COMMON CORRECTIONS
Round 1 QHP Certification Reviews

June 16, 2016

Qualified Health Plan (QHP)
Series VI

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Agenda

- Session Guidelines
- Key Dates
- Announcements
- Common Corrections: Round 1 QHP Certification Reviews
- Resubmission Tips for Issuers
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- Getting Help with Resubmission
- Open Q&A Session
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Session Guidelines

- This is a 60-minute webinar session
- 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

Upcoming Key Dates for QHP Certification

Date	Category	Activity
Ongoing	Submission	Issuers' QHP data in Health Insurance Oversight System (HIOS) Plan Preview HIOS Modules and System for Electronic Rate and Form Filing (SERFF) Transfer are open for data resubmission
May 12 – June 10, 2016	CMS Review	CMS conducts Round 1 review of Plan Year (PY) 2017 QHP Applications
June 15 – 16, 2016	CMS Notice	CMS sends Round 1 Correction Notice to issuers and state regulators
June 15 – 16, 2016	CMS Notice	CMS sends first Plan Crosswalk Notice to issuers and state regulators
June 30, 2016	**Submission**	**Round 2 deadline for HIOS submission and SERFF Transfer of updated QHP Application data**

Announcements

Common Corrections: Round 1 QHP Certification Reviews

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Licensure

- Issuers are required to be licensed for all of the products, plans, and/or service areas proposed in the issuer's QHP Application
  - Ensure issuers are licensed in the state(s) issuers intend to offer QHPs
  - Answer the Licensure questions in the Licensure module accordingly
  - Submit Licensure documentation that is equivalent to:
    - State license
    - Certificate of authority
    - Certificate of compliance
  - Ensure issuer's Licensure documentation has not expired

Good Standing

- Issuers deemed not in good standing are most frequently the result of the issuer not being licensed in the state in which the issuer intends to offer QHPs. An issuer must be licensed in order to be considered in good standing
  - Ensure issuers are licensed in the state(s) issuers intend to offer QHPs

Accreditation

- Issuers who are required to meet the year 4 accreditation requirements should submit an action plan describing when the issuer will be receiving the issuer's "Marketplace" accreditation with an approved year 4 accreditation status

Essential Community Providers (ECPs)

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

Essential Community Providers (Dental)

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

Quality Improvement Strategy (QIS)

- Issuers must indicate whether every health plan covered by the QIS is a “New Health Plan” or “Existing Health Plan” (e.g., Element 21)
- Issuers must check “Yes,” “No” or “Not Applicable” in all checkboxes, if relevant (e.g., Element 24)
- Issuers must provide valid *numerical* rates, numerators, and denominators for issuers’ measures (e.g., Element 24)
- Issuers must provide known and anticipated barriers to QIS implementation and potential mitigation activities to address each barrier (e.g., Element 26)

Non-Discrimination Formulary Outlier

Tips on correcting common issues:

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

Non-Discrimination Clinical Appropriateness

Tips on correcting common issues:

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

Non-Discrimination (Cost Sharing)

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

Cost Sharing Reduction

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

Cost Sharing Reduction (continued)

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

Cost Sharing Reduction (continued)

- 120000191-The zero cost-sharing plan variation has non-zero cost sharing for Essential Health Benefits (EHBs)
  - Issuers should ensure the zero cost sharing plan variation has **no** cost sharing for EHBs both in- and out-of-network
  - The only exception is that an EHB out-of-network may have a "100%" coinsurance only if the benefit is not covered out-of-network by the associated standard plan, meaning it also has a coinsurance of "100%"
  - If a benefit is partially covered out-of-network by the standard plan (i.e. a coinsurance of 50%), the zero cost-sharing plan variation must still cover the benefit completely

Standardized Plan Design

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

Resubmission Tips for Issuers

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Resubmitting: All Issuers

- For all issuers:
  - Revised QHP data must be submitted to the CMS by **June 30, 2016 at noon ET**
  - Issuers should only submit data in the system appropriate for the state in which the issuer is seeking certification

Resubmitting through HIOS

- For issuers resubmitting through HIOS:
  - Issuers who resubmit their templates must also reenter “cross validation complete” status in HIOS in order for their most recent data to be reviewed by CMS
  - The following steps must be completed prior to the **June 30th deadline**:
    - Validate each module and return to the **Final Submission** tab
    - On the Final Submission tab, click “Cross Validate” and then click “Submit”

Resubmitting through SERFF

- For issuers resubmitting through SERFF:
  - If the issuer submits a revised template, the issuer should contact the issuer's state to retransfer the QHP Application from SERFF to CMS as soon as possible. CMS will review the latest application data transferred by the June 30th deadline
  - **The issuer is responsible for working with the appropriate state regulator to ensure all updated application data is successfully retransferred**

Resubmitting through SERFF (continued)

- For issuers resubmitting through SERFF:
  - Revised data resubmitted through SERFF will be the official QHP Application of record for reviews and certification. These issuers' QHP Applications should not be submitted through HIOS. Data submitted through HIOS will not be reviewed for certification

Resubmission Tips for Common Errors

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Tips for Common Errors

The following slides contain additional details on common causes of the "Save Failed" error that some issuers are experiencing with the ECP/Network Adequacy Template.

