Best Practices for Data Change Requests

September 22, 2016

Qualified Health Plan (QHP)
Series IX

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

HTTPS://WWW.REGTAP.INFO

Agenda

- Session Guidelines
- Key Dates
- Announcements
- Best Practices for Data Change Requests
- Special Situations
- Changes Affecting Consumers
- Process Management
- Q&A
- Closing Remarks

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

August 24-September 09, 2016 – Federally-facilitated Marketplace (FFM) review of final QHP Application data.

September 15-16, 2016 – Certification Notices and QHP Agreements sent to issuers in FFM States, States performing plan management and State-based Marketplaces utilizing the federal platform for eligibility and enrollment (SBM-FPs).

September 19-23, 2016 – Issuers review and return final plan lists and signed QHP Agreements.

October 03-04, 2016 – Countersigned QHP Agreements sent to issuers in FFM States, States performing plan management and SBM-FPs.

Announcements

Best Practices for Data Change Requests

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What is a Data Change Request?

- Data change requests are submitted by issuers in order to request a change to issuers' QHP data after the application period closes.
- Requests can be submitted at any time, but are only reviewed by CMS during data correction windows.
  - Data Correction windows are announced via Health Insurance Oversight System (HIOS).
- Requests are sometimes also called "petitions."

State Marketplace Models

- This process applies to all issuers in the FFM, including issuers in states performing plan management functions.
- Issuers in SBM-FPs do not need to complete data change requests, including service area change requests, in order to make modifications to issuers' QHP data.
  - SBM-FPs issuers should direct data change requests to issuers' state Marketplace.

Timelines

- While issuers may submit a request at any time until the request deadline, CMS will set specific deadlines for data change windows.
- Issuers must submit all requests by the request deadline.
- Issuers must make approved changes by the deadline.

Required Elements of a Request

- Data Change Request Form
  - Details about the revisions needed, including original and revised values.
  - Must be signed and authorized by a representative of the issuer.
- State Approval Form
  - Required only for issuers in FFMs, or approval from CMS Form Filing if a QHP or dual issuer in direct enforcement state.
  - If an issuer in an FFM is unable to have the issuer's state complete a State Authorization of QHP Data Change Request Form, the issuer may instead submit other evidence of state approval. This usually is in the form of an e-mail from the state.
- Supplement A Form
  - Describes the consumer impact of the data change.
- Supplement B Workbook
  - Required for changes to Plan and Benefits, Business Rules or Service Area Template.

Required Elements of a Request

- Form Filing
  - Issuers must include copies of the relevant section of the form filing if the first justification is chosen in the “Reasons for Requested QHP or SADP Data Changes” section of the Data Change Request Form.
- Screenshots
  - If the second justification is chosen in the Data Change Request Form, issuers must include screenshots of the data errors.

Reason for Requested QHP or SADP Data Changes:

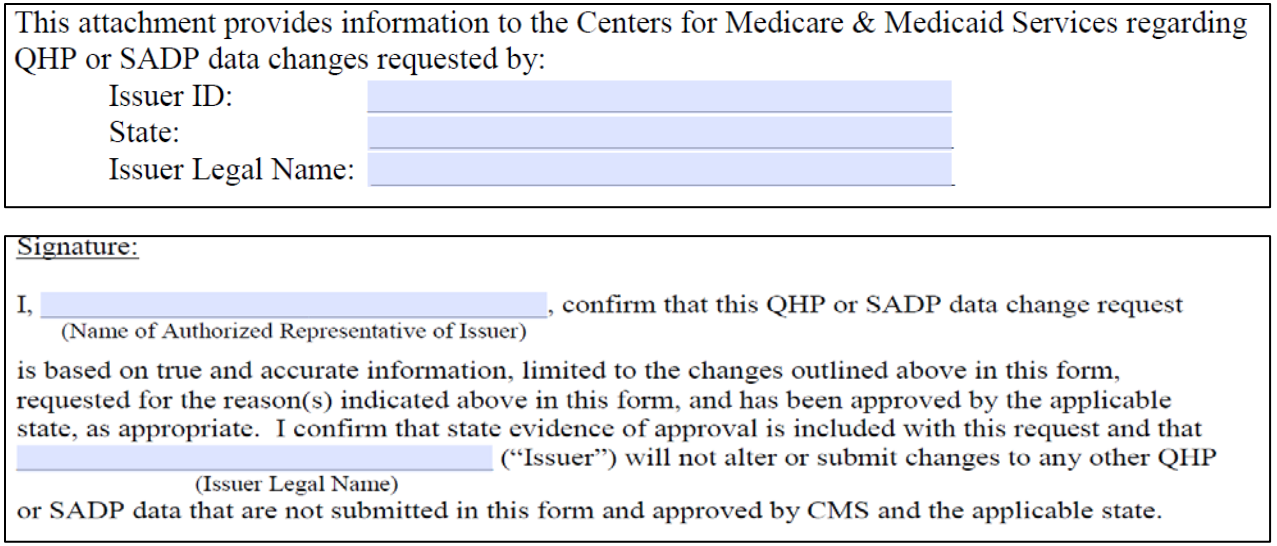
- Issuer submitted incorrect data on QHP/SADP template(s) and must make a change to align template(s) with QHP/SADP data previously approved by the applicable state (or CMS Form Filing if in a Direct Enforcement state). Evidence from the form filing section must be attached.
- Issuer submitted a typographical (i.e., data entry) error for which the first justification does not apply, resulting in incorrect data display on the Marketplace consumer portal. Evidence must be attached.
- Issuer is making routine updates to the administrative information, which includes URL changes.

One Change per Worksheet

- Complete one worksheet per issuer, per data change.
  - If an issuer is making the same change to multiple plans, plans can be on a single worksheet.
  - If an issuer is making changes to multiple data elements, data elements must be be on separate worksheets.
  - Example: if an issuer wants to change the Network URL for multiple plans, plans can be grouped together on a single worksheet.
  - Example: If an issuer wants to change the Network URL and copay for specialists, this would be considered as two separate data change requests, and two forms should be completed (even if the change is for the same Plan ID).

Issuer Identification

- Complete the top and bottom sections of the worksheet with the Issuer's Legal Name as represented in HIOS.
- HIOS Issuer ID and State must also be provided at the top.



This attachment provides information to the Centers for Medicare & Medicaid Services regarding QHP or SADP data changes requested by:

Issuer ID: _____

State: _____

Issuer Legal Name: _____

Signature:

I, _____, confirm that this QHP or SADP data change request
(Name of Authorized Representative of Issuer)

is based on true and accurate information, limited to the changes outlined above in this form, requested for the reason(s) indicated above in this form, and has been approved by the applicable state, as appropriate. I confirm that state evidence of approval is included with this request and that _____ ("Issuer") will not alter or submit changes to any other QHP
(Issuer Legal Name)
or SADP data that are not submitted in this form and approved by CMS and the applicable state.

