Transparency in Coverage QHP Plan Year (PY) 2020

June 27, 2019

2019 Qualified Health Plan (QHP) Series

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This presentation provides instructions for QHP issuers submitting transparency in coverage data for PY2020.

Agenda

- Session Guidelines
- Announcements
- Transparency in Coverage QHP PY 2020
- Question & Answer (Q&A) Session
- Resources
- Closing Remarks

Session Guidelines

- This is a 60-minute session.
- This webinar will provide an opportunity for Center for Consumer Information and Insurance Oversight (CCIIO) PM Subject Matter Experts (SMEs) to answer issuer questions.
- 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.

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

Transparency in Coverage QHP PY2020

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Agenda

- The purpose of this webinar is to review the:
  - Purpose of Transparency in Coverage data collection
  - Key changes for PY2020
  - Issuer level data elements
  - URL requirements
  - Plan level data elements
  - 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 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 PY2020. This includes Stand-alone Dental Plans (SADPs), Small Business Health Options Program (SHOP) QHPs, and Multi-State Plans.
- Based on the phased-in approach, there are no federal reporting requirements for issuers in SBEs at this time.
- Transparency reporting requirements are applicable to:
  - QHP issuers offering one (1) or more QHPs in PY2020.
  - On-Exchange QHPs only.

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 PY2020.
- 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 PY 2020

- Key changes for PY2020 include:
  - Plan level claims data.
  - Revised data submission template.
- The PY2020 Transparency template and instructions can be found here:
  - https://www.qhpcertification.cms.gov/s/Transparency%20in%20Coverage

Data Elements Required for Submission for Issuers that did not offer QHPs in 2018

- Most issuer-submitted data will be of PY2018 data.
- Issuers that **did not** offer QHPs in 2018 must still submit a Transparency in Coverage Template.
- In the following slides, the data elements that are required for QHPs that **did not offer** QHPs in 2018 will be identified by a caret (^) next to the data element name. If a field is not required, enter "N/A."

Data Elements Required for Submission for Issuers that did offer QHPs in 2018

- Issuers that **did offer** QHPs in 2018 must fill out all data elements on the Transparency Template.
- Issuers that **did offer** QHPs in 2018 must report on claims data for dates of service from January 1, 2018 to December 31, 2018. Issuers should only include 2018 data from on-Exchange plans that are participating on the Exchange in the 2020 plan year.

Issuer Level Data Elements Required for PY 2020 Transparency Template

OMB control number: 0938-1310/Expiration date: 04/22/2022

Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting
Plan Year 2020

Please complete the fields below, following the instructions in the Transparency in Coverage QHP Issuer Instruction Guide.

General Information	
Was this issuer on the Exchange in 2018?	
Issuer Name	
Issuer D/B/A, if Applicable	
Issuer HIOS ID	
Issuer Point of Contact Name	
Issuer Point of Contact E-mail Address	
Issuer Point of Contact Phone Number	
Issuer Backup Point of Contact	
Issuer Backup Point of Contact E-mail Address	
Issuer Backup Point of Contact Phone Number	
2020 Issuer Data: Reporting of all fields is required for 2020	
Claims Payment Policies & Other Information URL	
Number of Issuer Level Claims with Date(s) of Service (DOS) in 2018 That Were Also Received in Calendar Year 2018	
Number of Issuer Level Claims with DOS in 2018 That Were Also Denied in Calendar Year 2018	
Number of Issuer Level Internal Appeals Filed in Calendar Year 2018	
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2018 Appeals	
Number of Issuer Level External Appeals Filed in Calendar Year 2018	
Number of Issuer Level External Appeals Overturned from Calendar Year 2018 Appeals	
Notes: (Please enter any comments/notes here.)	

Issuer Level Data Elements Required for Submission

Year Reporting is Required	Data Element Name	Description
2020	Was this issuer on the Exchange in 2018?^	Enter Yes or No, indicating whether or not this issuer was on the Exchange in 2018. • If Yes, then the issuer must fill out claims and appeals data. • If No, then the issuer must enter 'N/A' to the claims and appeals data fields.
2020	Issuer Name^	Enter the issuer's legal name.
2020	Issuer D/B/A, if Applicable^	Enter the issuer's D/B/A. If not applicable, enter N/A.
2020	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.

Issuer Level Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2020	Issuer Point of Contact Name^	Enter the first and last name of the issuer's primary point of contact for transparency data.
2020	Issuer Point of Contact E-mail Address^	Enter the email address for the issuer's point of contact.
2020	Issuer Point of Contact Phone Number^	Enter the phone number for the issuer's point of contact.