Capitalization – Uppercase/Lowercase

Issuer has “052 Inpatient Psychiatry (Free-Standing inpatient psychiatric facility and psychiatric beds within an Acute Care Hospital)” in the Facility Type column of the **Facilities ECPs** tab, when it should be “052 Inpatient Psychiatry (Free-standing inpatient psychiatric facility and psychiatric beds within an Acute Care Hospital).

Facility Type*
052 Inpatient Psychiatry (Free-Standing inpatient psychiatric facility and psychiatric beds within an Acute Care Hospital)
052 Inpatient Psychiatry (Free-standing inpatient psychiatric facility and psychiatric beds within an Acute Care Hospital)
052 Inpatient Psychiatry (Free-Standing inpatient psychiatric facility and psychiatric beds within an Acute Care Hospital)

Capitalization – Uppercase/Lowercase (continued)

Issuer has “PHARMACY” in the Facility Type column of the **Facilities ECP** tab, when it should be “Pharmacy”.



Capitalization – Uppercase/Lowercase (continued)

Issuer has “057 Ambulatory Health Care Facilities – Infusion Therapy/oncology/Radiology”, in the Facility Type column of the **Facilities ECP** tab, when it should be “057 Ambulatory Health Care Facilities – Infusion Therapy/Oncology/Radiology”.

Facility Type*
057 Ambulatory Health Care Facilities - Infusion Therapy/Oncology/Radiology
057 Ambulatory Health Care Facilities - Infusion Therapy/oncology/Radiology

Capitalization – Uppercase/Lowercase (continued)

Issuer has “000 Other” in the Facility Type column of the **Facilities ECP** tab, when it should be “000 OTHER”.



Missing Hyphen

Issuer has a 9 digit zip code with no hyphen, when a hyphen is required.



State Capitalization

Issuer has a state code with a lowercase letter, when both are required to be capitalized.



Getting Help with Resubmission

Resolving Template Submission Errors

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

Open Q&A Session

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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" to submit your questions*

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 or **Email:** CMS_FEPS@cms.hhs.gov
- **National Association of Insurance Commissioners (NAIC)** with questions about state requirements/SERFF
  Email: serffplanmgmt@naic.org
- **CMS Help Desk** with questions about policy
  Call: 855-CMS-1515 or **Email:** CMS_FEPS@cms.hhs.gov

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 Marketplace

Plan Management Webinar Dates

The 2016 QHP June Webinar Series VI sessions continue on Tuesdays and Thursdays as shown below.

Date	Day	Time (ET)	Topic
6/21/16	Tuesday	3:00 p.m.—4:00 p.m.	Window Shopping and Decision Tools Wireframes Demonstration
6/23/16	Thursday	1:00 p.m.—2:00 p.m.	Open Q&A
6/28/16	Tuesday	3:00 p.m.—4:00 p.m.	Open Q&A
6/30/16	Thursday	1:00 p.m.—2:00 p.m.	Open Q&A

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.

Additional Webinar Dates

In addition to the twice-weekly PM webinar sessions, issuers are encouraged to attend the following sessions:

Program Area	Day	Time (ET)
Enrollment	Monday (bi-weekly)	12:00 p.m. – 1:30 p.m.
FF-SHOP	Tuesdays	1:00 p.m. – 2:00 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.

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

Resources

Resource	Resource Link
CMS	http://www.cms.gov/
CMS Regulations and Guidance	http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html?redirect=/home/regsguidance.asp
Data Templates	https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html
HealthCare.gov	http://www.healthcare.gov/
National Conference of State Legislatures	http://www.ncsl.org
Registration for Technical Assistance Portal (REGTAP)	https://REGTAP.info
U.S. Department of Health & Human Services (HHS)	http://www.hhs.gov/

Commonly Used Acronyms

Acronym	Definition
AV	Actuarial Value
BHP	Basic Health Program
ECP	Essential Community Provider
EHB	Essential Health Benefit
EIDM	Enterprise Identity Management
FFM	Federally-facilitated Marketplace
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
SBM	State-based Marketplace
SERFF	System for Electronic Rate and Form Filing
USP	United States Pharmacopeia

Closing Remarks

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