

CSR Reconciliation Issuer to MIDAS Inbound Specification

Subject: Cost-Sharing Reduction
Reconciliation Project

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ITC- ICSRRL0

CSR Reconciliation Inbound Specification

The purpose of this Message is to provide the details on cost-sharing reduction (CSR) reconciliation files that will be received in the Multidimensional Insurance Data Analytics System (MIDAS). The issuer will need to submit files to MIDAS in pipe delimited format. The file format that will be used is ASCII text and will use a CRLF as the line terminator. The file submitted by the issuers should have only ONE HIOS identifier. If the issuer is submitting data for multiple HIOS IDs, for example as the result of an acquisition, the issuer must create a separate file for each HIOS ID. The function code for the data submission will be CSRI.

CSR Reconciliation Submission Files:

The filenames proposed for usage by issuers will consist of the following sections:

1. Trading Partner (TP) Identifier (ID)
2. Application ID
3. Function Code
4. Date
5. Time
6. Environment Code
7. Direction

Trading Partner (TP) Identifier (ID):

TPID is the identification number assigned to the Trading Partner. The length of the TPID can range between 5-10 characters. The TPID that should be used for CSR Reconciliation must be the same as that has been used for 820 payments with function code F820.

Application ID:

The Application ID section of the filename is an ID for the application that processes the files. This section specifies the target application where the system routes the file. This is a static value and is MID for this process.

Function Code:

The Function Code section of the filename is an alphanumeric code indicating the functional purpose of the file within the application. This also helps identify specific processing once the system routes the file to the application. This is a static value and is CSRI for the data.

Date:

The Date section of the filename specifies the date the file transferred in **DYYMMDD** format. The first **D** is static text.

Time:

The Time section of the filename specifies the time created (timestamp) for the file in **THHMMSSmmm** format where **HH** is hours, **MM** is minutes, **SS** is seconds, and **mmm** is milliseconds. The **T** is static text and exactly nine numerals must follow.

Environment Code: The Environment Code section of the filename is a single character code indicating the environment to which the system transfers the file. Allowed values are as follows:

- P** for Production Environment (PROD)
- T** for Test Environment (TEST) and Implementation Environment (IMP)

Direction:

The Direction section of the filename indicates the direction in which the data flows, towards the Centers for Medicare & Medicaid Services (CMS) or away from CMS:

- IN** for to CMS
- OUT** for from CMS

All the sections need to be separated by a period (.)

Example of a sample filename: **12345678.MID.CSRLD151027.T123136760.P.IN**

<u>ID</u>	<u>Name</u>	<u>Min Use</u>	<u>Max Use</u>
01 Issuer Detail Record	ITC-ICSRRL0-Record ID	1	1
02 Plan Detail Record	ITC-ICSRRL0-Record ID	1	9999
03 Policy Detail Record	ITC-ICSRRL0-Record ID	1	999999

01 Issuer Summary Record

ITC-ICSRRL0-Record Id

Min Use: 1
Grp:

Max Use: 1
Fields: 27

Issuer Summary Information: Aggregate amounts of EHB claims, amounts paid by policy holders, the issuer, and CSR provided for all QHPs under this issuer.

<u>Pos</u>	<u>ID</u>	<u>FIELD</u>	<u>Type</u>	<u>Min Len</u>	<u>Max Len</u>	<u>Req</u>
01	101	Record-Code Purpose: Record Code – Always 01 for Issuer Summary Information.	Text	2	2	Mandatory
02	102	Trading Partner ID Purpose: The Trading Partner number assigned.	Text	5	10	Mandatory
03	103	Issuer State Code Purpose: Enter the 2-letter state code for issuer’s state of licensure.	Text	2	2	Mandatory
04	104	HIOS ID Purpose: The five-digit Health Insurance Oversight System (HIOS)–generated Issuer ID number	Numeric	5	5	Mandatory
05	105	Issuer Extract Date Purpose: Date information extracted by the issuer. Note: Valid date format is CCYYMMDD.	Numeric	6	6	Mandatory
06	106	Issuer Extract Time Purpose: Time information extracted by issuer. Note: Valid format is HHMMSS- (Hour, Minutes, and Seconds).	Numeric	8	8	Mandatory
07	107	Benefit Year Purpose: The calendar benefit year (January to December). Note: Valid format is YYYY. The values should be restricted to 2014 or 2015.	Numeric	4	4	Mandatory
08	108	Total CSR Amount Purpose: Total CSR amount provided by this QHP issuer to enrollees in all plan variations. Note: Maximum value is 99999999.99 with an explicit decimal. If not available then initialize to "0.00". The precision is restricted to 2 decimal points.	Numeric	4	11	Mandatory
09	109	Total CSR Amount Advanced to the Issuer Purpose: Amount the issuer shows received for the benefit year January 1 to December 31. Issuers should include retroactive adjustments to advance payments for the applicable benefit year that were made after the close of the benefit year but before or by April 30, 2016. Note: Maximum value is 99999999.99 with an explicit decimal. If not available then initialize to "0.00". The precision is restricted to 2 decimal points	Numeric	4	11	Mandatory
10	110	Reconciliation Methodology Purpose: Indicates the Reconciliation methodology used and the valid values are – STANDARD, SIMPLIFIED or SIMPLIFIED AV.	Text	20	25	Mandatory

