Plan Year (PY) 2018 – Common Deficiencies; PY 2018 Common Data Review Errors; PY 2017 Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Survey: Upcoming Results and Preview

August 2, 2017



Center for Consumer Information and Insurance Oversight (CCIIO)

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Open Q&A Series for States

- The monthly webinar series provide States with the opportunity to ask questions about the QHP Certification process, including QHP State review tools.
- The State webinar series will complement the Centers for Medicare & Medicaid Services' (CMS's) twice-weekly issuer QHP webinar series.
  - States are invited to attend and listen to issuer webinars.
- A listing of all State webinars can be found on the Registration for Technical Assistance Portal (REGTAP).
  - www.REGTAP.info
- States are encouraged to submit questions in advance of each webinar to CMS_FEPS@cms.hhs.gov.

Agenda

- Upcoming Key Dates for QHP Certification
- PY 2018 – Common Deficiencies
- PY 2018 Common Data Review Errors
- PY 2017 QRS and QHP Enrollee Survey: Upcoming Results and Preview
- Q&A

Upcoming Key Dates for QHP Plan Maintenance and Certification

Date	Category	Activity
June 22, 2017 – July 25, 2017	QHP Submission	CMS reviews Initial PY 2018 QHP Applications received as of June 21, 2017
July 6, 2017 – July 14, 2017	Plan Data Change	Issuers Submit Final Data Change Requests for the PY 2017 July Data Correction Window (DCW), including 4th Quarter Small Business Health Options Program (SHOP) Rate Changes
July 19, 2017 – July 25, 2017	Plan Data Change	July DCW for Approved PY 2017 Plan Data Changes
August 1, 2017 – August 2, 2017	QHP Submission	• CMS sends First PY 2018 Correction and Crosswalk Notices to Issuers • CMS sends alternate enrollment "Potential New Consumers" File and Outreach Notices to Issuers and States
August 4, 2017	QHP Submission	Deadline for PY 2018 Service Area Petition

PY 2018 – Common Deficiencies

Administrative Review Overview

Review Highlights:

- Issuer received a deficiency for each missing administrative field:
  - Did not provide a customer service phone number (either individual [020000211] or SHOP [020000261])
  - Did not provide a customer service toll free number (either individual [020000231] or SHOP [020000281])
  - Did not provide a customer service TTY number (either Individual [020000242] or SHOP [020000292])
  - Did not provide a customer service URL (either Individual [020000252] or SHOP [020000302])
  - Did not provide information regarding billing (e.g., address [020000152], city [020000172], state [020000182], zip [020000192])

Tips to Resolve Issues:

- Administrative information displayed on the www.healthcare.gov website is pulled from the Health Insurance Oversight System (HIOS) Plan Finder Module.
- Instructions on how to enter the information are in Sections 5.1 and 5.3 of the HIOS Plan Finder—Issuer User Manual at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIOS-PF-UserManual-032015.pdf.

Essential Community Providers (ECP) Review Overview

Review Highlights:

- One (1) or more networks did not meet the 20% threshold and *insufficient justification* was provided. (070000631)
- One (1) or more networks did not meet the 20% threshold and *no justification* was provided. (070000641)
- One (1) or more networks did not meet the alternate ECP threshold of 20% of available ECPs located within HPSAs or low-income ZIP codes and *no justification* was provided. (070000671)

Tips to Resolve Issues:

- Issuers that do not meet the ECP threshold should continue efforts to recruit providers. (070000631, 070000641, 070000671)
- Deficiencies resulting from no/insufficient justification can be corrected by closely following the instructions found in the ECP Supplemental Response Form. (070000631, 070000641, 070000671)
- https://www.qhpcertification.cms.gov/s/SuppDoc_ECP_Version2.pdf?v=1
    - The issuer should be specific in its supplemental response (e.g. names of providers contacted, dates of contacts, etc.).

ECP-Dental Review Overview

Review Highlights:

- One (1) or more networks did not meet the 20% threshold and *insufficient justification* was provided. (070000691)
- One (1) or more networks did not meet the 20% threshold and *no justification* was provided. (070000701)
- One (1) or more networks did not contain any dental ECPs and *insufficient justification* was provided. (070000381)
- One (1) or more networks did not contain any dental ECPs and *no justification* was provided. (070000301)

Tips to Resolve Issues:

- Issuers that do not meet the ECP threshold should continue efforts to recruit providers. (070000301, 070000381, 070000691, 070000701)
- Deficiencies resulting from no/insufficient justification can be corrected by closely following the instructions found in the ECP Supplemental Response Form. (070000301, 070000381, 070000691, 070000701)
- https://www.qhpcertification.cms.gov/s/SuppDoc_ECP_Version2.pdf?v=1
    - The issuer should be specific in its supplemental response (e.g. names of providers contacted, dates of contacts, etc.).

