CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Health Insurance Casework System (HICS) Enhancements



Center for Consumer Information and Insurance Oversight

April 25, 2016

Agenda

- Background and Casework Expectations
- Upcoming Health Insurance Casework System (HICS) Enhancements and Modifications
- Moving Forward
- Resources

Background and Casework Expectations

- CMS expects QHP and SADP issuers to thoroughly investigate and resolve consumer issues received directly from members or forwarded to the QHP or SADP issuer by the state through the issuer's internal customer service process and as required by state law
- Additionally, QHP and SADP issuers operating in the FFMs and SBM-FPs must investigate and resolve consumer cases, including complaints, forwarded by CMS in accordance with the requirements at 45 CFR 156.1010

Background and Casework Expectations

- CMS relies heavily on the Health Insurance Casework Systems (HICS) as a means to resolve a variety of consumer matters
- Currently two categories of cases are generally delegated to issuers for review and handling
  - Category 2 – Plan and Issuer Concerns
  - Category 5 – Machine Readable Discrepancy
- Issuers are expected to acquire and maintain sufficient access to the HICS, complying with all applicable CMS security and certification requirements

Background and Casework Expectations

- "Category 2" Cases that CMS may forward to issuers include (but are not limited to the following):
  - Cancellations or terminations for any reason (including for non-payment of premiums)
  - Reinstatement review
  - Premium or premium payment disputes
  - Proper application of the APTC and CSRs,
  - Adjustments of effective dates based on special enrollment periods (SEPs)
  - Final eligibility appeals decisions
  - Delayed enrollment processing, or other enrollment errors
  - Plan benefit issues

Background and Casework Expectations

- In all cases, CMS expects QHP and SADP issuers operating in the FFMs and SBM-FPs to conduct appropriate research using all of the tools and systems available to them, including but not limited to 834 transactions and pre-audit files
- Additionally, CMS expects QHP and SADP issuers operating in the FFMs and SBM-FPs to contact consumers as appropriate to conduct their investigations and research in order to ensure that issuers are using the most recent information available from the consumer
- Issuers may often need to contact a consumer prior to the resolution of a case as a critical part of the investigation and research process
- CMS expects that issuers will carry out the needed research for their cases in a comprehensive manner that assures consumers that issuers' case resolutions are based on all of the available and most current information
- CMS staff is available to assist QHP and SADP issuers by providing technical assistance on casework matters, and cases beyond issuers' control to resolve may result in reassignment of the case to CMS

Background and Casework Expectations

- “Category 5” Cases that CMS may forward to issuers relate exclusively to anonymized matters brought to CMS’ attention through consumer feedback about machine readable data provided by issuers, including plan provider network and formulary information
- Accordingly, CMS do not consider these matters to be “cases,” and requirements under 45 CFR 156.1010 does not apply to these cases
- CMS expects issuers to monitor these anonymized matters and use the data to identify trends that could indicate that their machine-readable files need to be corrected or updated
- These cases are loaded into HICS once per month, typically during the first week of the month

HICS Upcoming Technical Enhancements

- New Data Element in HICS Cases – “Has the consumer contacted the issuer?”
  - Intake Options: Yes, No, N/A
  - Added to Data Extract File
- Search Results >300 Cases
  - When search results exceed 300, only 300 will return but the total number of records will display (e.g. 564)
- Ability to add Casework Notes and Comments when a case is Resolved
  - Ability to add additional information after a case is closed to provide a complete record

