Open Q&A Webinar Series

July 6, 2016

Center for Consumer Information and Insurance Oversight (CCIIO)

CMS
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Open Q&A Series for States

- The monthly webinar series provides States with the opportunity to ask questions about the Qualified Health Plan (QHP) Certification process, including QHP State review tools.
- The State webinar series will complement CMS's twice-weekly issuer QHP webinar series.
  - States are invited to attend and listen to issuer webinars.
- State webinars will take place on the first Wednesday of each month from May - November, from 3 – 4 PM ET.
- States are encouraged to submit questions in advance of each webinar to CMS_FEPS@cms.hhs.gov.

Agenda

- Upcoming Key Dates for QHP Certification
- Upcoming Plan Management (PM) State Outreach Changes
- Plan Year (PY) 2017 Certification Reviews: Round 1 Common Corrections
- Program Attestation Review for States for Plan Year 2017

Upcoming Key Dates for QHP Certification:

Date	Category	Activity
Ongoing	Submission	Issuers' QHP data in Health Insurance Oversight System (HIOS) Plan Preview HIOS Modules and System for Electronic Rate and Form Filing (SERFF) transfer are open for data resubmission.
July 1 – August 2, 2016	CMS Review	Centers for Medicare & Medicaid Services (CMS) conducts Round 2 review of PY 2017 QHP Applications.
August 8 – 9, 2016	CMS Notice	CMS sends Round 2 **Correction Notice** to issuers and State Regulators.
August 8 – 9, 2016	CMS Notice	CMS sends second **Plan Crosswalk Notice** to issuers and State Regulators.
August 23, 2016	**Submission**	**Final deadline for submission of QHP Application data.** **Final SERFF transfer deadline.**

Upcoming PM State Outreach Changes

Upcoming PM State Outreach Changes

- In an effort to respond to feedback received from States, CMS has developed an improved process for State outreach that aims to better address State needs around Marketplace Plan Management.

- The new process aligns State outreach with issuer outreach to allow Plan Management to manage State communications more efficiently and decrease the time it takes to respond to State inquiries.

Sending Questions/Requests for Technical Assistance to Plan Management

- States should send all Plan Management-related questions and/or requests for technical assistance to the CMS Exchange Operations Support Center (XOSC) Help Desk at CMS_FEPS@cms.hhs.gov.
- State inquiries sent to the Help Desk will be managed via the same process as issuer inquiries.
- States will receive a Help Desk ticket number that tracks the inquiry and allows for follow-up on outstanding requests.
- For example, Plan Management-related questions may reference the following topics: QHP certification process, reviews, and timeline, data integrity and template submissions, issuer compliance, Small Business Health Options Program (SHOP) and agent/broker inquiries and health plan quality.

Receiving Emails from Plan Management

- States with Federally-facilitated Marketplaces (FFMs), States performing plan management functions in the FFM (SPMs), and State-based Marketplaces on the federal platform (SBM-FPs) will receive outreach from a new Plan Management-specific email inbox: PlanManagementStateCoordination@cms.hhs.gov.
  - This mailbox will send Marketplace Plan Management-related outreach **only**.
  - To ensure that Plan Management-related outreach is sent to the appropriate State Department of Insurance (DOI) contacts, States are encouraged to send updates to their staff's contact information to this mailbox.

Overview of State Outreach Changes

- FFM and SPM states will receive all Plan Management-related outreach from: PlanManagementStateCoordination@cms.hhs.gov.
- States should send all Plan Management-related questions and/or requests for technical assistance to the CMS XOSC Help Desk at CMS_FEPS@cms.hhs.gov.
- Plan Management will continue to conduct outreach using its other typical channels:
  - e.g., Health Insurance Marketplace Weekly Update, State Exchange Resource Virtual Information System (SERVIS), and State Regulator Webinar Series on QHP Certification.
- The FFM_Operational_Questions@cms.hhs.gov will continue to be used for non-Plan Management-related outreach.

PY 17 Certification Reviews: Round 1 Common Corrections

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Essential Community Providers (ECPs)

- **Common Deficiencies:**
  - 070000071: One (1) or more plan networks are below the 30 percent ECP threshold and no justification was provided.
  - 070000041: One (1) or more plan networks are below the 30 percent ECP threshold and insufficient justification was provided.
- **Tips on Correcting:**
  - If issuers have executed contracts with providers on the Final PY2017 ECP list or the recently released "Available ECP Write-in List for Round 2" that were not including in issuers' Round 1 submission, add them to issuers' Round 2 ECP/Network Adequacy (NA) template before resubmitting.
  - Issuers that fall short of satisfying the 30 percent standard or are unable to satisfy the ECP requirements outlined in the Annual Letter must submit an ECP narrative justification that:
    - Fully addresses all questions in the ECP supplemental response form;
    - Includes measurable evidence (such as number of contracts offered, additional outreach conducted, et cetera) of efforts to comply with the ECP standard.

