

Transparency in Coverage QHP Plan Year (PY) 2021

April 23, 2020

2020 Qualified Health Plan (QHP) Series

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Agenda

- Session Guidelines
- Key Dates
- Additional Webinar Sessions
- Announcements
- Transparency in Coverage QHP PY 2021
- Live Q&A Session
- Resources
- Closing Remarks

Session Guidelines

- This is a 60-minute session.
- This call is being recorded. The recording is not released to the public or posted in Registration for Technical Assistance Portal (REGTAP).
- This webinar will provide an opportunity for Center for Consumer Information and Insurance Oversight (CCIIO) Plan Management (PM) Subject Matter Experts (SMEs) to respond to questions from QHP issuers.
- For questions regarding content, contact the Centers for Medicare & Medicaid Services (CMS) Help Desk by email at: CMS_FEPS@cms.hhs.gov or by phone at: (855) 267-1515.
- For questions regarding logistics and registration, contact the Registrar at: (800) 257-9520.

WebEx Audio Issues

If you are listening to the webinar through WebEx and experience audio issues, please dial into 1-866-391-5945 and enter your six (6) digit PIN for phone access.

Upcoming Plan Year (PY) 2021 Key Dates for QHP Certification

Date	Category	Activity
Tuesday, April 21, 2020	Issuer Conference (Virtual)	2020 QHP Issuer Conference (Policy Updates & Initiatives)
Thursday, April 23, 2020	QHP Certification	Plan year (PY) 2021 QHP Application Submission Window Opens
Monday, April 27, 2020	Issuer Conference (Virtual)	2020 QHP Issuer Conference (Operational Training)
Wednesday, April 29, 2020	Issuer Conference (Virtual)	2020 QHP Issuer Conference (Operational Training)

Additional Webinar Sessions

All questions regarding Enrollment or External Data Gathering Environment (EDGE) Server can be addressed during the following webinar sessions:

Program Area	Day	Time (ET)
Enrollment	Mondays (Bi-weekly)	12:00 p.m. – 1:00 p.m.
EDGE Server	Tuesdays	11:30 a.m. – 1:00 p.m.

Please register if you wish to participate, even if you have registered for a previous series. For registration and additional information on CMS' webinar series, please log in to <https://www.REGTAP.info>.

Announcements

This presentation provides instructions for QHP issuers submitting transparency in coverage data for PY2021.

Agenda

- This webinar will review:
 - The purpose of Transparency in Coverage data collection
 - Key changes for PY2021
 - Issuer level data elements
 - Plan level data elements
 - URL requirements
 - Timeline and steps for data submission

Purpose of Collection

- Under section 1311(e)(3) of the Patient Protection and Affordable Care Act (PPACA), health insurance issuers seeking certification of a health plan as a QHP must make accurate and timely disclosures of certain information to the appropriate Exchange, Secretary of Health and Human Services (HHS), and state insurance commissioner; and make it available to the public.
- Section 2715A of the Public Health Service (PHS) Act, as added by the PPACA, extends the transparency reporting provisions under section 1311(e)(3) to non-grandfathered group health plans and health insurance issuers offering group or individual coverage, except that a plan or coverage not offered through an Exchange shall only be required to submit such information to the Secretary of HHS and state insurance commissioner, and make the information public.
- Regulations on QHP issuer requirements are at 45 CFR 156.220.

Issuers Required to Submit Transparency Data

- QHP issuers applying for QHP certification in the Federally-facilitated Exchanges (FFEs), including issuers in FFEs where states are performing plan management functions, and State-based Exchanges on the Federal Platform (SBE-FPs), must submit transparency data for PY2021. This includes Stand-alone Dental Plans (SADPs) and Small Business Health Options Program (SHOP) QHPs.
- There are no federal reporting requirements for issuers in State Based Exchanges (SBEs) at this time.
- Transparency reporting requirements are applicable to:
 - On Exchange issuers offering one (1) or more QHPs in PY2021.
 - Issuers not offering on Exchange QHPs in PY2021 are **not** required to submit transparency in coverage data.