HICS Upcoming Technical Enhancements

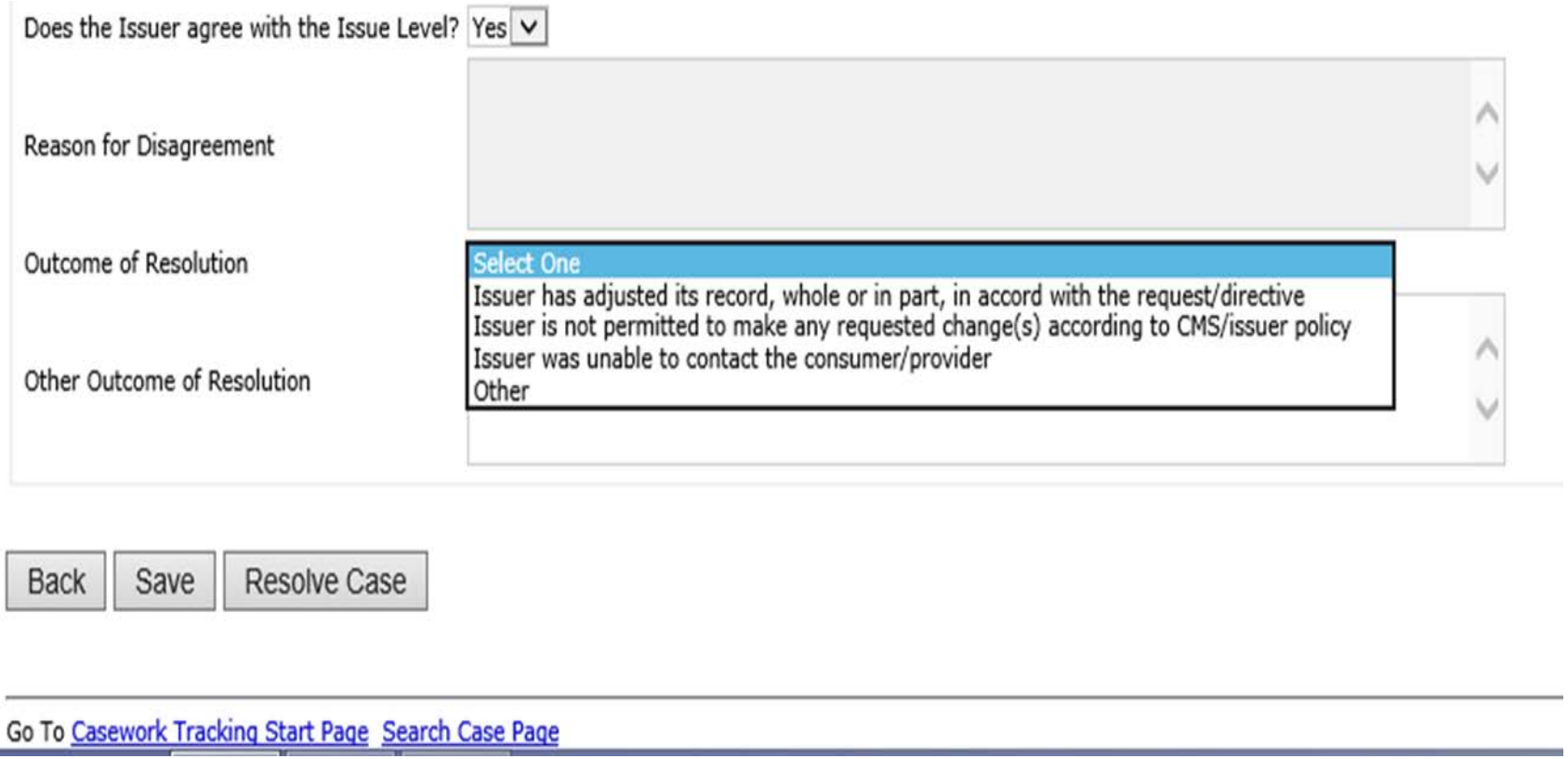
- Issuers can now enter more than one case ID on the Search page to return multiple cases
  - Separated by comma
- Changes to Case Information Screen
  - "Marketplace Model" Removed
    - This data will remain in the extract. Information in the Field can be disregarded
  - Flag for Potential Fraud, Waste, and Abuse
    - Yes or No Option
    - Data element added to the extract