Essential Community Providers (Dental)

- **Common Deficiencies:**
  - 070000291: One (1) or more dental networks are below the ECP threshold of 30 percent of available dental ECPs and insufficient justification was provided.
  - 070000311: One (1) or more dental networks are below the 30 percent ECP threshold and no justification was provided.
- **Tips on Correcting:**
  - If issuers have executed contracts with providers on the Final PY2017 ECP list or the recently released "Available ECP Write-in List for Round 2" that were not including in issuers' Round 1 submission, add them to issuers' Round 2 ECP/Network Adequacy (NA) template before resubmitting.
  - Issuers that fall short of satisfying the 30 percent standard or are unable to satisfy the ECP requirements outlined in the Annual Letter must submit an ECP narrative justification that:
    - Fully addresses all questions in the ECP supplemental response form;
    - Includes measurable evidence (such as number of contracts offered, additional outreach conducted, et cetera) of efforts to comply with the ECP standard.

Non-Discrimination Formulary Outlier and Clinical Appropriateness

Non-Discrimination Formulary Outlier

- **Tips on Correcting:**
  - Attempt to cover more drugs without restrictions.
  - Use the Formulary Review Suite's Formulary Outlier review to identify those categories and classes with a low number of unrestricted drugs.

Non-Discrimination Clinical Appropriateness

- **Tips on Correcting:**
  - Breast Cancer; Androgens
    - Cover the generic form of Methyltestosterone (10 mg oral capsule).
  - Rheumatoid Arthritis; DMARDs (Tofacitinib)
    - Cover Tofacitinib (Xeljanz; 5 mg oral tablet).

Non-Discrimination (Cost-Sharing)

- Copays for a variety of benefits were higher than the calculated State and national thresholds.
- **Tips on Correcting:**
  - Issuers need to reduce copay values to be equal to or less than the threshold value provided in the notification language.
  - An issuer could change a benefit with an outlier from being subject to the deductible to not being subject to the deductible. Benefits that are not subject to the deductible can be twice as high as the threshold provided in the notification language.
  - Alternatively, an issuer may submit a detailed justification stating why the issuer believes that the issuer's copay outliers are not discriminatory.

Cost Sharing Reduction (CSR)

- 120000521-The cost sharing increases as the Actuarial Values (AVs) increase for silver plan variations.
- **Tips on Correcting:**
  - Issuers should ensure the copay or coinsurance for the silver plan variations does not increase for plan variations with a higher AV.
  - This also means the cost-sharing among plan variations may not have a different structure for a benefit.
    - e.g., the 94% AV plan variation may not charge a copay if the 87% AV plan variation only charges a coinsurance.
    - e.g., it is acceptable for all plan variations to use a structure of a copay “before deductible;” however, it is not acceptable for one (1) plan variation to use this structure and another to have just a copay.

Cost Sharing Reduction (continued)

- 120000161-The Maximum Out-of-Pocket (MOOP) exceeds the permissible threshold for a silver plan variation.
- **Tips on Correcting:**
  - Issuers should update issuers' MOOP values to ensure the In-Network MOOP adheres to the following requirements:
    - For 73% AV plan variations: the Individual and Family-Per Person values must be **$5,700** or less and the Family-Per Group value must be **$11,400** or less.
    - For 87% AV and 94% AV plan variations: the Individual and Family-Per Person values must be **$2,350** or less and the Family-Per Group value must be **$4,700** or less.

Cost Sharing Reduction (continued)

- 120000191-The zero (0) cost-sharing plan variation has non-zero (0) cost sharing for Essential Health Benefits (EHBs).
- **Tips on Correcting:**
  - Issuers should ensure the zero (0) cost sharing plan variation has **no** cost sharing for in-network EHBs.

Standardized Plan Design

- 240000021 and 240000061-The plan indicates that it is using a standardized plan design. However, the values for the cost-sharing of AVC additional benefit design field do not match the standardized plan design guidance.
- **Tips on Correcting:**
  - First, issuers should use the Standardized Plan Design Add-In to populate the values as this will ensure all values match guidance.
  - Otherwise, issuers should change the value for the field and plan variation mentioned to be **exactly** what is in the correction language.
  - For more details on the requirement, it is recommended issuers reference the Payment Notice or the Plans & Benefits Instructions.