Data Elements Required for Submission

- Issuers are required to submit the data elements included on the CMS Transparency in Coverage Reporting Template (Transparency Template) for PY2021.
- This data collection effort is specific to implementation of the reporting requirements under PPACA section 1311(e)(3) for QHP issuers and does not apply to non-Exchange coverage, including health insurance issuers offering group and individual health insurance coverage and non-grandfathered group health plans.
 - Transparency reporting for those plans and issuers is set forth under 2715A of the PHS Act, incorporated into section 715(a)(1) of the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) of the Internal Revenue Code (Code) and will be addressed separately.

Key Changes for PY2021

- Key changes for PY2021 include:
 - The PY2021 deadlines will align with the QHP submission process; this includes the early bird submission deadline
 - Issuers will submit the Transparency in Coverage template through the Benefits and Service Area Module of Health Insurance Oversight System (HIOS)
 - The Claims Payment Policies and Other Information URL will be collected in the Supplemental Submission Module (SSM) of HIOS; URLs must be active at the time of submission
- The PY2021 Transparency template and instructions can be found here:
 - <https://www.qhpcertification.cms.gov/s/Transparency%20in%20Coverage>

Data Elements Required for Issuers that did not offer QHPs in 2019

Issuers that did not offer QHPs in 2019 must:

- Submit a Transparency in Coverage Template completing the general information section
- Enter N/A under claims data fields
- Provide an active URL upon submission

Data Elements Required for Issuers that did offer a QHP(s) in 2019

Issuers that offered QHPs in 2019 must:

- Complete all data elements on the Transparency Template
- Report on claims data for dates of service from January 1, 2019 to December 31, 2019
- Issuers should only include 2019 data from on-Exchange plans that are participating on the Exchange in the 2021 plan year

Transparency Template-Issuer Level Data Elements Required for PY2021

OMB control number: 0938-1310/Expiration date: 04/22/2022	
All fields with an asterisk (*) are required. To validate the template, press Validate button or Ctrl + Shift + I. To finalize the template, press Finalize button or Ctrl + Shift + F.	
Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting	
Plan Year 2021 v1.0	
Validate	
Finalize	
General Information	
Was this Issuer on the Exchange in 2019*	
Issuer HIOS ID*	
Issuer Level Data	
Number of Issuer Level Claims with Date(s) of Service (DOS) in 2019 That Were Also Received in Calendar Year 2019*	
Number of Issuer Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019*	
Number of Issuer Level Internal Appeals Filed in Calendar Year 2019*	
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2019 Appeals*	
Number of Issuer Level External Appeals Filed in Calendar Year 2019*	
Number of Issuer Level External Appeals Overturned from Calendar Year 2019 Appeals*	
Notes:	
Please enter any comments/notes here.	

Issuer Level Data Elements Required for Submission

Data Element Name	Description
Was this issuer on the Exchange in 2019?*	Enter Yes or No to indicate whether or not this issuer was on the Exchange in 2019. • If Yes, then the issuer must fill out claims and appeals data. • If No, then the issuer must enter 'N/A' in the claims and appeals data fields.
Issuer HIOS ID*	Enter the five-digit HIOS Issuer ID. If the issuer has more than one (1) HIOS ID, the issuer should submit a separate template for each HIOS ID.

*Data element required for issuers with plans both offered and not offered in 2019.

Issuer Level Data Elements Required for Submission (Continued)

Data Element Name	Description
Number of Issuer Level Claims with Date(s) of Service (DOS) in 2019 That Were Also Received in Calendar Year 2019	Enter the number of issuer level claims received by an issuer asking for a payment or reimbursement by or on behalf of an <u>in-network</u> healthcare provider (such as a hospital, physician, or pharmacy) that is contracted to be part of the network for an issuer (such as an HMO or PPO). Include pediatric dental and vision claims. Claims should be counted by date of service. Claims data must be reported with a single numerical value. • A claim means any individual claim line of service within a bill for services (medical and pharmacy, including pharmacy point of sale); a request for payment for services and benefits. • Include claims for all QHPs that fall under the reporting HIOS ID. If the issuer has more than one (1) HIOS ID, it should submit a separate spreadsheet for each HIOS ID. • Do not include out-of-network claims.