Cost Share Reduction Review Overview

Review Highlights:

- The most common deficiency was for having non-zero (0) cost sharing in the zero (0) cost sharing plan variation.
  - The error is often caused by incorrectly coding an out-of-network (OON) benefit in the zero (0) cost sharing plan variation as not covered.
- The next most common deficiency was for not following successive cost sharing.
  - Unlike past years where issuers failed for just swapping cost sharing structures, most of these deficiencies are for actually increasing cost sharing for increased plan variations.
- No change to review this year.

Tips to Resolve Issues:

- Several of the issues causing correction code 120000191 can be resolved by updating out of network benefit cost sharing
  - No benefits can have “Not Applicable” for both copay and coinsurance. If a benefit is not covered OON, it should have a copay of “Not Applicable” but a coinsurance of “100%.”
- To fix correction code 120000521: successive cost sharing must be followed for each individual benefit, so the silver plan variations must have the same cost sharing structure as the standard component, and the value must stay the same or decrease as the actuarial value (AV) increases.

Non-Discrimination Review (Cost Sharing) Review Overview

Review Highlights:

- All deficiencies were associated with copay values being higher than the associated thresholds.
- There were no major changes to the review criteria for PY 2018.
    - For PY 2018, the review will evaluate a cost sharing value against just the national threshold when the State threshold is equal to “No Result” due to insufficient amounts of data.

Tips to Resolve Issues:

- Issuers can reduce copay values to be equal to or less than the threshold value provided in the notification language (correction code 130000051).
- Alternatively, an issuer may submit a detailed justification stating why the issuer believes that the copay outliers are not discriminatory (correction code 130000051).

Non-Discrimination Review (Formulary Outlier) Review Overview

Review Highlights:

- Deficiencies were found in the Anti-Addiction / Substance Abuse Treatment; Opioid Reversal Agents class and the Antivirals; Anti-HIV agents classes, Immunological Agents, Immune Suppressants class, Antidepressants, Selective Serotonin Reuptake Inhibitors (SSRIs)/Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs) class (correction code 130000841).

Tips to Resolve Issues:

- Offer drugs in the deficient classes without restriction or submit a justification response. (correction code 130000841)
    - Justification response should describe why the prescription drug benefit design is non-discriminatory offering any clinical support or evidence for the design.

Stand-alone Dental Plan (SADP) Review (Essential Health Benefit [EHB] Benchmark) Review Overview

Review Highlights:

- Annual Dollar limitation on a service for an EHB (correction code 090000181).
- Condition limitation in free text on a service (correction code 090000321).
- Benefit limit quantity and limit unit below 75% of the EHB benchmark (correction code 090000101).
- There were no major changes to the review criteria for PY 2018.

Tips to Resolve Issues:

- Issuers should not put any limitations on EHBs that are more restrictive than the Federal and State benchmark plans. Applies to correction codes: 090000321, 090000181, and 090000101.
- Information on Federal standards for pediatric EHB dental care can be located at this website: https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2014/brochures/MetLife.pdf.
- Information on EHB Benchmark Plans can be located here: https://www.cms.gov/cciio/resources/data-resources/ehb.html

Simple Choice Plan Review Overview

Review Highlights:

- Most common deficiency was for having an incorrect value for a Simple Choice Plan benefit.
    - Maximum coinsurance for specialty drugs for all Simple Choice Plans is required to be empty.
    - SHOP plans cannot offer Simple Choice plans, and so must indicate a “Not Applicable” Design Type.
- There were no major changes to the review criteria for PY 2018.

Tips to Resolve Issues:

- For correction code 240000021: Issuers need to change the specific cost sharing values to match the value in the notice language.

Plan ID Crosswalk

Tips to Resolve Issues:

- For deficiency code 5: Plan ID ___ from PY 2017 has been crosswalked to Plan ID ___for PY 2018. However, the plans have different Issuer IDs.
  - In compliance with Guaranteed Renewability of Coverage standards established at 45 CFR 147.106(e)(3)(i), a product will be considered to be the same product when offered by a different issuer within an issuer's controlled group, provided it otherwise meets the standards for uniform modification of coverage. Issuers must submit to CMS authorization from the State and justification explaining the pertinent crosswalk(s).