11	111	Acquisition	Text	1	1	Mandatory
		Purpose: Has the issuer HIOS ID filing this reconciliation report been acquired by another issuer in the applicable benefit year? Valid values are Y or N.				
		Note: <u>This field value must be Upper Case.</u>				
12	112	Acquisition Effective Dates	Date	8	8	Conditional
		Purpose: Date the acquisition was final. Value is required if the Acquisition is set to Y.				
		Note: The valid date format is CCYYMMDD.				
13	113	Acquiring Issuer	Text	5	100	Conditional
		Purpose: HIOS ID of the acquiring issuer. Value is required if the Acquisition is set to Y.				
14	114	Merger	Text	1	1	Mandatory
		Purpose: Has the issuer HIOS ID filing this reconciliation report merged with another issuer in the applicable benefit year? Valid values are Y or N.				
		Note: <u>This field value must be Upper Case.</u>				
15	115	Merger Issuer	Text	5	100	Conditional
		Purpose: List the HIOS ID of the other issuer(s) party in the merger. Value is required if the Merger is set to Y.				
16	116	Merger Effective Dates	Date	08	08	Conditional
		Purpose: Date the merger was final. Value is required if the Merger is set to Y.				
		Note: Valid date format is CCYYMMDD.				
17	117	Total Number of CSR Variant Plans under this HIOS ID	Numeric	1	10	Mandatory
		Purpose: Total count of plan variations for this QHP issuer.				
18	118	Technical POC First Name	Text	15	100	Mandatory
		Purpose: To identify the first name of the Technical POC of the issuer.				
19	119	Technical POC Last Name	Text	15	100	Mandatory
		Purpose: To identify the last name of the technical POC of the issuer.				
20	120	Technical POC Email Address	Text	15	100	Mandatory
		Purpose: To identify the email address of the technical POC of the issuer.				
21	121	Technical POC Organization Title	Text	15	100	Mandatory
		Purpose: To identify the Organization of the technical POC of the issuer.				
22	122	Technical POC Phone Number	Numeric	15	100	Mandatory
		Purpose: To identify the Phone Number of the technical POC of the issuer.				
23	123	Business POC First Name	Text	15	100	Mandatory
		Purpose: To identify the first name of the Business POC of the issuer.				
24	124	Business POC Last Name	Text	15	100	Mandatory
		Purpose: To identify the last name of the Business POC of the issuer.				

25	125	Business POC Email Address	Text	15	100	Mandatory
		Purpose: To identify the email address of the Business POC of the issuer.				
26	126	Business POC Organization Title	Text	15	100	Mandatory
		Purpose: To identify the Organization Title of the Business POC of the issuer.				
27	127	Business POC Phone Number	Numeric	15	100	Mandatory
		Purpose: To identify the Phone Number of the Business POC of the issuer.				

02 Plan Summary Record

ITC-ICSRRL0-Record Id

Min Use: 1
Grp:

Max Use: 9999
Fields: 9

Plan Summary Record: Issuers will send plan-related data elements that list all QHPS, financial amounts and methodology.