Issuer Level Data Elements Required for Submission (Continued)

Data Element Name	Description
<i>(Continued from last slide)</i> Number of Issuer Level Claims with Date(s) of Service (DOS) in 2019 That Were Also Received in Calendar Year 2019	- Do not include claims that were pended or denied for additional information and subsequently paid more than once, i.e. do not count them twice. - For example, if an issuer were to have a total of 10,000 claims: 8,000 paid immediately. 1,000 pended or denied and resubmitted, of those, 700 subsequently paid. 300 subsequently denied at some point in the plan year. 1,000 denied immediately. - The total number of claims to be reported is 10,000, and the total number of claims denied to be reported is 1,300 (1,000 immediate denials + 300 subsequently denied at some point in the plan year). The total issuer level claims received data must include in-network claims for all QHPs in 2019, including QHPs not offered in 2021. Therefore, the plan level claims reported elsewhere in the template may not total the issuer level claims reported here.

Issuer Level Data Elements Required for Submission (Continued)

Data Element Name	Description
Number of Issuer Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019	Enter the number of issuer level claims received by an issuer that ask for a payment or reimbursement by or on behalf of an in-network healthcare provider (such as a hospital, physician, or pharmacy) that is contracted to be part of the network for an issuer (such as an HMO or PPO) that the issuer subsequently denied. • A claim means any individual claim line of service within a bill for services (medical and pharmacy, including pharmacy point of sale); a request for payment for services and benefits. • Include claims for all QHPs that fall under the reporting HIOS ID. If the issuer has more than one (1) HIOS ID, it should submit a separate spreadsheet for each HIOS ID. • Do not include claims that were pended or denied for additional information and subsequently paid. • Do not include out-of-network claims. • If a claim is denied for more than one (1) reason, it must only be counted as one (1) claim. • Include all denials in the total number of claims denied in calendar year 2019. This includes, but is not limited to: • Pediatric vision and dental denials, including SADPs. • Denials due to ineligibility. • Denials due to incorrect submission. • Denials for incorrect billing. • Duplicate claims.

Issuer Level Data Elements Required for Submission (Continued)

Data Element Name	Description
Number of Issuer Level Internal Appeals Filed in Calendar Year 2019	Enter the number of requests by the insured for internal appeals involving adverse determinations pursuant to 45 CFR §147.136. An internal review is a process by which the insured may have an adverse determination reviewed by the issuer with respect to a denial of payment, in whole or in part, for a service or treatment, or a rescission of coverage by the issuer. Include appeals that the issuer received in 2019 for DOS in 2019 that were fully adjudicated/completed within 2019. Do not include appeals that were subsequently withdrawn.
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2019 Appeals	Enter the number of final determinations adverse to the insured that are overturned upon request for internal review, in whole or in part pursuant to 45 CFR §147.136. An internal review is a process by which the insured may have an adverse determination reviewed by the issuer with respect to a denial of payment, in whole or in part, for a service or treatment, or a rescission of coverage by the issuer.

Issuer Level Data Elements Required for Submission (Continued)

Data Element Name	Description
Number of Issuer Level External Appeals Filed in Calendar Year 2019	Enter the number of requests by the insured for external appeals of final adverse determinations to an external review organization pursuant to 45 CFR §147.136. An external appeal request is a process by which an insured may have an adverse benefit determination (or final internal adverse benefit determination) reviewed by an independent third-party reviewer. Include appeals that the issuer received in 2019 for DOS in 2019 that were fully adjudicated/completed within 2019. Do not include appeals that were subsequently withdrawn.
Number of Issuer Level External Appeals Overturned from Calendar Year 2019 Appeals	Enter the number of final adverse determinations overturned upon request for external review, in whole or in part pursuant to 45 CFR §147.136. An external appeal request is a process by which an insured may have an adverse benefit determination (or final internal adverse benefit determination) reviewed by an independent third-party reviewer.