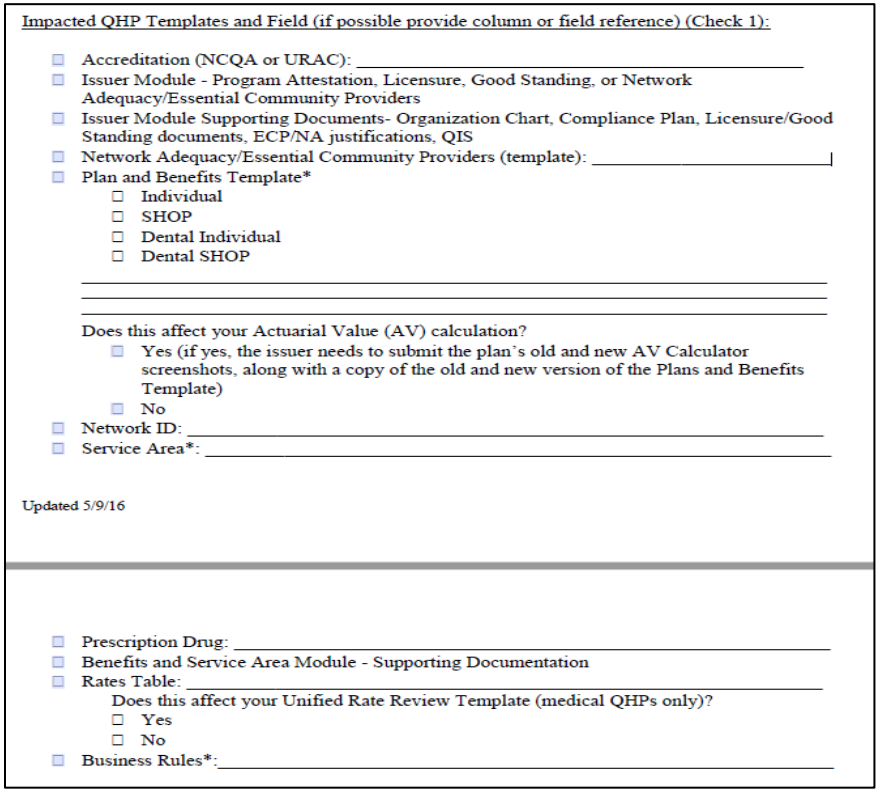
Plan IDs

- Full Plan IDs should be provided.
- Cost share variation identifiers should be provided if applicable.
- Example of cost share variation identified:
  - Plan ID 77777YA100001-06

Impacted Plan IDs:

Templates and Data Fields

- Issuers should select the specific template requiring revision.
- If possible, provide the column or field reference.
  - Example: Issuer selects “Plan and Benefits Template,” “Individual” and in the field writes “Benefits Package 4, Row 66, Column E ‘Hospice Services.’”



Impacted QHP Templates and Field (if possible provide column or field reference) (Check 1):

- ☐ Accreditation (NCQA or URAC): _____
- ☐ Issuer Module - Program Attestation, Licensure, Good Standing, or Network Adequacy/Essential Community Providers
- ☐ Issuer Module Supporting Documents- Organization Chart, Compliance Plan, Licensure/Good Standing documents, ECP/NA justifications, QIS
- ☐ Network Adequacy/Essential Community Providers (template): _____
- ☐ Plan and Benefits Template*
  - ☐ Individual
  - ☐ SHOP
  - ☐ Dental Individual
  - ☐ Dental SHOP

_____
_____
_____

Does this affect your Actuarial Value (AV) calculation?

- ☐ Yes (if yes, the issuer needs to submit the plan's old and new AV Calculator screenshots, along with a copy of the old and new version of the Plans and Benefits Template)
- ☐ No

- ☐ Network ID: _____
- ☐ Service Area*: _____

Updated 5/9/16

- ☐ Prescription Drug: _____
- ☐ Benefits and Service Area Module - Supporting Documentation
- ☐ Rates Table: _____

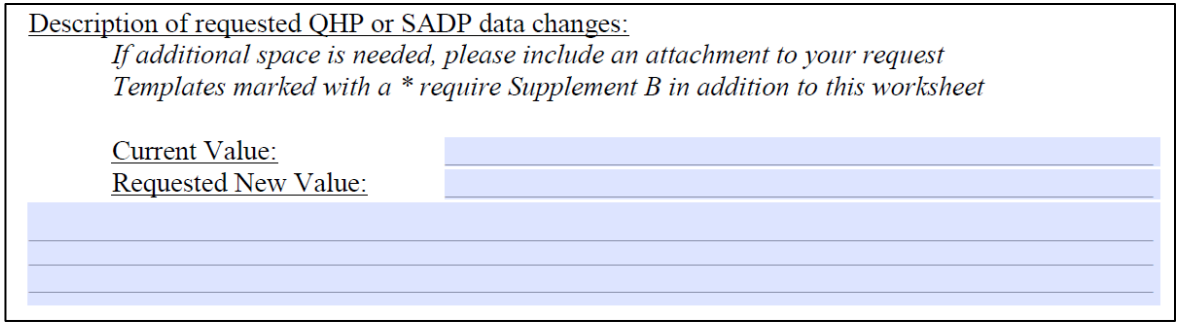
Does this affect your Unified Rate Review Template (medical QHPs only)?