<u>Pos</u>	<u>ID</u>	<u>FIELD</u>	<u>Type</u>	<u>Min Len</u>	<u>Max Len</u>	<u>Req</u>
01	201	Record-Code	Text	2	2	Mandatory
		Purpose: Record type to indicate that this refers to the Plan details.				
		Note: Should always be 02 for Plan Summary Record.				
02	202	QHP ID	Text	16	16	Mandatory
		Purpose: Enter the 16-digit HIOS-generated qualified health plan identification number. This includes the 14-digit standard plan ID plus the 2-digit variant ID.				
03	203	Total Annual Premium	Numeric	4	11	Mandatory
		Purpose: Aggregate billed premium for this plan for the applicable benefit year.				
		Note: This is the Total Premium Amount. Maximum value is 99999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.				
04	204	Total Allowed Costs for EHB	Numeric	4	11	Mandatory
		Purpose: Aggregate total allowed costs for essential health benefits for all enrollees in this plan. Issuers including issuers of capitated plans may use plan-specific percentage estimates of non-EHB claims submitted on the Uniform Rate Review Template or any other reasonable method to determine total allowed costs for EHB.				
		Note: This is the Total allowed costs for EHB. Maximum value is 99999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.				
05	205	Total Actual Amount the Issuer Paid for EHB	Numeric	4	11	Mandatory
		Purpose: The amount the issuer paid providers for EHB for all services to enrollees in this plan. This includes cost-sharing reduction reimbursement amounts to fee-for-service providers to the extent the issuer reimbursed fee-for-service providers. Issuers that provide for essential health benefits on a partially or fully capitated basis should enter all amounts paid by the issuer for those services. This value does not include enrollee liability.				
		Note: This is the total actual amount the issuer paid for EHB. Maximum value is 99999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.				
06	206	Total Actual Amount Paid For EHB by Enrollees	Numeric	4	11	Mandatory
		Purpose: Total amount all enrollees in this plan paid (or are liable for) in cost sharing for all EHB services.				
		Note: This is the Total actual amount paid for EHB by enrollees. Maximum value is 99999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.				
07	207	Total actual amount for EHB enrollees would have paid				

in the standard plan Numeric 4 11 Mandatory

Purpose: The amount the enrollee(s) would have paid for the same claims had he/she/they been enrolled in the standard plan without cost-sharing reductions. For the standard methodology, dollar amounts entered here must be calculated in accordance with HHS guidance on re-adjudication of claims.

Note: This is the total actual amount for EHB enrollees would have paid in the standard plan. Maximum value is 99999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.

08 208

**Total value of CSR
Provided**

Numeric 4 11 Mandatory

Purpose: The total amount all enrollees would have paid under the standard plan, minus the amount the enrollees did pay under the plan variation (and reimbursed to fee-for-service providers, if applicable.)

Note: This is the total value of CSR provided. Maximum value is 99999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.

09 209

**Total number of Exchange
Subscriber IDs in this plan variation
for the benefit year**

Numeric 1 10 Mandatory

Purpose: Total count of unique Exchange subscriber IDs in this plan variation at any point during the benefit year during the time that the subscriber was enrolled in the plan variation.

03 Policy Detail Record

ITC-ICSRRL0-Record Id

Min Use: 1
Grp:

Max Use: 999999
Fields: 14

Policy Detail Information: Issuers will send policy related data elements for all QHPs, financial amounts and methodology.

<u>Pos</u>	<u>ID</u>	<u>FIELD</u>	<u>Type</u>	<u>Min Len</u>	<u>Max Len</u>	<u>Req</u>
01	301	Record-Code	Text	2	2	Mandatory
		Purpose: Record code to indicate that this refers to the Policy details.				
		Note: Should always be 03 for Policy Detail Records.				
02	302	Exchange assigned Subscriber ID	Text	10	50	Mandatory
		Purpose: The subscriber identification number assigned by the Exchange.				
03	303	Plan Benefit Start Date	Date	8	8	Mandatory
		Purpose: First date subscriber enrolled in this plan variation.				
		Note: Format is CCYYMMDD.				
04	304	Plan Benefit End Date	Date	8	8	Mandatory
		Purpose: Last date subscriber enrollment in this plan variation ended.				
		Note: Format is CCYYMMDD. Please do not include / or -.				
05	305	Total Monthly Premium	Numeric	4	11	Mandatory
		Purpose: The monthly premium amount for this policy for the applicable benefit year. If the policy changed to self-only or other than self-only during the benefit year, or if the monthly premium amount changed during the applicable benefit period as the result of other circumstances, enter the average monthly premium for this policy over the months in which it was in effect. Issuers should include retroactive adjustments to premium for the applicable benefit year that were made after the close of the applicable benefit year but before or by April 30, 2016.				
		Note: This is the Total Premium Amount. Maximum value is 99999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.				
06	306	Self Only/Other than self-only	Text	1	1	Conditional
		Purpose: For the Simplified methodology and Simplified Actuarial Value only, report whether coverage under this policy is self only, or other than self-only.				
		Note: Required only if the methodology is SIMPLIFIED and SIMPLIFIED AV. Valid values are Self (S) or Other (O).				
07	307	Annual limitation on cost Sharing for the standard Plan	Numeric	4	10	Conditional
		Purpose: This is the annual limitation on cost sharing for the standard plan associated with this plan variation as reported to CMS for plan certification for the applicable benefit year. Value is required for Simplified and Simplified actuarial value methodology.				
		Note: Maximum value is 99999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points				
08	308	Actuarial value amount of the Standard plan	Numeric	4	10	Conditional
		Purpose: This is the actuarial value of the standard plan associated with this plan variation as				

reported to CMS for plan certification for the applicable benefit year. Required for the simplified actuarial value methodology only.

