Common QHP Corrections & Data Integrity Review Errors

August 15, 2018



Center for Consumer Information and Insurance Oversight (CCIIO)

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

HTTPS://WWW.REGTAP.INFO

Agenda

- Session Guidelines
- Key Dates
- Plan Year (PY)19 Common QHP Corrections
- PY19 Common Data Integrity Review Errors
- Question & Answer (Q&A) Session
- Closing Remarks

Intended Audience

- Please be advised that the intended audience for this webinar is state regulators in Federally-facilitated Exchange (FFE) states performing plan management activities. This is not an open press call.
- Members of the press or a media outlet should disconnect the call at this time and contact the Centers for Medicare & Medicaid Services (CMS) Press Office for further information.

Session Guidelines

- This is a 45-minute webinar session.
- Throughout the webinar, you may submit questions via the Q&A Panel.
- We will address questions during the Q&A session at the end of the presentation.
- For questions regarding content or logistics, contact the Registration for Technical Assistance Portal (REGTAP) Registrar at registrar@regtap.info or (800) 257-9520.

Upcoming PY19
Key Dates for QHP Certification

Date	Category	Activity
August 10, 2018	QHP Certification	CMS Uploads the First Correction Notice to the PM Community
August 10, 2018	Alternate Enrollment	CMS Sends “Potential New Consumers” file to State and Issuers based on Federal Hierarchy
August 13, 2018	QHP Certification	Deadline for PY 2019 Service Area Data Change Request
August 22, 2018	QHP Certification	Deadline for issuers to change PY 2019 QHP Applications
August 22, 2018	Alternate Enrollment	Deadline for States to Confirm whether they will Direct or Defer Alternate Enrollment Crosswalk
August 23 – September 12, 2018	CMS Reviews	CMS Reviews QHP Applications as of August 22, 2018 and releases Final Round Review results to PM Community on a rolling basis

Key Dates for PY18 Data Submission

Date	Category	Activity
March 15, 2018	URRT Deadline	PY18 Q3 Unified Rate Review Template Submission Deadline
April 11, 2018	DCRQ Submission	Deadline for submitting PY18 Data Change Requests for the April DCW (SHOP Q3 Rate Change Window)
Prior to May 16, 2018	Refresh Date	Approximate Refresh Date for the PY18 April DCW
June 15, 2018	URRT Deadline	PY18 Q4 Unified Rate Review Template Submission Deadline
July 11, 2018	DCRQ Submission	Deadline for submitting PY18 Data Change Requests for the July DCW (SHOP Q4 Rate Change Window)
Prior to August 16, 2018	Refresh Date	Approximate Refresh Date for the PY18 July DCW

Announcements

PY19 – Common QHP Corrections



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 3.1 and 3.2 of the HIOS Plan Finder—Issuer User Manual at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIOS-PF-UserManual-04_00_00.pdf.

Accreditation Review Overview

Review Highlights:

- Issuer does not appear on accrediting entity data (correction code 010000241 or 010000252).
- Issuer is not accredited (010000161).

Tips to Resolve Issues:

- Issuers should contact their accrediting entity and request that their HIOS ID be added to the data file transmitted to CCIIO.
- Issuers should provide documentation identifying the steps (and the associated timeline) the issuer is taking to become accredited prior to November 1.

Essential Community Providers (ECP) Review Overview

Review Highlights:

- One (1) or more of the issuer's networks do not meet the 20 percent ECP threshold and *no justification* was provided (070000641).
- One (1) or more of the issuer's plan networks do not contain any ECPs and *no justification* was provided (070000061).
- One (1) or more of the issuer's plan networks do not meet the ECP threshold of 20 percent of available ECPs and *insufficient justification* was provided (070000631).
- One or more issuer plan networks do not contain any ECPs and *insufficient justification* was provided (070000151).

Tips to Resolve Issues:

- Issuers that do not meet the ECP threshold should continue efforts to recruit providers (070000061, 070000151, 070000631, & 070000641).
- Deficiencies resulting from no/insufficient justification can be corrected by closely following the instructions found in the ECP Supplemental Response Form (070000061, 070000151, 070000631, & 070000641).
- 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, et cetera.).