- ☐ Yes
- ☐ No

- ☐ Business Rules*:_____

Details about Revisions Needed

- Issuers should provide both the original value of the field and the new value requested.
  - For example, if requesting a change to the Primary Care Physician (PCP) copay from $45 to $50, the current value would be "$45 copay before deductible for Benefit 'Primary Care Visit to Treat an Injury or Illness'" and the requested new value would be "$50 copay before deductible for Benefit 'Primary Care Visit to Treat an Injury or Illness.'"
- If the change would impact other fields or be related to other fields, additional details should be provided.
- Issuers may submit via the data change request ticket an attachment such as a completed template with the changes highlighted, but must still provide adequate details in the worksheet to describe the requested changes.


Description of requested QHP or SADP data changes:
If additional space is needed, please include an attachment to your request
*Templates marked with a * require Supplement B in addition to this worksheet*

Current Value:
Requested New Value:

Reasons

- Select at least one reason for the data change:

Reason for Requested QHP or SADP Data Changes:

- ☐ Issuer submitted incorrect data on QHP/SADP template(s) and must make a change to align template(s) with QHP/SADP data previously approved by the applicable state (or CMS Form Filing if in a Direct Enforcement state). Evidence from the form filing section must be attached.
- ☐ Issuer submitted a typographical (i.e., data entry) error for which the first justification does not apply, resulting in incorrect data display on the Marketplace consumer portal. Evidence must be attached.
- ☐ Issuer is making routine updates to the administrative information, which includes URL changes.

- If the first justification is chosen, issuers must include copies of the relevant section of issuer's form filing.
- If the second justification is chosen, issuers must include screenshots of data errors. The second justification cannot be chosen if the first justification applies.

Signature

- Data Change Request Forms must be signed and dated by an authorized representative of the issuer.
- The form must note the title of the authorized representative.

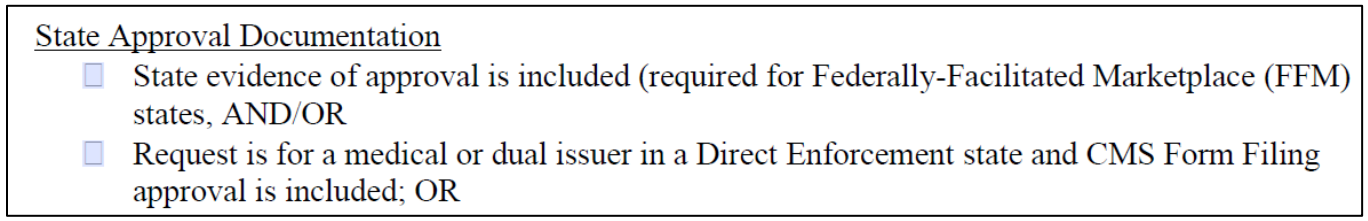
I understand that it is the issuer's responsibility to ensure that the plan(s) affected by this change is in compliance with federal QHP certification standards as laid out in the Affordable Care Act, federal and state regulations, and the 2017 Letter to Issuers in the Federally-facilitated Marketplaces (FFMs). CMS recommends that issuers check their templates using the QHP Application Review Tools to ensure compliance with these standards. I understand that CMS will be reviewing the resubmission of the Issuer's QHP or SADP data, and changes beyond what CMS authorized or noncompliance may result in the suppression of the Issuer's QHP or SADP.

(Signature) (Date)

(Print Name) (Title of Issuer Representative)

State Approval: FFM

- At the bottom of the form, FFM issuers must select one of the state approval options.
- FFM issuers must submit documented state approval (or request form filing approval for direct enforcement states) for all data change requests.
- State approvals must be specific to that data change request and date of the request.
- If the issuer selected “align with form filings” or “data entry error” as a reason for the request, the state approval documentation must include that the state agrees with that reason.