Note: Required only for Simplified Actuarial Value methodology. Maximum value is 99999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column.

09 **309** **Total allowed costs for EHB** Numeric 4 11 Mandatory

Purpose: Total allowed costs for essential health benefits incurred by the enrollee(s) on this policy. Issuers including issuers of capitated plans may use plan-specific percentage estimates of non-EHB claims submitted on the Uniform Rate Review Template or any other reasonable method to determine total allowed costs for EHB.

Note: Maximum value is 99999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.

10 **310** **Actual amount the issuer paid for EHB** Numeric 4 11 Mandatory

Purpose: This is the total dollar amount the issuer paid to providers for all EHB services to enrollees on this policy. This includes cost-sharing reduction reimbursement amounts to fee-for-service providers to the extent the issuer reimbursed fee-for-service providers. Issuers that provide for essential health benefits on a partially or fully capitated basis should enter all amounts paid by the issuer for those services. This value does not include enrollee liability.

Note: Maximum value is 99999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.

11 **311** **Actual amount the enrollee(s) paid for EHB** Numeric 4 11 Mandatory

Purpose: The amount all enrollees on this policy paid (or are liable for) in cost sharing for all EHB services.

Note: Maximum value is 99999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.

12 **312** **Actual amount the enrollee(s) would have paid under the standard plan** Numeric 4 11 Mandatory

Purpose: The amount the enrollee(s) would have paid for the same EHB claims had he/she/they been enrolled in the standard plan without cost-sharing reductions.

Note: Maximum value is 99999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.

13 **313** **CSR Provided** Numeric 4 11 Mandatory

Purpose: The CSR amount is the amount enrollees would have paid under the standard plan, minus the amount the enrollees did pay under the applicable plan variation (and reimbursed to fee-for-service providers, if applicable.).

Note: Maximum value is 99999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.

14 **314** **QHP Plan ID** Text 16 16 Mandatory

Purpose: Enter the 16-digit HIOS-generated qualified health plan identification number. This includes the 14-digit standard plan ID plus the 2-digit variant ID.

CSR Reconciliation Business Validations for Issuer, Plan and Summary

Business Validations for Issuer Summary

ID #	Element Name	Business Validation	CMS Action if Validation Fails
1.	Record-Code	Values equal "01".	CMS will reject the file.
2.	Trading ID	Validate the TPID and HIOSID association using FEPS reference data.	CMS will reject the file.
3.	Issuer State Code	N/A	N/A
4.	HIOS ID	Validate the existence of HIOS ID in the FEPS Master Reference issuer list based on the benefit year.	CMS will reject the file.
5.	Issuer Extract Date	N/A	N/A
6.	Issuer Extract Time	N/A	N/A
7.	Benefit Year	Benefit Year will be 2014 or 2015.	CMS will reject the file.
8.	Total CSR Amount	The TOTAL CSR AMOUNT at the issuer level must match the sum of all TOTAL VALUE OF CSR PROVIDED at the plan level. The tolerance threshold for payment amount validation is less than \$1.	CMS will accept and process the file, but send an error.
9.	Total CSR Amount Advanced To The Issuer	N/A	N/A
10.	Reconciliation Methodology	The methodologies that are accepted are STANDARD, SIMPLIFIED, SIMPLIFIED AV. These fields will be case insensitive.	CMS will reject the file.
11.	Acquisition	The accepted values for this field are Y and N.	CMS will accept and process the file, but send an error.
12.	Acquisition Effective Dates	Acquisition Effective Date is required if there was an Acquisition (Acquisition set to Y).	CMS will accept and process the file, but send an error.