ECP-Dental Review Overview

Review Highlights:

- One (1) or more of the issuer's dental networks do not meet the ECP threshold of 20 percent of available dental ECPs and *insufficient justification* was provided (070000691).
- One (1) or more of the issuer's dental networks do not meet the ECP threshold of 20 percent of available dental ECPs and *no justification* was provided (070000701).
- One (1) or more of the issuer's dental networks do not contain any dental ECPs and the issuer *did not submit a justification* (070000301).

Tips to Resolve Issues:

- Issuers that do not meet the ECP threshold should continue efforts to recruit providers (070000301, 070000691, 070000701).
- Deficiencies resulting from no/insufficient justification can be corrected by closely following the instructions found in the ECP Supplemental Response Form (070000301, 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, et cetera.).

Compliance Plan and Organizational Chart (CPOC) Review Overview

Review Highlights:

- Issuer received a deficiency in each of the following compliance plan and organizational chart fields:
  - Compliance plan and organizational chart cover sheet is not included or is blank (030000362).
  - The issuer attested that it has a compliance plan, but the compliance plan does not include required components (030000322).
  - The organization's Compliance Officer does not have a reporting relationship directly to the organization's Board of Directors (030000682).

Tips to Resolve Issues:

- Ensure that the PY19 Compliance Plan and Organizational Cover Sheet is completed and submitted with the QHP Application.
- Evaluate the submitted compliance plan against the criteria in the PY19 Compliance Plan and Organizational Chart Cover Sheet at https://www.qhpcertification.cms.gov/s/PY2019CPOCCoverSheet.pdf?v=1
- Ensure that the submitted organizational chart and compliance plan show a direct reporting relationship to the organization's Board of Directors or other senior governing body.

Quality Improvement Strategy (QIS) Review Overview

Review Highlights:

- The most common deficiencies for which issuers received correction notices were due to missing information in the *QIS Implementation Plan and Progress Report* form (QIS form) or not submitting a QIS form:
  - The QIS Implementation Plan and Progress Report form that was submitted is missing the following element(s) and/or criteria: [list of missing fields] (210000012).
  - Issuer did not submit at least one (1) *QIS Implementation Plan and Progress Report* form (210000041).

Tips to Resolve Issues:

- Missing information deficiencies will include a list of the specific Elements and/or Criteria that are missing or incomplete. Complete all Elements and/or Criteria that are listed.
- In Elements where there are check boxes and text fields, do not include text in the field unless required to do so (e.g., for Criteria 28a, if 'Not Applicable' is selected do not include comments in the associated text field).
- If submitting progress on an existing QIS, responses to modification questions should be consistent throughout the form (e.g., if 'Continuing a QIS with No Modifications' then select 'No' in Elements 18, 23, and 24 when asked if modifications made and select 'Not Applicable' in Element 28).
- Refer to the QIS Technical Guidance and User Guide for more detailed instructions about completing the QIS form. Issuers who receive a "did not submit" notification, should submit their QIS form.

Cost Share Reduction Review Overview

Review Highlights:

- The most common deficiency was having non-zero cost sharing for an Essential Health Benefit (EHB) in the zero cost sharing plan variation (120000191).
  - The error is often caused by the issuer incorrectly coding an out-of-network (OON) benefit in the zero cost sharing plan variation as not covered.
  - There are also cases where the zero cost sharing plan variation has benefits labeled “No Charge after deductible”, which is an invalid cost sharing amount for a zero cost sharing plan variation.
- The second most common deficiency was caused by issuers not following the successive cost sharing requirement (120000521).
  - Most often, issuers used different cost sharing structures across plan variations by alternating between copay- and coinsurance-based cost sharing for the same benefit. Successive cost sharing must be followed for each individual benefit, which includes using the same cost sharing structure.
  - Some issuers increased cost sharing as the Actuarial Value (AV) increased between plan variations. As the value of a plan increases (higher AV), the coverage of each individual benefit must increase (lower consumer cost sharing).
- The next most common deficiency was exceeding the permissible Maximum Out-of-Pocket (MOOP) threshold for the silver plan variation (120000161).
- No change to review this year.