- For deficiency code 38: In the following counties, Plan ID ___from PY 2017 has been crosswalked to Plan ID ____for PY 2018 with a Reason for Crosswalk equal to "Renewing product; renewal in a different plan within the product"; however, the PY 2017 and PY 2018 product IDs are not equal.
  - To indicate that the product will continue in PY 2018, but the PY 2017 Plan ID will be crosswalked to a different Plan ID within the same product for PY 2018, issuers should crosswalk to a plan with the same 10 digit product ID and in compliance with 45 CFR 155.335(j)(1) and select a crosswalk reason of "**Renewing product: renewal in a different plan within product"**.
  - To indicate that the plan is being crosswalked to a plan in a different product, issuers should select a crosswalk reason of **"Continuing product: no plan available in the particular service area under that product; enrollment in a different product"**.

PY 2018 Common Data Review Errors

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Data Integrity Review Overview

Review Highlights:

- "QHPs Missing in the URRT" (correction code 990000531) deficiencies:
- "Consistent EHB Percent of Total Premium Between Plans & Benefits & URRT" (correction code 990000461) deficiencies:
- "Compliance with Federal Age Curve for QHPs" (correction code 990000371) deficiencies:

Tips to Resolve Issues:

- Correction codes 990000531 and 990000461: Issuers should validate their templates using the public facing DIT prior to submission. This will ensure plan IDs and EHB Percent of Total Premium values match.
- Correction code 990000371: Issuers should refer to the State Specific Age Curve Variations website to view new PY18 Age Curve specifications. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/StateSpecAgeCrv053117.pdf.

PY 2018 Common DIT Review Errors

QHPs and SADPs (Deficiency Code):

1. QHPs Missing in the URRT (#990000531)
2. Zero Dollar Rates in Age Bands (#990000411)
3. Compliance with Federal Age Curve for QHPs (#990000371)
4. Consistent EHB Percent of Total Premium Between Plans & Benefits & URRT (#990000461)
5. Not Applicable Values for In Network and Combined In/Out of Network MOOPs (#990000251)
6. Deductible and MOOP Comparison (#990000701)
7. Invalid Copay or Coinsurance Value (#990000241)
8. HSA Eligible Plan with a Deductible Less than Required Minimum (#990000671)
9. Consistent Plan Type Between Plans & Benefits and URRT (#990000511)
10. Format of Formulary URL (#990000571)

QHPs Missing in the URRT (#990000531)

Sample Message:

DIT ERROR: Plan ID 12345XY0010005 in the Plans & Benefits Template is missing in the Unified Rate Review Template. All QHPs in the Plans & Benefits Template must be reported in the Unified Rate Review Template.

Zero Dollar Rates in Age Bands (#990000411)

Sample Message:

DIT ERROR: Plan ID 12345XY0030001 has a $0.00 rate for Rating Area 1 for the following age bands: 15, 16 for effective dates 1/1/2018 – 3/31/2018.

Compliance with Federal Age Curve for QHPs (#990000371)

Sample Message:

DIT ERROR: Plan ID 12345XY0100001 in Rating Area 3 varies by $2.00 or more from the federal age curve for the following age bands: 17 for effective dates 1/1/2018 – 12/31/2018.

Consistent EHB Percent of Total Premium Between Plans & Benefits & URRT (#990000461)

Sample Message:

DIT ERROR: Plan ID 12345XY0090017 has an EHB percent of total premium 0.9983 in the Plans & Benefits Template and an EHB percent of total premium 0.9974 in the Unified Rate Review Template.

Values for EHB percent of total premium between the Plans & Benefits Template and Unified Rate Review Template must match when rounded to three decimal places.

Not Applicable Values for In-Network and Combined In/Out-of-Network MOOPs (#990000251)

Sample Message:

DIT ERROR: Plan ID 12345XY0020003-01 has both an In-Network and Combined In/Out-of-Network combined Family per group MOOP equal to "Not Applicable." One of these values must be equal to a dollar value less than or equal to the annual limitation on cost sharing ($14,700).

Deductible and MOOP Comparison (#990000701)

Sample Message:

DIT ERROR: Plan ID 12345XY0010030-01 has a combined Out-of-Network Individual deductible equal to $19,950 and a corresponding MOOP equal to $13,300. The deductible is greater than the corresponding MOOP. Please confirm that you have accurately entered your deductible and MOOP values.