Issuer Level Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2020	Issuer Backup Point of Contact^	Enter the first and last name of the issuer's back-up point of contact.
2020	Issuer Backup Point of Contact E-mail Address^	Enter the email address for the issuer's back-up point of contact.
2020	Issuer Backup Point of Contact Phone Number^	Enter the phone number for the issuer's back-up point of contact.

Issuer Level Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2020	Claims Payment Policies & Other Information URL^	Enter the active and easily accessible URL. A URL is easily accessible when: • It can be viewed on the plan's public website through a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number; and • If an issuer offers more than one (1) plan, when an individual can easily discern what information applies to which plan The URL is the web address on the issuer website that consumers use to view the providers claims information. All URLs should be live, with one (1) URL for a landing page or single page with a link providing the information indicated below: 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); and i. Coordination of benefits (COB). ***See the URL checklist on the next three (3) slides***

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.

Issuer Level Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2020	Number of Issuer Level Claims with date(s) of service (DOS) in 2018 That Were Also Received in Calendar Year 2018	Enter the number of issuer level claims received by an issuer asking 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). 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 claims that were pended or denied for additional information and subsequently paid. I.e., do not count them twice. • Do not include out-of-network claims.

Issuer Level Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description

2020	Number of Issuer Level Claims with DOS in 2018 That Were Also Denied in Calendar Year 2018	Enter the number of issuer level claims received **by an issuer** asking 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.
		• Include all denials in the total number of claims denied in calendar year 2018. 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; and
		  • Duplicate claims.

Issuer Level Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2020	Number of Issuer Level Internal Appeals Filed in Calendar Year 2018	Enter the number of requests by the insured for internal reviews of grievances involving adverse determinations. 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 2018, for DOS in 2018 that were fully adjudicated/completed within 2018. Do not include appeals that were subsequently withdrawn.
2020	Number of Issuer Level Internal Appeals Overturned from Calendar Year 2018 Appeals	Enter the number of final adverse determinations overturned upon request for internal review. 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 an issuer.

Issuer Level Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2020	Number of Issuer Level External Appeals Filed in Calendar Year 2018	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 2018, for DOS in 2018, that were fully adjudicated/completed within 2018. Do not include appeals that were subsequently withdrawn.
2020	Number of Issuer Level External Appeals Overturned from Calendar Year 2018 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 PY 2020 Transparency Template

Center for Medicare & Medicaid Services (CMS) Qualified Health Plan Transparency in Coverage Reporting
Plan Year 2020
Please complete the fields below, following the instructions in the Transparency in Coverage QHP Issuer Instruction Guide.

General Information			2020 Plan Data: Reporting of all fields is required for 2020								Notes
Issuer HIOS ID	2020 Plan ID	State	Number of Plan Level Claims with DOS in 2018 That Were Also Received in Calendar Year 2018	Number of Plan Level Claims with DOS in 2018 That Were Also Denied in Calendar Year 2018	Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2018	Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to an Out-Of- Network Provider/Claims in Calendar Year 2018	Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2018	Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to Lack of Medical Necessity, ***excluding*** Behavioral Health in Calendar Year 2018	Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health ***only*** , in Calendar Year 2018	Number of Plan Level Claims with DOS in 2018 That Were Also Denied for "Other" Reasons in Calendar Year 2018	Notes: (Please enter any comments/notes here.)

Note: If the issuer was not on the Exchange in 2018, please mark N/A for the claims data fields.

Plan Level Data Elements Required for Submission

Year Reporting is Required	Data Element Name	Description
2020	Issuer HIOS ID^	Enter the five-digit HIOS Issuer ID on the Plan Level Data tab. If the issuer has more than one (1) Plan ID to report, the HIOS Issuer ID should be repeated on each line.
2020	2020 Plan ID^	Enter the 14-digit PY2020 Plan ID on the Plan Level Data tab. The Plan ID is composed of the five (5) digit Issuer HIOS ID, the two (2) character state abbreviation, and the seven (7) digit unique digits for the plan. If there is more than one (1) PY2020 Plan ID to report for a single HIOS Issuer ID, this information should be added line by line in the Plan Level Data tab.
2020	State^	Enter the State abbreviation for this HIOS Issuer ID

Plan Level Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2020	Number of Plan Level Claims with DOS in 2018 That Were Also Received in Calendar Year 2018	Enter the number of in-network **plan level** claims received by an issuer asking for a payment or reimbursement by or on behalf of an 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, 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. • Do not include out-of-network claims.

Plan Level Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description

2020	Number of Plan Level Claims with DOS in 2018 That Were Also Denied in Calendar Year 2018	Enter the number of **plan level** claims received by an issuer asking 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 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 Plan ID.
		• Include all denials in the total number of claims denied in calendar year 2018. 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; and
		  ○ Duplicate claims.
		