13.	Acquiring Issuer	Issuers should list HIOS ID of the acquiring issuer. It is required if there was an Acquisition (Acquisition set to Y).	CMS will accept and process the file, but send an error.
14.	Merger	The accepted values for this field are Y and N.	CMS will accept and process the file, but send an error.
15.	Merger Issuer	Merger Issuers should be on the list of HIOS ID's that have been merged. It is required if there was a Merger (Merger set to Y).	CMS will accept and process the file, but send an error.
16.	Merger Effective Dates	Merger Effective Date is required if there was a Merger (Merger set to Y).	CMS will accept and process the file, but send an error.
17.	Total Number Of CSR Variant Plans Per HIOS ID	The total number of plans submitted at the Plan summary level (Record code =02) should match the number of CSR variant plans per HIOS ID.	CMS will accept and process the file, but send an error.
18.	Technical POC First Name	N/A	N/A
19.	Technical POC Last Name	N/A	N/A
20.	Technical POC Email Address	N/A	N/A
21.	Technical POC Organization Title	N/A	N/A
22.	Technical POC Phone Number	N/A	N/A
23.	Business POC First Name	N/A	N/A
24.	Business POC Last Name	N/A	N/A
25.	Business POC Email Address	N/A	N/A
26.	Business POC Organization Title	N/A	N/A
27.	Business POC Phone Number	N/A	N/A

Business Validations for Plan Summary

ID#	Element Name	Business Validation	CMS Action if Validation Fails
1.	Record-Code	Values equal "02".	CMS will accept and process the file, but send an error.
2.	QHP ID	QHP ID should be a valid plan identifier provided by the issuer for a specific coverage year.	CMS will accept and process the file, but send an error.
3.	Total Annual Premium	N/A	N/A
4.	Total Allowed Costs For EHB	N/A	N/A
5.	Total Actual Amount The Issuer Paid For EHB	The value of TOTAL ACTUAL AMOUNT THE ISSUER PAID FOR EHB cannot exceed the Total Allowed Costs For EHB.	CMS will accept and process the file, but send an error.
6.	Total Actual Amount Paid For EHB By Enrollees	Total Actual Amount Paid For EHB By Enrollees should be the difference between the TOTAL ALLOWED COSTS FOR EHB and the TOTAL ACTUAL AMOUNT THE ISSUER PAID FOR EHB. The tolerance threshold for payment amount validation is less than \$1.	CMS will accept and process the file, but send an error.
7.	Total Actual Amount For EHB Enrollees Would Have Paid In The Standard Plan	N/A	N/A
8.	Total Value Of CSR Provided	The Total Value of CSR Provided should be the difference between the AMOUNT THE ENROLLEE(S) WOULD HAVE PAID UNDER THE STANDARD PLAN and the AMOUNT THE ENROLLEE(S) PAID. The tolerance threshold for payment amount validation is less than \$1.	CMS will accept and process the file, but send an error.

ID#	Element Name	Business Validation	CMS Action if Validation Fails
9.	Total Number Exchange Subscriber IDs In This Plan Variation For The Benefit Year	Total number of Exchange Subscriber IDs for the Plan variation must match the Count of records listed in Policy details (03 records).	CMS will accept and process the file, but send an error.

Business Validations for Policy Details

ID #	Element Name	Business Validation	CMS Action if Validation Fails
1.	Record-Code	Values equal "03".	CMS will reject the file.
2.	Exchange Assigned Subscriber Id	Validate against the FEPS enrollment data for Individual market places only. The values will be validated for FFM plans only.	CMS will reject the file.
3.	Plan Benefit Start Date	N/A	N/A
4.	Plan Benefit End Date	N/A	N/A
5.	Total Monthly Premium	N/A	N/A
6.	Self /Other	Input is required if the issuer elected Simplified method or Simplified AV as their Reconciliation Methodology. The values entered must be S or O.	CMS will accept and process the file, but send an error.
7.	Annual Limitation On Cost Sharing For The Standard Plan	Input is required if the issuer elected Simplified and Simplified Actuarial Value method as their Reconciliation Methodology.	CMS will reject the file.
8.	Actuarial Value of the Standard Plan	Input is required if the issuer elected Simplified AV method as their Reconciliation Methodology.	CMS will reject the file.
9.	Total Allowed Costs For EHB	The value cannot exceed the TOTAL ALLOWED COSTS FOR EHB at the plan summary level (02).	CMS will reject the file.

ID #	Element Name	Business Validation	CMS Action if Validation Fails
10.	Amount the Issuer Paid	<p>1. The value of AMOUNT THE ISSUER PAID cannot exceed the total actual amount the issuer paid for EHB.</p> <p>2. The value of AMOUNT THE ISSUER PAID cannot exceed the total allowed costs for EHB from the plan level (02).</p>	CMS will reject the file.
11.	Amount the Enrollee(s) Paid	<p>The AMOUNT THE ENROLLEE(S) PAID is the difference between the total allowed costs for EHB and the amount the issuer paid.</p> <p>The tolerance threshold for payment amount validation is less than \$1.</p>	CMS will reject the file.
12.	Amount the enrollee(s) would have paid under the standard plan	N/A	N/A
13.	CSR provided	<p>The CSR PROVIDED is the amount the enrollee(s) would have paid under the standard plan less the amount the enrollee(s) paid.</p> <p>The tolerance threshold for payment amount validation is less than \$1.</p>	CMS will reject the file.
14.	QHP Plan ID	QHP ID should be a valid plan identifier provided by the issuer for a specific coverage year.	CMS will reject the file.