Invalid Copay or Coinsurance Value (#990000241)

Sample Message:

DIT ERROR: Plan ID 12345XY0050021-01 has a copay equal to “$3,500.00" for Skilled Nursing Facility. This is not a valid copay value.

HSA Eligible Plan with a Deductible Less than Required Minimum (#990000671)

Sample Message:

DIT ERROR: Plan ID 12345XY0040012-01 is listed as HSA eligible but has a combined In-Network Family per person deductible value of $2600 per person, which is less than the required minimum value ($2,700 for family coverage). The 2018 HSA parameters can be found at https://www.irs.gov/pub/irs-drop/rp-17-37.pdf. Family per person deductible values for HSA eligible plans are subject to the IRS family coverage minimum value ($2700), not the self-only coverage value ($1350). IRS Publication 969 (https://www.irs.gov/pub/irs-pdf/p969.pdf) states:

"If either the deductible for the family as a whole or the deductible for an individual family member is less than the minimum annual deductible for family coverage, the plan does not qualify as an HDHP."

Consistent Plan Type Between Plans & Benefits and URRT (#990000511)

Sample Message:

DIT ERROR: Plan ID 12345XY0010003 has a plan type of HMO in the Plans & Benefits Template and a plan type of EPO in the Unified Rate Review Template. QHP plan type must match between the Plans & Benefits Template and URR Template.

Format of Formulary URL (#990000571)

Sample Message:

DIT ERROR: Formulary ID XYF005 does not have an acceptable Formulary URL format. Each URL must begin with either http:// or https://.

2017 QRS and QHP Enrollee Survey: Upcoming Results and Preview

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Accessing 2017 QRS Results

- Starting on August 14, 2017, QHP issuers and Marketplace administrators may preview 2017 QRS results for their respective QHP issuers' reporting units via the Health Insurance Oversight System Marketplace Quality Module (HIOS-MQM).
- Instructions for accessing 2017 QRS results:
  - Log in to the HIOS-MQM website.
    - Users new to HIOS need to request access to HIOS and the MQM through the CMS Enterprise Portal (https://portal.cms.gov/).
    - Existing HIOS users who are new to the MQM need to request a new role: Ratings/Reports Viewer or Marketplace Operator. These roles authorize the user to perform predetermined functions and access certain data sets.
    - Detailed instructions for registering for access to HIOS and the MQM can be found in the HIOS-MQM Quick Reference Guide located on CMS' MQI website (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html).

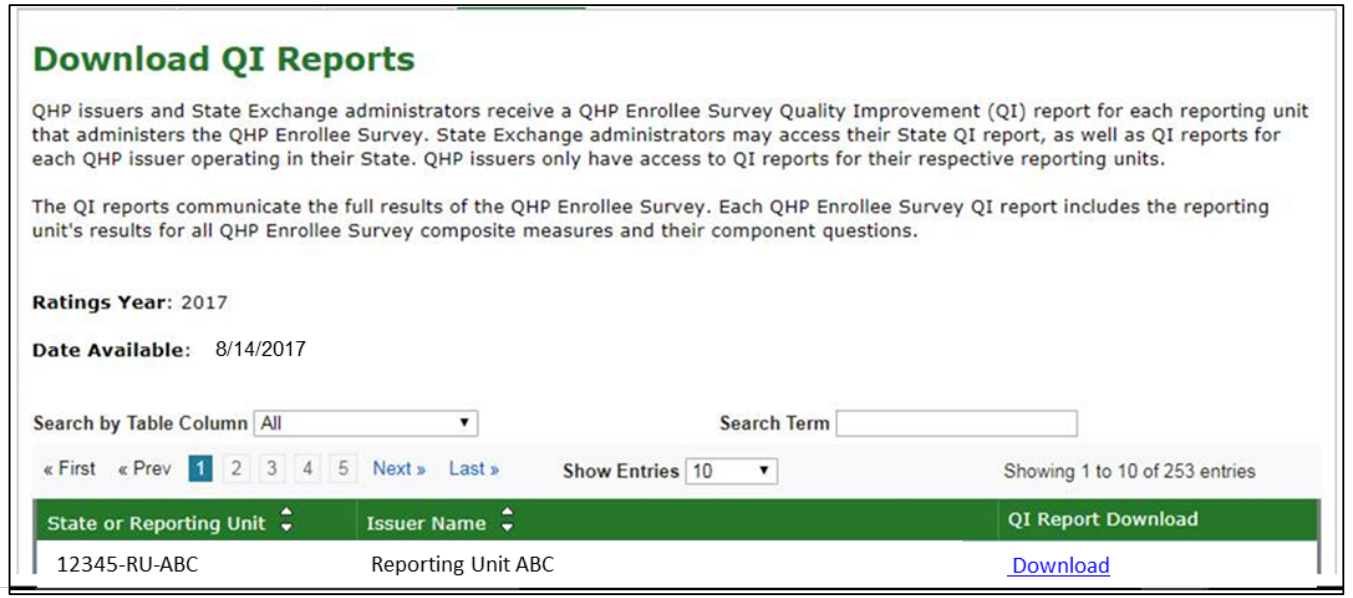
Accessing 2017 QRS Results (Continued)