		• Do not include the following claims:
		  ○ Claims that were pending or initially denied for additional information and subsequently paid.
		  ○ Out-of-network claims.

Plan Level Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2020	Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2018	Enter the number of in-network **plan level** denial for non-emergency 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. *If the plan does not require prior approval for services, please enter N/A.* 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 supplied 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. • Out-of-network claims.

Plan Level Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2020	Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2018	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. *If the plan does not have a closed network, please enter N/A.* 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 PPO) 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. • In-network claims.

Plan Level Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2020	Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2018	Enter the number of **plan level** denial of claims for services excluded or non-covered services. Issuers should include (individual claim line of service item): • In-network claims • 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 and 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. • Out-of-network claims

Plan Level Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2020	Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to Lack of Medical Necessity, Excluding Behavioral Health in Calendar Year 2018	Enter the number of in-network **plan level** denial of claims for health care 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. 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. Do not include the following claims: • Behavioral or mental health claims or payment for services should not be counted in reporting for this section. • Claims that were pending or initially denied for additional information and subsequently paid. • Out-of-network claims.

Plan Level Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2020	Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health only, in Calendar Year 2018	Enter the number of in-network **plan level** denial of claims for health care services or supplies that do not meet the acceptable standards to diagnose or treatment of an illness, injury, condition disease, or its symptoms, related to behavioral/mental health. 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. Do not include the following claims: • Payment for services related to medical surgical diagnosis including medical, pharmacy and pharmacy point of sales. • Claims that were pending or initially denied for additional information and subsequently paid. • Out-of-network claims. Note: Issuers may enter "N/A" in this field for SADPs.

Plan Level Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2020	Number of Plan Level Claims with DOS in 2018 That Were Also Denied for "Other" Reasons in Calendar Year 2018	Enter the number of in-network **plan level** denial of claims rejected for a variety of reasons. Issuers should include (individual claim line of service item): • Incorrect bill coding; • Patient no insured by the plan; • Coverage terminated; • Duplicate claims; • Coordination of benefits issues/failures; • 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.

Data Submission Window

Issuers are required to use the deadlines below for transparency data submission.

Activity	Dates
Initial QHP Transparency Submission Window	07/29/2019 - 09/13/2019
CMS Reviews Initial QHP Data Submissions as of 09/13/2019	09/16/2019 - 09/20/2019
CMS Sends First Correction Notice	09/23/2019 - 09/25/2019
Deadline for Submission of Revised QHP Data	10/02/2019
CMS Reviews Revised QHP Data as of 10/02/2019	10/03/2019 - 10/08/2019

Please note: The PY 2021 deadlines will align with the QHP submission process.

Submitting the Data

1. Test all URL(s) to ensure proper function prior to submission.
2. Complete the Transparency Template **for each HIOS ID**, providing the required information.
3. Use only the tabs provided in the Transparency template and do not add additional tabs.
4. Enter all Plan Level Data in the Plan Level Data tab. One (1) Plan ID should be captured in each row.
5. Save the file as an Excel file.
6. Once completed, submit the Transparency template using the following naming convention: "PY2020_Transparency_in_Coverage_Template_[ISSUER ID]".
7. Submit the completed Transparency Template to: Transparency@cms.hhs.gov by the required deadline. Once you have submitted the template, you will receive an automated response indicating your data has been received.
8. Issuers requiring resubmission of any data elements should follow the previous steps for resubmission and correct any identified error(s).
9. If issuers have questions about the transparency data submission process, contact the CMS Marketplace Service Desk at 855-CMS-1515 or via email at CMS_FEPS@cms.hhs.gov.

Open Q&A Session

Questions?

- 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."*

Submission of Inquiries

Users/Issuers can contact:

- **CMS Help Desk** with questions about specific situations, the Federal Templates and their functionality and HIOS
  - **Call: 855-CMS-1515**
  - **Email:** CMS_FEPS@cms.hhs.gov
- **National Association of Insurance Commissioners (NAIC)** with questions about state requirements/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 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 July Webinar sessions occur on Thursdays as shown below:

Date	Day	Time (ET)	Topic
07/11/19	Thursday	1:00 p.m. – 2:00 p.m.	Plan Year Comparison Reports
07/18/19	Thursday	1:00 p.m. – 2:00 p.m.	Open Q&A
07/25/19	Thursday	1:00 p.m. – 2:00 p.m.	Plan ID Crosswalk Template for Automatic Re-Enrollment - Refresher

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://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/

HTTPS://WWW.REGTAP.INFO

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