Plan Level Data Elements Required for PY2021 Transparency Template

All fields with an asterisk (*) are required. To validate the template, press Validate button or Ctrl + Shift + I. To finalize the template, press Finalize button or Ctrl + Shift + F.
All plan IDs submitted via Plans & Benefits Template(s) must be included in this template.

Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting

Plan Year 2021

Plan Level Data

Plan ID*	Number of Plan Level Claims with DOS in 2019 That Were Also Received in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to an Out-Of-Network Provider/Claims in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, <u>excluding</u> Behavioral Health in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health <u>only</u> , in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied for "Other" Reasons in Calendar Year 2019*	Notes: (Please enter any comments/notes here.)
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Note: If the issuer was not on the Exchange in 2019, please mark N/A for the claims data fields.

Plan Level Data Elements Required for Submission

Data Element Name	Description
2021 Plan ID*	Enter the 14-digit PY2021 Plan ID on the Plan Level Data tab. The Plan ID is composed of the five-digit Issuer HIOS ID, the two (2) character state abbreviation, and the seven-digit unique digits for the plan. If there is more than one (1) PY2021 Plan ID to report for a single HIOS Issuer ID, this information should be added line by line in the Plan Level Data tab. <i>All plan variants should be rolled up to one (1) plan ID or line in the template.</i> Sample plan level claims reporting: • Reported claims for XXXXXXXXXXXXX56 would include claims that fall under this Plan ID from Members on all associated plan variants: ○ XXXXXXXXXXXXX56-01: 100 claims. ○ XXXXXXXXXXXXX56-02: 500 claims. ○ XXXXXXXXXXXXX56-03: 200 claims. ○ XXXXXXXXXXXXX56-04: 50 claims. Reporting Plan ID XXXXXXXXXXXXX56 should be entered as one (1) Plan ID in one (1) row of the template with a total of 850 claims for the applicable data field.

*Data element required for both plans offered and not offered in 2019.

Plan Level Data Elements Required for Submission (Continued)

Data Element Name	Description
Number of Plan Level Claims with DOS in 2019 That Were Also Received in Calendar Year 2019	Enter the number of in-network plan level claims received by an issuer that ask for a payment or reimbursement by or on behalf of a healthcare provider (such as a hospital, physician, or pharmacy) that is contracted to be part of the network for an issuer (such as an HMO or PPO). Include pediatric dental and vision claims. Claims should be counted by date of service. Claims data must be reported with a single numerical value. <i>If a plan is new to the exchange for PY21, please enter N/A in this field.</i> • A claim means any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment for services and benefits. • Include claims for all QHPs that fall under the reporting Plan ID. • Claims that were pending or initially denied for additional information and subsequently paid, should only be counted once (see example on slide 13) • Do not include out-of-network claims. The total issuer level claims received data may include plans not offered in 2021. Therefore, the plan level claims total may not total the issuer level claims. Dental Plans: Issuers must enter a numeric value in this field for SADPs; 0 is acceptable.

Plan Level Data Elements Required for Submission (Continued)

Data Element Name	Description
Number of Plan Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019 (<i>Plan Level Claims Denied</i>)	Enter the number of plan level claims received by an issuer that ask for a payment or reimbursement by or on behalf of an in-network healthcare provider (such as a hospital, physician, or pharmacy) that is contracted to be part of the network for an issuer (such as an HMO or PPO) that the issuer subsequently denied. <i>If a plan is new to the exchange for PY21, please enter N/A in this field.</i> • A claim means any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment for services and benefits. • Include claims for all QHPs that fall under the reporting Plan ID. • Include all denials in the total number of claims denied in calendar year 2019. This includes, but is not limited to: • Pediatric vision and dental denials, including for SADPs. • Denials due to ineligibility. • Denials due to incorrect submission. • Denials for incorrect billing. • Duplicate claims.