Resubmission Reminders

- For all issuers and types of Marketplace using the federal eligibility and enrollment platform:
  - Revised QHP data must be submitted to CMS by **August 23, 2016.**
  - CMS encourages State regulators to work with issuers in the State to meet QHP data submission deadlines using the system appropriate for the State.

Resubmitting through HIOS

- Issuers in States with FFMs where the State is not performing plan management functions must resubmit through **HIOS**.
  - Issuers who resubmit templates must also reenter "cross validation complete" status in HIOS in order for their most recent data to be reviewed by CMS.
  - The following steps must be completed prior to the **August 23, 2016 deadline**:
    - Validate each module and return to the **Final Submission** tab;
    - On the Final Submission tab, click "Cross Validate" and then click "Submit."

Resubmitting through SERFF

- Issuers in States performing plan management functions in the Federally-facilitated Marketplace (SPMs) and State-Based Marketplaces on the Federal Platform (SBM-FPs) must resubmit through **SERFF.**
  - Issuers submitting revised templates should contact the issuer's State to retransfer the QHP Application from SERFF to CMS as soon as possible. CMS will review the latest application data transferred by the August 23rd deadline.
  - **The issuer is responsible for working with the appropriate State regulator to ensure all updated application data is successfully retransferred.**
    - When transferring data, States using SERFF should only select the individual plans they wish to resubmit. States should not select "submit all" unless they need to resubmit every plan.
  - Revised data resubmitted through SERFF will be the official QHP Application of record for reviews and certification. These issuers' QHP Applications should not be submitted through HIOS. Data submitted through HIOS will not be reviewed for certification.

Resolving Template Submission Errors

- Issuers or States that need assistance in resolving template submission errors, such as the “Save Failed” error associated with ECP/NA Template, should email the XOSC Help Desk at CMS_FEPS@cms.hhs.gov and provide the following information:
  - HIOS Issuer ID;
  - State;
  - A brief description of the error;
  - An attachment of the template associated with the error; and
  - The name and phone number of the issuer’s primary contact for additional technical assistance on the issue.

Program Attestation Review for States for PY 2017

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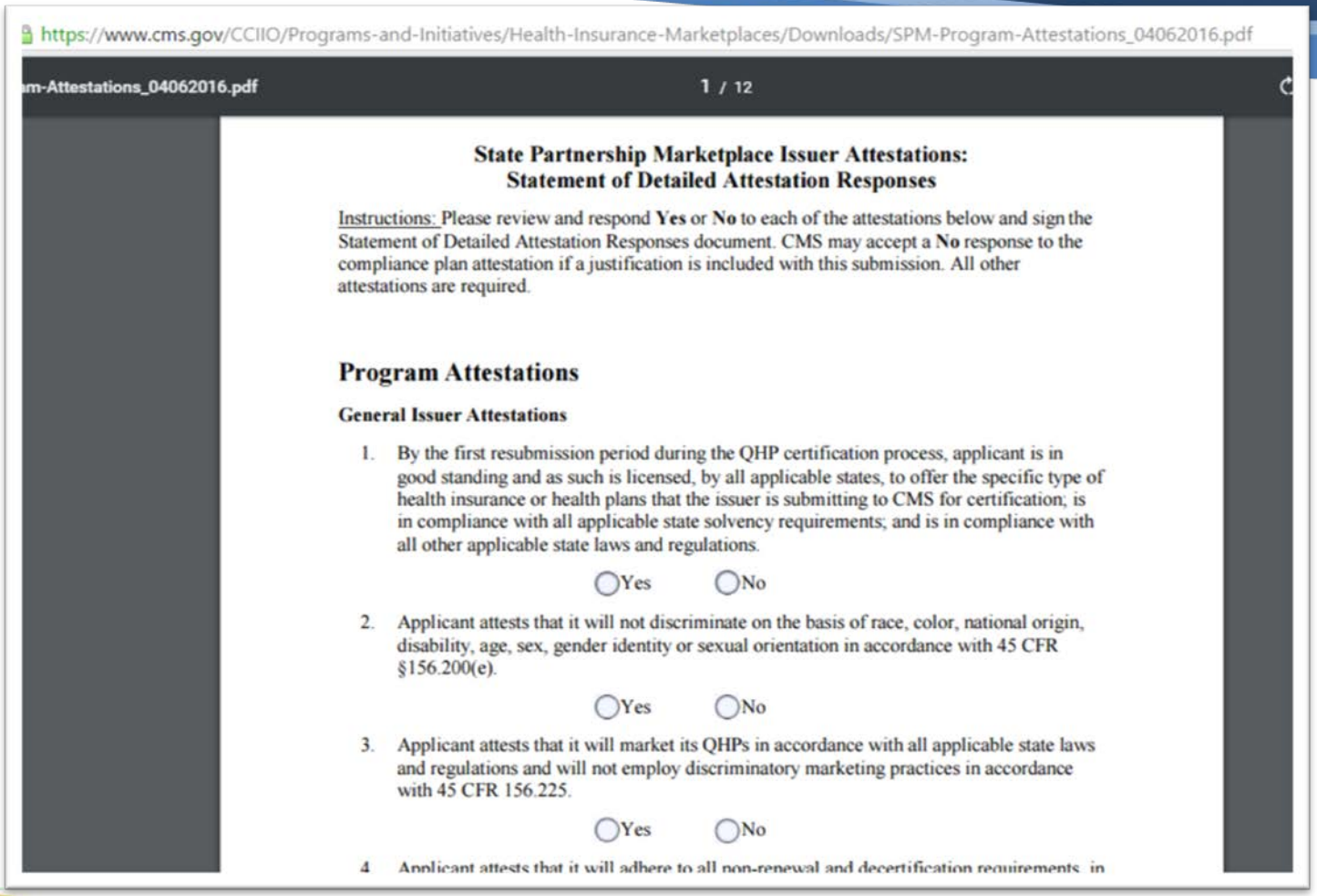
Program Attestations Overview