Appendix A

1.1 Enterprise File Transfer (EFT) Location

CMS will only accept submissions through EFT.

For direct SFTP (for automation) - `sftp://eft.feeps.cms.gov`

- When using SFTP, send files using the “Inbound 30” folder.

The folder structure is applicable to both test and production. Differentiation is based on the .T or .P within the file name.

1.2 Error handling

If the data submitted fails any of the business validations (see tables above), an error report will be generated, the issuer will receive an email indicating that the file has been submitted with errors, and the CSR Reconciliation Outreach Team will be notified. The file will be rejected when mandatory data elements are not included or are input incorrectly, and the issuer will receive an email indicating that the file has been rejected and cannot be processed. A comprehensive error report will be generated and will be sent to the issuer’s outbound folder through the EFT. Every issuer will get a summary report for all processing statuses, including successful submission without errors.

Refer to the business validation tables on Pages 10-14 for CMS processing responses to files based on field validations.

1.3 Resubmission Process

1.3.1 Resubmissions by Issuers

CMS will consider every resubmission as a new submission. The name of the file must be unique. Every resubmission by issuers must have a new date and time. CMS will not accept or process resubmissions with identical dates and times in the file name. Each time an issuer resubmits, it must submit the entire file (i.e. the full pipe-delimited file). Because CMS will not process partial resubmissions, issuers should plan accordingly by saving their flat, pipe-delimited file in a separate environment so that it can be modified and resubmitted as necessary.

1.3.2 CSR Outreach Team

An outreach team is being formed to facilitate the accurate and timely submissions of files from the issuers to CMS. The outreach team will provide coordination between CMS and contract partners. The files submitted by issuers and the files’ statuses are communicated across stakeholders to identify any issues/errors in file submission to be resolved by issuers. Tracking and reporting the success or failure of each issuer’s file by submission month will occur on a daily basis. The outreach team can be reached for questions and assistance at CSRreconquestions@cms.hhs.gov.

Appendix B

Email Messages to Issuers Regarding Status of Files

Scenario	Status	Email Message/Error Message
<p>CMS has accepted and processed the issuer's file submission, but still needs to confirm that attestation forms have been received and processed successfully. The data submission passed all CMS validations. Note: The issuer will not receive any validation errors in the scenario where they have submitted a file but have not submitted data specifically for one or more QHP IDs, so issuers should review the summary report in their EFT to determine if CMS has identified any QHP IDs for which data is missing.</p>	<p>Accepted and Processed</p>	<p>CMS has processed your CSR reconciliation file submission. Your submission passed all CMS validation checks. Your data submission will be marked as complete contingent on your attestation(s) submission being accepted and processed successfully.</p> <p>You will receive a summary report in your EFT folder within the next 24 hours that includes your CSR reconciliation amount, which was calculated based on the data you have submitted to date. Please review the report. It will include any QHP IDs for which you have not submitted data, if applicable.</p>

<p>CMS has received and processed the issuer's data file submission, but the file has errors.</p>	<p>FILE ACCEPTED BUT WITH ERRORS</p>	<p>CMS has processed your CSR reconciliation file submission, but the file has errors. You will receive an error report in your EFT folder within the next 24 hours that summarizes the errors. Review the error report to determine if you need to correct the data, in which case you should resubmit the entire file to CMS.</p> <p>Additionally, the report includes your CSR reconciliation amount, which was calculated based on the data you have submitted to date. The report will also include any QHP IDs for which you have not submitted data, if applicable. Your data submission will be marked as complete contingent on your attestation(s) submission being accepted and processed successfully.</p>
<p>CMS has rejected the issuer's file submission due to data formatting or other critical error(s).</p>	<p>FILE REJECTED</p>	<p>CMS has rejected your CSR reconciliation file submission due to formatting or other critical errors. You will receive an error report in your EFT folder within the next 24 hours that summarizes the errors. Review the error report to determine what you need to correct, and then resubmit the entire file to CMS. All data resubmissions must include the required attestations in order for your submission to be considered complete.</p>