Plan Level Data Elements Required for Submission (Continued)

Data Element Name	Description
<i>(Continued from last slide)</i> Number of Plan Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019 (<i>Plan Level Claims Denied</i>)	Do not include the following claims: • Claims that were pending or initially denied for additional information and subsequently paid (see example on slide 13). • Out-of-network claims. <i>The total number of Plan Level Claims Denied in the specified calendar year should also be accounted for in the six (6) “Plan Level Claims Denial” categories. Note, however, that the totals from the “Plan Level Claims Denial” categories will not add up to the total number of Plan Level Claims Denied.</i> Dental Plans: Issuers must enter a numeric value in this field for SADPs, 0 is acceptable.

Plan Level Data Elements Required for Submission (Continued)

Data Element Name	Description
<i>(Continued from last slide)</i> Number of Plan Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019 (<i>Plan Level Claims Denied</i>)	An example of how to report for this data field: • # of Plan Level Claims Received: Plan has a total of 20,000 claims. • # of Plan Level Claims Denied: Plan denies 3,000 of those claims for various reasons. • The issuer would further report the reasons for the 3,000 claims denied in one (1) or more of six (6) denial categories: 1. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2019. 2. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2019. 3. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2019. 4. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, Including Behavioral Health in Calendar Year 2019. 5. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, excluding Behavioral Health in Calendar Year 2019. 6. Number of Plan Level Claims with DOS in 2019 That Were Also Denied for “Other” Reasons in Calendar Year 2019. In this example, an issuer could report denial <i>reasons</i> greater than 3,000, in the six (6) reporting categories, but the number of plan level claims denied would be 3,000.

Plan Level Data Elements Required for Submission (Continued)

Data Element Name	Description
Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2019 (Plan Level Claims Denied)	Enter the number of in-network plan level denials for non-emergency-related claims for service that required prior/pre-authorization, referral, prior approval, or precertification; in this instance the claim was denied for plans that require a prior/preauthorization, referral, prior approval, or precertification. <i>Issuers may also enter N/A in this field for PPOs or new plans.</i>

Plan Level Data Elements Required for Submission (Continued)

Data Element Name	Description
<i>(Continued from last slide)</i> Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2019 <i>(Plan Level Claims Denied)</i>	Issuers should include the following claims (individual claim line of service item): • Total number of claims denied for services or supplies received after prior/pre- authorization, referral, prior approval, or pre-certification has been denied. • Total number of claims denied for services or supplies when an enrollee is required to receive prior/pre-authorization, referral, prior approval, or precertification, but fails to. • A claim means any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment or reimbursement for services and benefits. • Health services obtained without a referral when a referral is necessary. • Include claims for all QHPs that fall under the reporting Plan ID. Do not include the following claims: • Claims that were pending or initially denied for additional information and subsequently paid (see example on slide 13). • Out-of-network claims. Dental Plans: Issuers must enter a numeric value in this field for SADPs, 0 is acceptable.

Plan Level Data Elements Required for Submission (Continued)

Data Element Name	Description
Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2019 <i>(Plan Level Claims Denied)</i>	Enter the number of plan level denial of claims for services from outside of the plan's network of healthcare providers when the plan has a closed network. <i>Issuers may enter N/A in this field for PPO plans. If a plan is new to the exchange for PY21, please enter N/A in this field.</i> Issuers should include the following claims (individual claim line of service item): • Total number of claims denied for point of service benefit provided by someone (example: healthcare provider, clinic, pharmacy, or hospital) that is not contracted to be in the plans (HMO or closed network plans) network. • A claim means any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment or reimbursement for services and benefits. Do not include the following claims: • Claims that were pending or initially denied for additional information and subsequently paid (see example on slide 13). • In-network claims. Dental Plans: Issuers must enter a numeric value in this field for SADPs, 0 is acceptable.

