInfo element at a later date.



Appendix D.xlsx