<p>Attestation form(s) has been accepted.</p>	<p>ATTESTATION FORM(S) ACCEPTED AND PROCESSED SUCCESSFULLY</p>	<p>CMS has received your CSR reconciliation attestation form(s) and it has been processed successfully. Your form(s) passed CMS's validation checks. Your submission will be marked as complete contingent on your data file being submitted and processed successfully.</p>
<p>Attestation form(s) has been rejected and need to be resubmitted</p>	<p>ATTESTATION FORM(S) HAS BEEN REJECTED</p>	<p>CMS rejected your attestation form(s) because it failed the validation process. Your attestation form(s) needs to be corrected and resubmitted. You will receive an error report in your EFT folder within the next 24 hours that summarizes the errors. Review the error report to determine what corrections need to be made, and then submit a corrected form(s).</p>
<p><u>Email Reminder</u></p>	<p>REMINDER EMAIL TO ISSUERS WHO HAVE NOT SUBMITTED DATA/ATTESTATION FILES</p>	<p>CMS has not received your CSR reconciliation file and/or attestation form(s). The due date for submission is April 30, 2016 at 11:59 p.m. Eastern Standard Time (if April 30 falls on a Saturday or Sunday, you have until 11:59 p.m. Eastern Standard Time the following Monday to provide the submission to CMS).</p>

Appendix C

Error Logs Sample

SCENARIO #1 : FILE PASSED ALL VALIDATIONS

VALIDATING ISSUER SUMMARY (01 Records)

QHPIDs in 02 Records : 10191PA026000501 10191PA026000502

Number of 01 Records having invalid TPIDs : 0

Number of 01 Records having invalid Issuer Extract date: 0

Number of 01 Records having invalid Issuer Extract time : 0

Number of 01 Records having invalid Benefit Year : 0

VALIDATING PLAN SUMMARY (02 Records)

QHPIDs in 02 Records : 10191PA026000501 10191PA026000502

Number of 02 Records having invalid QHPIDs : 0

Number of 02 Records having invalid Total Annual Premium : 0

Number of 02 Records having invalid Total allowed cost for EHB : 0

Number of 02 Records having invalid Actual Amt Issuer Paid for EHB : 0

Number of 02 Records having invalid Actual Amt Enrollee paid for EHB : 0

Number of 02 Records having invalid EHB enrollees paid in the std plan : 0

Number of 02 Records having invalid Actual Value CSR provided : 0

VALIDATING POLICY DETAIL (03 Records)

Number of 03 Records having invalid Exchange Assigned Subscriber ID : 0

Number of 03 Records having invalid Benefit Start Date : 0

Number of 03 Records having invalid Benefit End Date : 0

Number of 03 Records having invalid Total monthly Premium : 0

Number of 03 Records having invalid Self/Other : 0

Number of 03 Records having invalid Annual Limitation on CS for Standard Plan : 0

Number of 03 Records having invalid Actuarial Value of Standard Plan : 0

Number of 03 Records having invalid Total Allowed cost for EHB : 0

Number of 03 Records having invalid Amount the Issuer Paid : 0

Number of 03 Records having invalid Amount the Enrollees Paid : 0

Number of 03 Records failed Business Calc - Amount the Enrollees Paid : 0

Number of 03 Records having invalid Amount the Enrollees Paid under STD plan : 0

Number of 03 Records having invalid CSR provided : 0

Sum of CSR Provided in Policy Detail Records: 0

CSR Amount for 2014 from Reference Data : 0

Difference between the Allocated and submitted CSR amounts : 0

Missing QHPID's List :

10191PA026000501,10191PA026000502,10191PA026000503,10191PA026000505,10191PA026000556,10191PA026000578,10191PA026000590

SCENARIO #2: CMS HAS RECEIVED AND PROCESSED THE ISSUER'S FILE SUBMISSION, BUT THE FILE HAS ERRORS.

VALIDATING ISSUER SUMMARY (01 Records)

QHPIDs in 02 Records : 10191PA026000501 10191PA026000502

Number of 01 Records having invalid TPIDs : 0

Number of 01 Records having invalid Issuer Extract date: 0

Number of 01 Records having invalid Issuer Extract time : 0

Number of 01 Records having invalid Benefit Year : 0

VALIDATING PLAN SUMMARY (02 Records)

QHPIDs in 02 Records : 10191PA026000501 10191PA026000502

Number of 02 Records having invalid QHPIDs : 0

Number of 02 Records having invalid Total Annual Premium : 0

Number of 02 Records having invalid Total allowed cost for EHB : 0

Number of 02 Records having invalid Actual Amt Issuer Paid for EHB : 0

Number of 02 Records having invalid Actual Amt Enrollee paid for EHB : 0

Number of 02 Records having invalid EHB enrollees paid in the std plan : 0

Number of 02 Records having invalid Actual Value CSR provided : 0

VALIDATING POLICY DETAIL (03 Records)