- The attestations section of the QHP Application requires issuers to attest to issuers' adherence to a variety of regulations set forth in 45 CFR 155 and 156 as well as programmatic requirements necessary for the operational success of the FFM.
- The attestations apply to all QHP issuers seeking to participate in the FFM, which maintain responsibility for the compliance of any downstream or delegated entities (including vendors and contractors of the QHP issuer or company).
- To ensure compliance with FFM requirements, it is important to CMS to receive affirmative responses to all required Program Attestations from QHP issuers.

SPM Statement of Detailed Attestation Responses Form



https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/SPM-Program-Attestations_04062016.pdf

m-Attestations_04062016.pdf 1 / 12

State Partnership Marketplace Issuer Attestations:
Statement of Detailed Attestation Responses

Instructions: Please review and respond **Yes** or **No** to each of the attestations below and sign the Statement of Detailed Attestation Responses document. CMS may accept a **No** response to the compliance plan attestation if a justification is included with this submission. All other attestations are required.

Program Attestations

General Issuer Attestations

1. By the first resubmission period during the QHP certification process, applicant is in good standing and as such is licensed, by all applicable states, to offer the specific type of health insurance or health plans that the issuer is submitting to CMS for certification; is in compliance with all applicable state solvency requirements; and is in compliance with all other applicable state laws and regulations.

   ◯Yes ◯No

2. Applicant attests that it will not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation in accordance with 45 CFR §156.200(e).

   ◯Yes ◯No

3. Applicant attests that it will market its QHPs in accordance with all applicable state laws and regulations and will not employ discriminatory marketing practices in accordance with 45 CFR 156.225.

   ◯Yes ◯No

4 Applicant attests that it will adhere to all non-renewal and decertification requirements, in

Submission through SERFF

- Issuers in States performing plan management functions in the FFM should submit their 2017 QHP Applications through SERFF.

- The SPM Statement of Detailed Attestation Responses form should be uploaded to SERFF as part of the 2017 QHP Application.

Required Attestations

- General Issuer Attestations
- Organizational Chart Attestations
- Operational Attestations
- Benefit Design Attestations
- Stand-Alone Dental Attestations
- Rate Attestations
- Enrollment Attestations
- Financial Management Attestations
- SHOP Attestations
- Reporting Requirements Attestations
- Accreditation Attestations
- ECP Attestations
- Network Adequacy Attestations

Required Attestations (continued)

- CMS anticipates that all QHP issuers recommended by the State for certification should respond "**yes**" to all required attestations.

Optional Attestations

- Compliance Plan Attestation is the only optional attestation for which a "**no**" response may be accepted.
- If an issuer responds "**no**" to the Compliance Plan Attestation, the issuer must submit a justification.

State Partnership Marketplace Issuer Attestations:
Statement of Detailed Attestation Responses

Attestation Justification

Provide a justification for any attestation for which you indicated **No**. Be sure to reference the specific attestation in your justification.

Common Issues

- Issuer responds “no” to one (1) or more required attestations.
- Issuer submits FFM Statement of Detailed Attestation Responses.
- Issuer responds “no” to optional attestation, but does not submit a justification.
- Issuer left one (1) or more attestations blank.

Questions

Please help us provide an accurate response by identifying your State when asking a question.

If you are not able to ask your question during today's session, or if your question is best answered by subject matter experts outside Plan Management, you may submit it via CMS_FEPS@cms.hhs.gov with the subject line "State Question."