State Approval Documentation

- ☐ State evidence of approval is included (required for Federally-Facilitated Marketplace (FFM) states, AND/OR
- ☐ Request is for a medical or dual issuer in a Direct Enforcement state and CMS Form Filing approval is included; OR

State Approval: States Performing Plan Management Functions

☐ Request is for an issuer in a state performing plan management functions

- Issuers in states performing plan management functions should request approval from issuers' states at the same time issuers are requesting approval from CMS.
- Issuers should work with issuers' states to determine the submission deadline for revisions prior to the System for Electronic Rate and Form Filing (SERFF) transfer deadline.
- Issuers in states performing plan management functions do not need to submit state approval with issuer's data change request.
- Issuers in states performing plan management functions should check the appropriate box (above).

Supplement B

- Issuers requesting changes to the Plans and Benefits (P&B) Template, Business Rules Template or Service Area Template must complete Supplement B.
- There are four worksheets: one for the P&B Benefits Package tab, one for the P&B Cost Share Variances tab, one for the Business Rules Template and one for Service Area.
  - —Fill out the tab that corresponds to the template the issuer is requesting to change. All other tabs should be blank.
  - —Each tab to include fields to be filled out as appropriate to the intended changes. These fields correspond to the templates the fields represent.
  - —Each field will have a pop-up message box with guidance on what data may be entered into each field.

Supplement B (continued)

- The “Original Field Value” and “Revised Field Value” fields represent the data values of the field or data element being changed (from/to). The “Original Field Value” represents the data being changed from a previously submitted version of the template, and the “Revised Field Value” represents the data value being changed to in the next version of the template to be submitted.
  - Data changes: Enter the changing value and the intended value in the “Original Field Value” and “Revised Field Value” fields, respectively.
  - Data additions: “Original Field Value” should be blank (representing that this data did not exist in template previously), and the “Revised Field Value” field should be populated with the data being added.
  - Data deletions: “Original Field Value” should be populated with the data being deleted, and the “Revised Field Value” should be blank (representing that the data should not exist in the next version of the template).

Supplement B (continued)

- Once all intended changes have been entered, please save the workbook file using the following file name structure: DCR_IssuerID_Date (mm-dd-yyyy).
  - For example: DCR_12345_10-15-2016

Special Situations

CMS Instructed Data Changes

- Rarely, CMS may contact an issuer directly with instructions to make a data change.
- Issuers must still complete the data change request approval process.
- Issuers may be instructed to complete the data change prior to formal approval; if so, CMS will send a written request.
- Issuers should include CMS's written request as documentation when submitting the data change request worksheet.

Changes Affecting Consumers

Changes Affecting Consumers

- For changes that issuers request after Open Enrollment begins, CMS will consider the impact of the change on consumers.
- The impact of the change on consumers will be considered separately from CMS' approval/disapproval of the change.
- CMS will communicate an initial determination of consumer impact with the approval of a change request.

Benefit Display Errors in Plan Compare

- Errors can cause consumers to see incorrect premium, benefits and cost-sharing displayed for certain plans on Plan Compare.
- Marketplace benefit display errors include situations where:
  - A discrepancy is identified between an issuer's QHP data and the issuer's state-approved form filings.
  - Issuer makes a data entry error.
  - Coding on HealthCare.gov caused benefits to display incorrectly.

Resolving Benefit Display Errors

- Display errors can be corrected during data correction windows.
- When an issue is corrected, CMS reviews each error to assess:
  - whether there was any enrollee impact.
  - whether the change will be in the consumer's favor.
- If CMS determines an error was likely to result in one of these outcomes, the issuer has the option to either honor the benefit as it was originally displayed or advise impacted enrollees of the error.
- If the change is not in the consumer's favor, and the issuer does not honor the plan as it was incorrectly displayed, the enrollee is eligible for a special enrollment period to select another plan through the Marketplace.

Data Errors with No Consumer Impact

- Issuer action: work with CMS to resolve error during data correction window.
- Generally, CMS reserves this for errors in which impacted plans had no enrollees at the time of correction.

Data Errors with Consumer Impact

- The issuer will notify the consumer in writing of the error and the correct benefit and advise impacted enrollees they have a special enrollment period to select another plan through the Marketplace.

Supplement A to Data Change Request

- Issuers with data change requests that would affect consumer display should complete Supplement A to the data change request.
- Supplement A covers the enrollee impact of the data change.
- The supplement should be submitted at the same time as the data change request, if possible.