Cost Share Reduction Review Overview (continued)

Tips to Resolve Issues:

- To fix correction code 120000191 (in zero cost sharing plan variation):
  - No benefits can have "Not Applicable" for both copay and coinsurance. If a benefit is not covered OON, issuers should mark the copay of "Not Applicable" and use a coinsurance of "100%."
  - Other issues can be resolved by reducing benefit cost sharing values to $0.
- To fix correction code 120000521: The issuer can adjust the cost sharing structure of the silver plan variation to all use a copay or to all use a coinsurance for that benefit. The issuer also must ensure that each benefit's cost sharing remains the same or decreases as the actuarial value (AV) of the plan variation increases.
- To fix correction code 120000161: issuers must reduce MOOP values for silver plan variations to be equal to or less than the allowable MOOP limits for individuals and families, respectively.

Plan ID Crosswalk

Tips to Resolve Issues:

- For deficiency code 13: Plan ID __ from 2018 has been crosswalked to Plan ID __ for 2019 in the following county or counties; however, these counties are not covered by the service area of Plan ID ___ for 2019: ____.
  - Ensure that the 2019 plan covers all of the counties covered by the 2018 plan. If the desired 2019 crosswalk plan doesn't cover the entire service area of the 2018 plan, crosswalk to the 2019 plan at the county level instead of the plan level. For the counties not covered by the desired 2019 plan, select a different 2019 plan that covers those counties. If an issuer is no longer covers the entire service area of the 2018 plan, they should discontinue the 2018 plan in the counties that are no longer covered.

- For deficiency code 91: The issuer has not submitted evidence of State Authorization of their plan crosswalk. Issuers must submit a State Authorization form. Please see our template instructions for more details which can be found on the CCIIO website at https://www.qhpcertification.cms.gov/s/Plan%20Crosswalk.
  - Follow the instructions detailed in the described deficiency language. If you have a question after reading the instructions at the provided link, please contact the CMS Help Desk by email at: CMS_FEPS@cms.hhs.gov or by phone at: (855) 267-1515.

Plan ID Crosswalk (continued)

Tips to Resolve Issues:

- For deficiency code 11: Plan ID ___ from 2018 has been crosswalked to Plan ID ___ in one (1) or more counties for 2019. However, Plan ID ___ is an off-Exchange plan. As noted in the template instructions, CMS will not accept any 2019 Plan IDs for plans only sold outside the Marketplace.
  - In compliance with 45 CFR 155.335(j), on-Exchange plans must be crosswalked to a plan that will also be offered on-Exchange. Issuers should ensure that all 2019 crosswalk plans are offered on-Exchange. If the issuer no longer offers on-Exchange plans, they should discontinue the plan.

- For deficiency code 57: In the below counties, Plan ID ___ from 2018 has a Reason for Crosswalk equal to "Discontinuing product; no enrollment option." However, there is at least one (1) plan in product ___ that exists in 2019 as indicated in the issuer's submitted 2019 Plans & Benefits and Service Area Templates. "Discontinuing product; no enrollment option" should be selected only if the product has been entirely discontinued: ___.
  - If the product is still offered on the Exchange for 2019, "Discontinuing product; no enrollment option." cannot be used as a reason for crosswalk. If the issuer intends on discontinuing the 2018 plan in counties where they no longer offer coverage, instead choose the crosswalk reason of "Continuing product; no plan available in the particular service area under that product; no enrollment option."

Non-Discrimination Review (Cost Sharing) Review Overview

Review Highlights:

- All deficiencies were associated with coinsurance values being higher than both of the corresponding state and national thresholds.

Tips to Resolve Issues:

- Issuers can reduce coinsurance values to be equal to or less than the threshold value provided in the notification language (130000041).
- Alternatively, an issuer may submit a detailed justification stating why the issuer believes that the coinsurance outliers are not discriminatory (130000041).

Non-Discrimination Review (Clinical Appropriateness) Review Overview

Review Highlights:

- Deficiencies (130000911) were found in the following conditions and classes:
  - Breast Cancer condition – Alkylating Agents and Progestins classes
  - Diabetes condition – Insulin – Intermediate Acting Analogs, Insulin – Long Acting Analogs, and Insulin – Rapid Acting Analogs classes
  - Hepatitis C condition – Direct Acting Antivirals (DAAs) class
  - Multiple Sclerosis condition – Potassium Channel Blockers and Skeletal Muscle Relaxants classes
  - Opioid Use Disorder condition – Buprenorphine, Buprenorphine/Naloxone class

Tips to Resolve Issues:

- Offer drugs or remove prior authorization or step therapy restrictions in the deficient classes.
- Submit a justification response.
  - Justification response should describe why the prescription drug benefit design is non-discriminatory offering any clinical support or evidence for the design.