Plan Level Data Elements Required for Submission (Continued)

Data Element Name	Description
Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2019 <i>(Plan Level Claims Denied)</i>	Enter the number of in-network plan level denial of claims for services excluded or non- covered services. <i>If a plan is new to the exchange for PY21, please enter N/A in this field.</i> Issuers should include (individual claim line of service item): • Total number of claims denied due to limitations or exclusions of certain services, test, treatment, admissions, supplies, etc., that are excluded, not covered, and/or limited under the plan, including claims denied as a result of a drug not being on the formulary. • A claim means any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment or reimbursement for services and benefits. Do not include the following claims: • Claims that were pending or initially denied for additional information and subsequently paid (see example on slide 13). • Out-of-network claims. Dental Plans: Issuers must enter a numeric value in this field for SADPs, 0 is acceptable.

Plan Level Data Elements Required for Submission (Continued)

Data Element Name	Description
Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, <u>Excluding Behavioral Health</u> in Calendar Year 2019 (<i>Plan Level Claims Denied</i>)	Enter the number of in-network plan level denial of claims for healthcare services or supplies that do not meet the accepted standards to diagnose or treat an illness, injury, condition, disease, or its symptoms related to medical services. <i>If a plan is new to the Exchange for PY2021, please enter N/A in this field.</i> Issuers should include the following claims denials for lack of medical necessity (individual claim line of service item): • Payment for services related to medical surgical diagnosis including medical, pharmacy, and pharmacy point of sales.

Plan Level Data Elements Required for Submission (Continued)

Data Element Name	Description
<i>(Continued from last slide)</i> Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, <u>Excluding Behavioral Health</u> in Calendar Year 2019 (Plan Level Claims Denied)	Do not include the following claims: • Behavioral or mental health claims or payment for services. ▪ Behavioral health claims or payments are those benefits associated with mental health or substance use disorders. ▪ Mental health claims or payments are those benefits associated with mental health conditions; the classification of mental health claims should align with the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Disease (ICD). Report claims as behavioral or mental health if the primary/principal diagnosis code reported is classified as behavioral or mental health according to the current version of the DSM. ▪ Substance use disorder claims or payments are those benefits associated with the treatment or diagnosis of substance use conditions; the classification of mental health claims should align with the current version of the DSM, the most current version of the ICD. • Claims that were pending or initially denied for additional information and subsequently paid (see example on slide 13). • Out-of-network claims.

Plan Level Data Elements Required for Submission (Continued)

Data Element Name	Description
Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, <u>Behavioral Health only</u>, in Calendar Year 2019 <i>(Plan Level Claims Denied)</i>	Enter the number of in-network plan level denial of claims for healthcare services or supplies that do not meet the acceptable standards to diagnose or treat an illness, injury, condition disease, or its symptoms, related to behavioral/mental health. <i>If a plan is new to the exchange for PY21, please enter N/A in this field.</i> Issuers should include the following claims denials for lack of medical necessity (individual claim line of service item): • Behavioral or mental health claims or payment for services, including pharmacy claims and pharmacy point of sales related to behavioral health. • Behavioral health claims or payments are those benefits associated with mental health or substance use disorders. • Mental health claims or payments are those benefits associated with mental health conditions; the classification of mental health claims should align with the current version of the DSM, the most current version of the ICD. Report claims as behavioral or mental health if the primary/principal diagnosis code reported is classified as behavioral or mental health according to the current version of the DSM. • Substance use disorder claims or payments are those benefits associated with the treatment or diagnosis of substance use conditions; the classification of mental health claims should align with the current version of the DSM, the most current version of the ICD, federal, or state guidelines.

Plan Level Data Elements Required for Submission (Continued)

Data Element Name	Description
Number of Plan Level Claims with DOS in 2019 That Were Also Denied for “Other” Reasons in Calendar Year 2019 <i>(Plan Level Claims Denied)</i>	Enter the number of in-network plan level denial of claims rejected for a variety of reasons. If a plan is new to the exchange for PY21, please enter N/A in this field. Issuers should include (individual claim line of service item): • Incorrect bill coding. • Patient not insured by the plan. • Coverage terminated. • Duplicate claims. • Coordination of benefits issues/failure. • Untimely claims filings based on an issuers time frame for filing a claim. • Denial because a procedure is considered experimental, cosmetic, or investigational. • Any other claim denied for any services not appropriate for the previous plan level categories. Do not include out-of-network claims. Dental Plans: Issuers must enter a numeric value in this field for SADPs, 0 is acceptable.