Required Elements to Supplement A

- Short description of data change
- Description of the enrollee impact of the change
- Estimated number of enrollees impacted
- Description of the steps the issuer is proposing to take in response
- Description of any discussions with appropriate state agencies

Supplement A - Description of Change

- The description should be a simple restatement of the data change.
- The description should describe the change in a way that assists with assessment of the enrollee impact.

Section 1:

This attachment provides supplemental information to the Centers for Medicare & Medicaid Services regarding QHP or SADP data changes requested by:

Issuer ID: _____

State: _____

Issuer Legal Name: _____

The changes affect the following plan IDs and templates/data elements:

Supplement A - Enrollee Impact

- Should describe the difference that the enrollees will see or experience in enrollee's plan.
- All changes that affect plan display have enrollee impact.

Section 2:

What is the consumer/enrollee impact of the requested changes?

Supplement A - Number of Enrollees

- Issuers should estimate the number of enrollees affected by the change based on the number enrolled in each Plan ID and Cost Sharing Reduction (CSR).
- If the affect on enrollees would differ by CSR or Plan ID, the number can be listed separately.
  - E.g., “Plan ID 12345JH00001-01 10 enrollees”
    “Plan ID 12345JH000001-06 50 enrollees”

How many enrollees are currently enrolled in the affected Plan IDs (and thus potentially eligible for a notification of the change or a Special Enrollment Period to change plans)?

Supplement A - Enrollee Remediation

- Issuers should list any proposed steps for enrollee remediation.
- Issuers may list any previous enrollee communication that is related (such as information listed in the plan brochure) but should also consider what further steps are needed.
- Approval of the data change request does not constitute approval of proposed enrollee remediation, and issuers will be contacted by CMS after the change is made to confirm next steps.

What steps will you take to inform or remediate with enrollees?

Supplement A - State Communication

- Issuers should indicate with which state agencies issuers have discussed the proposed change and the outcome of any discussions.
- If available, issuers should list a contact person at the state agency. CMS may reach out to that person directly.

Have you discussed next steps with the appropriate state agency (DOI or Consumer Protection)? If so, state the agency name and what is the result of that discussion? If appropriate, list the state contact person for follow up.

Next Steps - CMS Approval

- CMS approvals of data change requests will include a statement of whether CMS believes the change has an enrollee impact.
- If there is enrollee impact, issuers will work with CCIIO, the issuer's state and the issuer's Account Manager on next steps, including special enrollment periods or other enrollee remediation.

Process Management

Help Desk

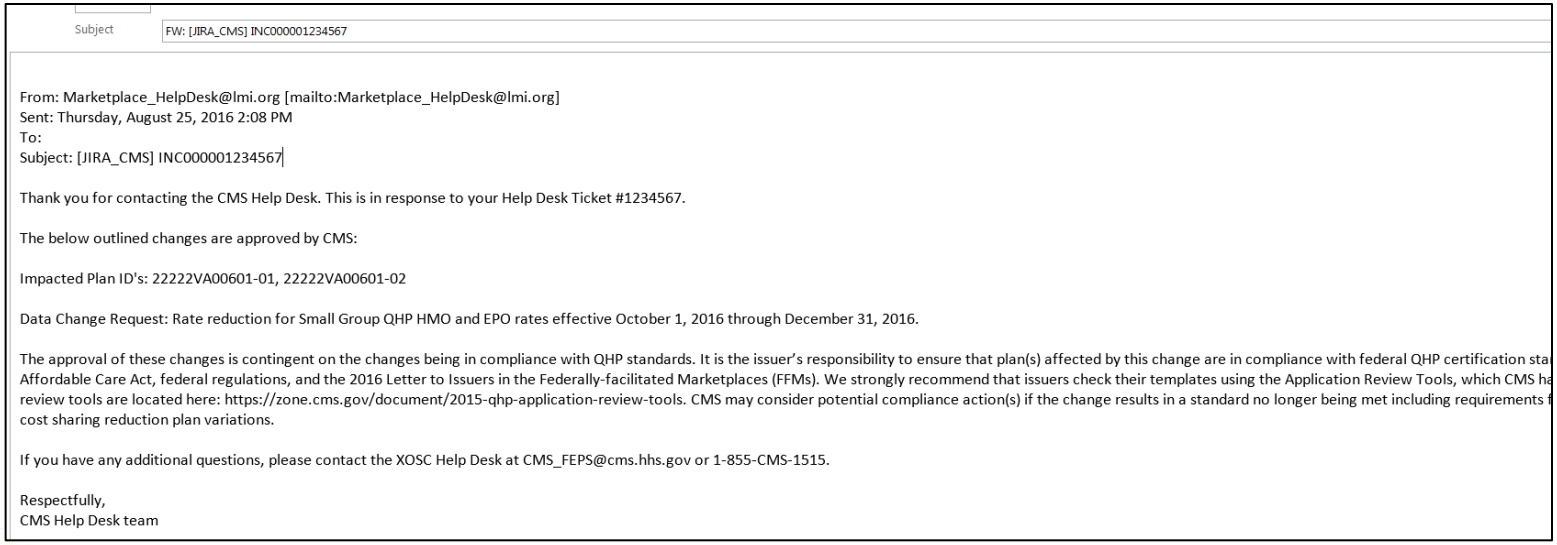
- When submitting a request to the Exchange Operations Support Center (XOSC) Help Desk make sure to:
  - Name the email “Request for Changes to QHP Data.”
  - Include all documents/information in a single email.
  - Include issuer contact information in the body of the email.