– Navigate to the “Preview Ratings” webpage and search for the corresponding QHP issuer. To access the QRS Preview Report and QRS Proof Sheet, click the appropriate links at the bottom of the page.



Accessing 2017 QHP Enrollee Survey Quality Improvement (QI) Reports

- QHP issuers can access the 2017 QHP Enrollee Survey results via HIOS-MQM (following the instructions on slide 2).
- Navigate to the “Download QI Report” webpage and search for the corresponding QHP issuer to review the QHP Enrollee Survey Results in the form of **QI reports**.



Download QI Reports

QHP issuers and State Exchange administrators receive a QHP Enrollee Survey Quality Improvement (QI) report for each reporting unit that administers the QHP Enrollee Survey. State Exchange administrators may access their State QI report, as well as QI reports for each QHP issuer operating in their State. QHP issuers only have access to QI reports for their respective reporting units.

The QI reports communicate the full results of the QHP Enrollee Survey. Each QHP Enrollee Survey QI report includes the reporting unit's results for all QHP Enrollee Survey composite measures and their component questions.

Ratings Year: 2017

Date Available: 8/14/2017

Search by Table Column All ▾ Search Term

« First « Prev 1 2 3 4 5 Next » Last » Show Entries 10 ▾ Showing 1 to 10 of 253 entries

State or Reporting Unit	Issuer Name	QI Report Download
12345-RU-ABC	Reporting Unit ABC	Download

2017 QRS and QHP Enrollee Survey Results

- Exchanges will receive the following for each respective QHP issuer's reporting unit:
  - One (1) QRS Preview Report including the QRS ratings
    - The ratings are provided on a 5-star scale for all QRS hierarchy components (i.e., composites, domains, summary indicators, and the global result).
  - One (1) PDF file version of the QRS Proof Sheet including the outputs for each step of the QRS rating methodology
  - One (1) CSV file version of the QRS Proof Sheet including additional information (e.g., measure indicator values and sub-measure indicator values)
  - One (1) QHP Enrollee Survey QI Report including results on all ratings, composites and measures in the QHP Enrollee Experience Survey*
    - Results in the QI Reports are sorted from highest to lowest, and indicate which reporting units performed above or below the national average.

*Composites in the QHP Survey reports are based on Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and are not identical to those used in the QRS.

Submitting Inquiries about 2017 QRS and QHP Enrollee Survey Results

- Please submit questions about the QRS ratings no later than 6:00 PM ET on August 25, 2017. Include "MQI-QRS Preview" in the subject line of email.
  - States and Marketplace administrators: Please submit questions to your respective State Officer.
  - QHP issuers and all other users: Please submit questions to the Exchange Operations Support Center (XOSC) Help Desk via email at CMS_FEPS@cms.hhs.gov or via phone at 1-855-CMS-1515 (1-855-267-1515). Please reference “Marketplace Quality Initiatives (MQI)-QRS” in the subject line.

Questions

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

To submit or withdraw questions by phone:

- **To submit a question, dial 'star(*) pound(#)' on your phone's keypad.**
- **To withdraw a question, dial 'star(*) pound(#)' on your phone's keypad.**

To submit questions by webinar:

- **Type your question in the text box under the 'Q&A' tab and click 'Send.'**

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

State Regulators Webinar Session Survey

- CMS welcomes your feedback regarding this webinar series and values any suggestions that will allow us to enhance this experience for you.
- Shortly after this call, we will send a link to you for a convenient way to submit any ideas or suggestions you wish to provide that you believe would be valuable during these sessions.
- Please take time to complete the survey and provide CMS with any feedback.



Closing Remarks

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