URL Data Elements Required for Submission (Continued)

Data Element Name	Description
Claims Payment Policies & Other Information URL	The Claims Payment Policy and Other Information URL will be collected in the Supplemental Submission Module (SSM) in HIOS. Please refer to the SSM user guide for instructions on how to submit the URL. The information below provides an overview of the type of information that needs to be included on the Transparency in Coverage URL. Enter the active and easily accessible URL. A URL is easily accessible when: • It can be viewed on the plan's public website via a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number; and • When an individual can easily discern which information applies to each plan the issuer offers.

URL Data Elements Required for Submission (Continued)

Data Element Name	Description
<i>(Continued from last slide)</i> Claims Payment Policies & Other Information URL	The URL is the web address on the issuer website that consumers use to view pertinent information about the issuer's practices. All URLs should be live, with one (1) URL for a landing page or a single page with a link providing the information indicated below. Issuers that have unique HIOS IDs in the same state may submit the same URL, if the Transparency in Coverage information is the same across the HIOS IDs. Note: If the URL content makes reference to the plan year, the plan year should be up to date (2021). a. Out-of-network liability and balance billing b. Enrollee claim submission c. Grace periods and claims pending d. Retroactive denials e. Recoupment of overpayments f. Medical necessity and prior authorization timeframes and enrollee responsibilities g. Drug exception timeframes and enrollee responsibilities (not required for SADPs) h. Explanation of benefits (EOBs) i. Coordination of benefits (COB) <i>See the URL checklist on the next three (3) slides</i>

Transparency in Coverage URL Checklist

URL Information

- ☐ URL is live upon Transparency submission.
- ☐ URL is accessible on the plan's public website without requiring an individual to create or access an account or enter a policy number.
- ☐ One (1) URL for a single landing page. *Please note: Issuers that have unique HIOS IDs in the same state may submit the same URL, if the Transparency in Coverage information is the same across the HIOS IDs.*

Claims Payment Policies and Practices URL Data Display Elements

Out-of-network liability and balance billing, includes the following:

- ☐ Information regarding whether an enrollee may have financial liability for out-of-network services.
- ☐ Information regarding any exceptions to out-of-network liability, such as for emergency services.
- ☐ Information regarding whether an enrollee may be balance-billed.

Enrollee claim submission, includes the following:

- ☐ General information on how an enrollee can submit a claim in lieu of a provider, if the provider failed to submit the claim. If claims can only be submitted by a provider, this should be indicated as well.
- ☐ A time limit to submit a claim, if applicable.
- ☐ Links to download any applicable claim forms.
- ☐ A physical mailing address to mail claims documents

Transparency in Coverage URL Checklist (Continued)

Grace periods and claims pending, includes the following:

- ☐ An explanation of what a grace period is.
- ☐ An explanation of what claims pending is.
- ☐ An explanation that it will pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.

Retroactive denials, includes the following:

- ☐ An explanation that claims may be denied retroactively, even after the enrollee has obtained services from the provider, if applicable.
- ☐ Ways to prevent retroactive denials when possible, for example paying premiums on time.

Recoupment of overpayments, includes the following:

- ☐ Instructions to enrollees on obtaining a refund of premium overpayment.

Medical necessity and prior authorization timeframes and enrollee responsibilities, includes the following:

- ☐ An explanation that some services may require prior authorization and/or be subject to review for medical necessity.
- ☐ Any ramifications should the enrollee not follow proper prior authorization procedures.
- ☐ A time frame for the prior authorization requests.