Getting All Requests Reviewed

- After submitting a data change request, issuers will receive a ticket number from XOSC.
- Issuers should record all ticket numbers.
- Issuers may be contacted by issuer's Account Manager prior to the end of the data change window with a list of requests and the ticket numbers. This is an opportunity for issuers to verify that CMS has received all data change requests from the issuer.

Receiving Approvals

- CMS will issue approvals or disapprovals for data change requests through the Help Desk.
- All Help Desk responses will include the ticket number at the beginning of the email.
- Issuers should carefully read responses for specific approvals, disapprovals or additional instructions from CMS.



Subject: FW: [JIRA_CMS] INC000001234567

From: Marketplace_HelpDesk@lmi.org [mailto:Marketplace_HelpDesk@lmi.org]
Sent: Thursday, August 25, 2016 2:08 PM
To:
Subject: [JIRA_CMS] INC000001234567

Thank you for contacting the CMS Help Desk. This is in response to your Help Desk Ticket #1234567.

The below outlined changes are approved by CMS:

Impacted Plan ID's: 22222VA00601-01, 22222VA00601-02

Data Change Request: Rate reduction for Small Group QHP HMO and EPO rates effective October 1, 2016 through December 31, 2016.

The approval of these changes is contingent on the changes being in compliance with QHP standards. It is the issuer's responsibility to ensure that plan(s) affected by this change are in compliance with federal QHP certification sta
Affordable Care Act, federal regulations, and the 2016 Letter to Issuers in the Federally-facilitated Marketplaces (FFMs). We strongly recommend that issuers check their templates using the Application Review Tools, which CMS ha
review tools are located here: https://zone.cms.gov/document/2015-qhp-application-review-tools. CMS may consider potential compliance action(s) if the change results in a standard no longer being met including requirements f
cost sharing reduction plan variations.

If you have any additional questions, please contact the XOSC Help Desk at CMS_FEPS@cms.hhs.gov or 1-855-CMS-1515.

Respectfully,
CMS Help Desk team

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."*

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 Small Business Health Options Program (SHOP) or Individual Marketplace.

PM Webinar Dates

The 2016 QHP September Webinar Series IX sessions conclude on Thursday as shown below:

Date	Day	Time (ET)	Topic
9/29/16	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 weekly PM webinar sessions, issuers are encouraged to attend the following sessions:

Program Area	Day	Time (ET)
Enrollment	Mondays	12:00 p.m. – 1:00 p.m.
EDGE Server	Tuesdays	11:30 a.m. – 1:00 p.m.
FF-SHOP	Tuesdays	1:00 p.m. – 2:00 p.m.
SHOP - New Issuer Series	Thursdays	2:00 p.m. – 3:00 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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