HICS Upcoming Technical Enhancements

- New Required “Outcome of Resolution” Field on Resolution Screen, with four options:
  1. “Issuer has adjusted its record, whole or in part, in accord with the request/directive”
  2. Issuer is not permitted to make any requested change(s) according to CMS/issuer policy”
  3. Issuer was unable to contact the consumer/provider”
  4. Other (opens Other text box with 1000 character entry)”
- Allow for easier data analysis and outcome monitoring for issuers and CMS
- Joint suggestion from AHIP and BCBSA

HICS Upcoming Technical Enhancements

- **Addition to Case Resolution Screen will look like this:**



HICS Upcoming Technical Enhancements

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
Case ID	CHAR REQUIRED	11	Case ID assigned by HICS. The Case ID must already exist in HICS.	E1234567890
Casework Notes	CHAR REQUIRED	4,000	Summary description regarding the complaint and its resolution. Only include new notes. Any notes already entered in the HPMS CTM should not be included in the upload. Please note: if the user is closing the complaint the Casework Note becomes the Resolution Summary.	Casework notes
Close Case Y/N	CHAR REQUIRED	1	Enter "Y" if the case should be resolved. Enter "N" if the case should remain open.	Y
Comments (External)	CHAR OPTIONAL	4,000	If desired, provide any notes that the plan should see when performing their plan resolution. Otherwise, leave this field blank.	Comments
Pending XOSC Help Desk	CHAR REQUIRED	1	Enter "Y" if the case has been sent to the XOSC Help Desk. Enter "N" if the case has not been sent to the XOSC Help Desk.	Y
Date Case Referred to XOSC Help Desk	CHAR CONDITIONAL	10	If "Y" was entered for Pending XOSC Help Desk, then enter the date the case was referred (MM/DD/YYYY). If "N" was entered for Pending XOSC Help Desk, then leave this field blank	01/01/2014
Date of Resolution Notification	CHAR OPTIONAL	10	Enter the date of resolution notification (MM/DD/YYYY).	01/05/2014
Does the Issuer Agree with the Issue Level?	CHAR REQUIRED	1	Enter "Y" if the user agrees with the Issue Level. Enter "N" if the user disagrees with the Issue Level.	Y
Issue Level Disagreement Text	CHAR OPTIONAL	1000	This field is optional if the user selects N to the field above. Enter the reason the user disagrees with the Issue Level.	Reason
Outcome of Resolution	NUM CONDITIONAL	1	If "Y" was entered for Close Case, then the Outcome of Resolution field is required. Enter the number associated with the Outcome of Resolution per below. 1. Issuer has adjusted its record, whole or in part, in accord with the request/directive 2. Issuer is not permitted to make requested changes(s) according to CMS/issuer policy 3. Issuer was unable to contact the consumer/provider 4. Other	4
Outcome of Resolution Other Text	CHAR CONDITIONAL	1000	If "4" was entered for the Outcome of Resolution, then the Other Outcome of Resolution field is required.	Other Text

Moving Forward

- CMS will be working to classify HICS cases in accordance with the issue level parameters detailed in 45 CFR 156.1010, by more frequently and consistently identifying Level 1 cases requiring more immediate attention
  - Issuers will be advised when we begin this effort
- CMS will be increasing collaboration with states, sharing information suggestive of issuer performance problems and providing more HICS access to state regulators
  - Promoting increased availability and access to HICS for state departments of insurance

Moving Forward

- “Deep Dive” exercise – CMS is currently working on an effort to examine the underlying root causes of the most common issues we saw at the start of the benefit year to determine ways we can improve the consumer experience
- CMS will continue to work with QHP and SADP issuers to identify ways to improve the customer service experience for consumers in FFM and SBM-FP states, including promoting best practices, enhancing the HICS, refining casework guidance, **and seeking to minimize cases assigned to issuers in HICS for their review and handling**

Resources

- HICS Access Guide distributed on May 21, 2015
- Oct 1, 2015 Presentation for Issuers on HICS
- Dec 17, 2015 Decision Support Features Complaints (Machine Readable Complaint Guidance)
- Updated Plan User Manual for HICS
  - Available ~5/10/16 in HICS