Non-Discrimination Review (Formulary Outlier) Review Overview

Review Highlights:

- Deficiencies (130000841) were found in the following categories and classes:
  - Anti-Addiction / Substance Abuse Treatment category; Opioid Reversal Agents class
  - Antidepressants category; Antidepressants, Other and Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors (SSRIs/SNRIs) classes
  - Antivirals category; Anti-HIV agents, Protease Inhibitors
  - Anxiolytics category; Anxiolytics, Other and SSRIs/SNRIs classes
  - Blood Glucose Regulators category; Insulins class

Tips to Resolve Issues:

- Offer drugs in the deficient classes without restriction or submit a justification response (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 Overview

Review Highlights:

- Free text for benefit lists an age limitation on a service (090000331).
- Condition limitation in free text on a service (090000321).
- There were no major changes to the review criteria for PY2019.

Tips to Resolve Issues:

- Issuers should not put any age limitations on EHBs in the Free Text fields that are more restrictive than the Federal and State benchmark plans. For example: "*Child age limited to age 19*" should be corrected to make clear that the EHB is covered "*to the end of the month in which they turn 19*." Applies to correction code 090000331.
- Issuers should not put any limitations on EHBs in the Free Text fields that are more restrictive than the Federal and State benchmark plans. For example: *"…only covers treatment for a congenital anomaly related to or developed as a result of cleft palate, with or without cleft lip*." This language should be removed completely as it limits service(s) to a specific diagnosis – which is more restrictive than Federal language. Applies to correction code 090000321.
- 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.

Stand-alone Dental Plan (SADP) Review - Actuarial Value (AV) Supporting Document Overview

Review Highlights:

- Supporting AV Documentation was submitted, but the name of the actuary is not on the American Academy of Actuaries roster (110000132).
- No AV Supporting Documentation was submitted for SADP (110000142).
- Supporting Documentation was submitted, but no AV value was identified (110000152).
- For PY19, all SADP issuers are required to report the AV level of coverage for pediatric dental EHB on the AV Supporting Documentation form, which was updated to include space for issuers to submit the AV value.

Tips to Resolve Issues:

- Issuers should confirm that the actuary they are using is listed as active on the American Academy of Actuaries roster, available online. Applies to correction code: 110000132.
- Issuers should confirm that they have submitted the required supporting documentation for their SADPs, and that their documentation lists all Plan IDs. Applies to correction code: 110000142.
- Issuers should confirm that the supporting documentation they are submitting is using the updated PY2019 form, which has been updated to include a line for issuers to include AV value information. Applies to correction code: 110000152.
- For further clarification, please review the section “Supporting Documentation and Submission Criteria” within the “2019 Qualified Health Plan Issuer Application Instructions”, located here: https://www.qhpcertification.cms.gov/s/Application%20Instructions.

Stand-alone Dental Plan (SADP) Review - Essential Health Benefit (EHB) Supporting Document Overview

Review Highlights:

- Supporting documentation was not submitted for the individual plan (090000362).
- Supporting documentation was submitted for the individual plan but the name of the actuary is not on the roster of actuaries (090000372).
- Supporting documentation was submitted for individual plan but adult rates were included In the calculation of EHB apportionment (090000382).
- Supporting documentation was submitted for individual plan but the issuer did not provide sufficient detail (090000392).
- There were no major changes to the review criteria for PY19.

Tips to Resolve Issues:

- Issuers should confirm that they have submitted the required supporting documentation for their SADPs, and that their documentation lists: all Plan IDs, EHB percentage for pediatric plans only – issuers should not include percentage information for their adult plans, and is signed by an actuary. Applies to correction codes: 090000362, 090000382, 090000392.
- Issuers should confirm that the actuary they are using is listed as active on the American Academy of Actuaries roster, available online. Applies to correction code: 090000372.
- For further clarification, please review the section “Supporting Documentation and Submission Criteria” within the “2019 Qualified Health Plan Issuer Application Instructions”, located here: https://www.qhpcertification.cms.gov/s/Application%20Instructions.