Number of 03 Records having invalid Exchange Assigned Subscriber ID : 0

Number of 03 Records having invalid Benefit Start Date : 0

Number of 03 Records having invalid Benefit End Date : 0

Number of 03 Records having invalid Total monthly Premium : 0

Number of 03 Records having invalid Self/Other : 0

Number of 03 Records having invalid Annual Limitation on CS for Standard Plan : 0

Number of 03 Records having invalid Actuarial Value of Standard Plan : 0

Number of 03 Records having invalid Total Allowed cost for EHB : 0

Number of 03 Records having invalid Amount the Issuer Paid : 0

Number of 03 Records having invalid Amount the Enrollees Paid : 0

Number of 03 Records failed Business Calc - Amount the Enrollees Paid : 0

Number of 03 Records having invalid Amount the Enrollees Paid under STD plan : 0

Number of 03 Records having invalid CSR provided : 0

Sum of CSR Provided in Policy Detail Records: 0

CSR Amount for 2014 from Reference Data : 0

Difference between the Allocated and submitted CSR amounts : 0

Missing QHPID's List :

10191PA026000501,10191PA026000502,10191PA026000503,10191PA026000505,10191PA026000556,10191PA026000578,10191PA026000590

ERROR_CODE_IDENTIFIER|RECORD_CODE_IDENTIFIER|RECORD_IDENTIFIER_COMMENT|ETL_LOAD_DATE

CSRIFIL37|03|Invalid value in Technical POC First Name |2016-04-23

SCENARIO #3: CMS HAS REJECTED THE ISSUER'S FILE SUBMISSION DUE TO DATA FORMATTING OR ANOTHER CRITICAL ERROR.

VALIDATING ISSUER SUMMARY (01 Records)

QHPIDs in 02 Records : 10191PA026000501 10191PA026000502

Number of 01 Records having invalid TPIDs : 0

Number of 01 Records having invalid Issuer Extract date: 0

Number of 01 Records having invalid Issuer Extract time : 0

Number of 01 Records having invalid Benefit Year : 0

VALIDATING PLAN SUMMARY (02 Records)

QHPIDs in 02 Records : 10191PA026000501 10191PA026000502

Number of 02 Records having invalid QHPIDs : 0

Number of 02 Records having invalid Total Annual Premium : 0
Number of 02 Records having invalid Total allowed cost for EHB : 0
Number of 02 Records having invalid Actual Amt Issuer Paid for EHB : 0
Number of 02 Records having invalid Actual Amt Enrollee paid for EHB : 0
Number of 02 Records having invalid EHB enrollees paid in the std plan : 0
Number of 02 Records having invalid Actual Value CSR provided : 0

VALIDATING POLICY DETAIL (03 Records)

Number of 03 Records having invalid Exchange Assigned Subscriber ID : 0
Number of 03 Records having invalid Benefit Start Date : 0
Number of 03 Records having invalid Benefit End Date : 0
Number of 03 Records having invalid Total monthly Premium : 0
Number of 03 Records having invalid Self/Other : 0
Number of 03 Records having invalid Annual Limitation on CS for Standard Plan : 0
Number of 03 Records having invalid Actuarial Value of Standard Plan : 0
Number of 03 Records having invalid Total Allowed cost for EHB : 0
Number of 03 Records having invalid Amount the Issuer Paid : 0
Number of 03 Records having invalid Amount the Enrollees Paid : 0
Number of 03 Records failed Business Calc - Amount the Enrollees Paid : 0
Number of 03 Records having invalid Amount the Enrollees Paid under STD plan : 0
Number of 03 Records having invalid CSR provided : 0
Sum of CSR Provided in Policy Detail Records: 0
CSR Amount for 2014 from Reference Data : 0
Difference between the Allocated and submitted CSR amounts : 0

Missing QHPID's List :
10191PA026000501,10191PA026000502,10191PA026000503,10191PA026000505,10191PA02600

0556,10191PA026000578,10191PA026000590

ERROR_CODE_IDENTIFIER|RECORD_CODE_IDENTIFIER|RECORD_IDENTIFIER_COMMENT|ETL_LOAD_DATE

CSRIFIL37|02|10191PA026000501 Invalid 2015 QHPID|2016-04-23

CSRIFIL37|02|10191PA026000502 Invalid 2015 QHPID|2016-04-23

CSRIFIL37|03|0000906142 Invalid against the FEPS enrollment data (FFM plans only) Exchange Assigned Subscriber Id|2016-04-23