Transparency in Coverage URL Checklist (Continued)

Drug exception timeframes and enrollee responsibilities (not required for SADPs), including the following:

- ☐ An explanation of the internal and external exceptions process for people to obtain non-formulary drugs.
- ☐ The time frame for a decision based on a standard review or expedited review due to exigent circumstances.
- ☐ How to complete the application.

Explanation of benefits (EOB), includes the following:

- ☐ An explanation of what an EOB is.
- ☐ Information regarding when an issuer sends EOBs (i.e., after it receives and adjudicates a claim or claims).
- ☐ How a consumer should read and understand the EOB.

Coordination of benefits, includes the following:

- ☐ An explanation of what coordination of benefits is (i.e., that other benefits can be coordinated with the current plan to establish payment of services).

Additional information on URL requirements can be found in the [Transparency Issuer Instructions](#).

Open Q&A Session

Questions?

- To Submit or Withdraw Questions by Phone:
 - *If you are listening through your computer speakers and want to submit a question by phone, dial 1-866-391-5945 and enter your unique six-digit PIN, then dial “star(*) pound(#)” on your phone’s keypad.*
 - *If you are already dialed in by phone and want to submit a question, then dial “star(*) pound(#)” on your phone’s keypad.*
 - *If you would like to withdraw a question and you are dialed in by phone, then 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.”

Submission of Inquiries

Users/Issuers can contact:

- **CMS Help Desk** with questions about specific situations, the Federal Templates and their functionality and Health Insurance Oversight System (HIOS)
 - **Call: 855-CMS-1515**
 - **Email: CMS_FEPS@cms.hhs.gov**
- **National Association of Insurance Commissioners (NAIC)** with questions about state requirements/System for Electronic Rate and Form Filing (SERFF)
 - **Email: serffplanmgmt@naic.org**

Best Practices- Submitting Help Desk Tickets

- Include HIOS ID, issuer state and issuer legal name.
- Include screenshots or attach templates when asking about an error or issue with the template.
- Submit separate Help Desk requests for different, unrelated questions.
- Put the question in the body of the email; do not attach Excel or Word documents with lists of questions.
- Identify or note whether a question is for the Small Business Health Options Program (SHOP) or Individual Exchange.

HIOS User Group Conference Call

- HIOS User Group Conference Call occurs every Wednesday from 2:00 p.m. to 3:30 p.m. Eastern Time (US & Canada) (GMT-05:00)
- Call Access: 1-888-455-8828; Passcode: 6714482

Plan Management Webinar Dates

The QHP April Webinar sessions occur as shown below:

Date	Day	Time (ET)	Topic
4/28/20	Tuesday	3:00 p.m. – 4:00 p.m.	Open Q&A
4/30/20	Thursday	1:00 p.m. – 2:00 p.m.	Master Review Tool & Cost Sharing Review Tool

Please refer to the Weekly QHP E-flyer for updated Webinar topics.

Resources for QHP Plan Maintenance and Certification

Resource	Resource Link
CMS Regulations and Guidance	https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html
Qualified Health Plan (QHP) Application Materials	https://www.qhpcertification.cms.gov/s/Application%20Materials
QHP Application Review Tools	https://www.qhpcertification.cms.gov/s/Review%20Tools
Registration for Technical Assistance Portal (REGTAP)	https://www.REGTAP.info
Health Insurance Oversight System (HIOS)	https://portal.cms.gov/wps/portal/unauthportal/home/
System for Electronic Rate and Form Filing (SERFF)	https://login.serff.com/

Commonly Used Acronyms

Acronym	Definition
AV	Actuarial Value
BHP	Basic Health Program
ECP	Essential Community Provider
EHB	Essential Health Benefit
EIDM	Enterprise Identity Management
FFE	Federally-facilitated Exchange
HIOS	Health Insurance Oversight System

Commonly Used Acronyms (Continued)

Acronym	Definition
MSP	Multi-State Plans
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
QHP	Qualified Health Plan
SBE	State-based Exchange
SERFF	System for Electronic Rate and Form Filing
USP	United States Pharmacopeia

Closing Remarks