PY19 Common Data Integrity Review Errors

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Data Integrity Review Overview

Most Frequent Data Integrity Review Errors:

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

Tips to Resolve Issues:

- Correction code 990000461: Issuers should validate their Plans & Benefits template and Unified Rate Review Template (URRT) using the Data Integrity Tool (DIT) prior to submission. As a best practice, issuers should paste the value for EHB percent of total premium from the Plans & Benefits template into the URRT.
- Correction code 990000371: Issuers should validate their Plans & Benefits and Rates Table templates using the DIT prior to submission. Rates must align with the federal QHP age curve found at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Guidance-Regarding-Age-Curves-and-State-Reporting-12-16-16.pdf
- Correction code 990000531: Issuers should validate their Plans & Benefits template and URRT using the DIT prior to submission. All QHP plan IDs in the Plans and Benefits template must be in the URRT.

PY19 Common Data Integrity Review Errors

QHPs and SADPs (Deficiency Code):

1. Consistent EHB Percent of Total Premium Between Plans & Benefits & URRT (#990000461)
2. Compliance with Federal Age Curve for QHPs (#990000371)
3. QHPs Missing in the URRT (#990000531)
4. Consistent Plan Type Between Plans & Benefits and URRT (#990000511)
5. Service Areas with Missing Rates (#990000551)
6. Rate Effective and Rate Expiration Dates for Individual Market Plans (#990000381)
7. EHB % of Premium Equal to One and Plan Covers non-EHB Adult Vision, Adult Dental, or Long Term Nursing (#990000661)
8. HSA Eligible Plan with a MOOP Greater than Required Maximum (#990000791)
9. Not Applicable Values for In Network and Combined In/Out of Network MOOPs (#990000251)
10. HSA Eligible Plan with a Deductible Less than Required Minimum (#990000671)

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 of 0.9983 in the Plans & Benefits Template and an EHB percent of total premium of 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 four decimal places.

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 1/1/2019 – 12/31/2019.

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.

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.

Service Areas with Missing Rates (#990000551)

Sample Message:

DIT ERROR: Plan ID 12345XY0010003 is missing rates for Rating Area 3. Plan ID 12345XY0010003 is associated with service area ID XYS01, which covers the following counties in Rating Area 3: Douglas, Warmer, Thompson.

Rate Effective and Rate Expiration Dates for Individual Market Plans (#990000381)

Sample Message:

DIT ERROR: The following individual market plans have a rate effective date of 1/31/2019 and a rate expiration date of 3/31/2019: 12345XY0010003.

All individual market plans must have a rate effective date of 1/1/2019 and a rate expiration date of 12/31/2019 in order to display on HealthCare.gov.

EHB % of Premium Equal to One and Plan Covers non-EHB Adult Vision, Adult Dental, or Long Term Nursing (#990000661)

Sample Message:

DIT ERROR: The following plans have a value of 100% in the EHB Percent of Premium field of the Plans & Benefits Template and cover Routine Dental Services (Adult), Basic Dental Care - Adult, Routine Eye Exam (Adult): 12345XY0010003.

The EHB Percent of Premium field should be less than 100% to account for the plans' coverage of non-EHBs. Please note, pursuant to 45 CFR 156.115, the following benefits are excluded from EHB, even though an EHB-benchmark plan may cover them: routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, non-medically necessary orthodontia.

HSA Eligible Plan with a MOOP Greater than Required Maximum (#990000791)

Sample Message:

DIT ERROR: Plan ID 12345XY0010003 is listed as HSA eligible but has a combined In Network Individual MOOP value of $7,350, which is greater than the required maximum value ($6,750 for self-only coverage). The 2019 HSA parameters can be found at https://www.irs.gov/pub/irs-drop/rp-18-30.pdf.

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 Network combined Family per person 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 ($7,900).

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 2019 HSA parameters can be found at https://www.irs.gov/pub/irs-drop/rp-18-30.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."

Live Q&A

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