

## Comment Summaries in Response to Paperwork Reduction Act Notice Published November 18, 2015<sup>1</sup>

### Initial Plan Data Collection to Support QHP Certification (CMS-10433)

No.	Comment Type	Comment Summary	Template Area	Response
1	Data collected	Strongly supports the collection of issuer logos on the FFM.	N/A	We will consider this for the future as we prioritize IT needs.
2	Data collected	Recommends that CMS provide more detail explaining how issuers would need to fill out each data element and how CMS will use the data for certification and/or display on <a href="http://healthcare.gov">healthcare.gov</a> .	N/A	CMS intends to provide further information at the 2017 Issuer Conference this year, as well as during the ongoing QHP issuer webinars.
3	Data collected	Requests that CMS release the final 2017 templates and template instructions as soon as possible.	N/A	We are releasing the final information as soon as possible and will also provide demonstrations at the 2017 Issuer Conference and during the ongoing QHP issuer webinars.
4	Data collected	Suggests that CMS change the template for 2017 to capture age requirements for grandchildren and dependents of minor dependents. Suggests that CMS include definitions for each dependent category. Suggests that CMS consider removing dependent categories that are not supported by the Exchange enrollment process.	Business Rules Template	We will consider this for the future as we prioritize IT needs.
5	Data collected	Requests clarification in the instructions for the Business Rules Template as to how issuers should complete the template related to questions regarding secondary subscribers if there are any modifications as a result of the Supreme Court ruling on same-sex marriage.	Business Rules Template	The information does not address the classification of same-sex <i>spouses</i> . Rather, the questions refer to whether an issuer treats domestic partners or same-sex partners – i.e. unmarried individuals – as secondary subscribers. Neither domestic partners nor same-sex partners are married.
6	Data collected	Recommends that data elements that	Network	Issuers should submit the number of FTE

<sup>1</sup> Two commenters incorporated by reference their comments to the 60-Day Federal Register Notice. These comments were addressed by CMS previously and therefore are not included in this comment summary document.

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		require issuers enter the number of contracting/authorized individual providers (e.g., MDs, DOs, PAs, NPs) for individual ECPs and ECP facilities remain optional.	Adequacy/Essential Community Providers Template	contracted practitioners for each ECP that it enters on its ECP template. This will help CMS assess ECP availability in an issuer's provider network and make facility and FTE comparisons where necessary to justify ECP patterns for 2017. If the number of FTE contracted practitioners for an ECP is not yet available to the issuer for 2017, the issuer will enter a null value to complete template validation.
7	Data collected	Requests template instructions for the "Select ECPs" tab to clarify the purpose for this tab and how issuers should use it to report ECP data.	Network Adequacy/Essential Community Providers Template	The "Select ECPs" tab will contain the final ECP list for PY 2017. This tab allows issuers to select ECPs within the final ECP list to auto-populate their ECP template, rather than having to manually enter each ECP from the HHS list with whom an issuer has contracted.
8	Data collected	Recommends adding fields, including provider's phone number, web address, office hours, whether the provider is accepting new QHP patients, the time period for accepting new QHP patients, non-English languages spoken by the provider and staff, physical and programmatic accessibility of the provider's facility, and an indicator for pediatric experience, to assist in evaluating adequacy.	Network Adequacy/Essential Community Providers Template	We appreciate the commenter's concern; however, some of this information is included in provider directories, which are required to be updated regularly by issuers. We do not believe additional information is necessary for the certification process.
9	Data collected	Expresses concern that the template does not collect information on the range of providers that treat certain conditions (e.g., Certified Alcohol and Drug Abuse Counselors, LCSWs, prenatal care, nurse midwives, pediatric specialists, etc.).	Network Adequacy/Essential Community Providers Template	We will consider this for the future as we prioritize IT needs.
10	Data collected	Recommend that CMS not combine the Network Adequacy Template and Essential	Network Adequacy/Essential	We appreciate the comment; however, we believe the merged template reduces issuer

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		Community Provider Template into a single template.	Community Providers Template	burden related to entering the provider data, particularly in the longer term.
11	Data collected	Does not support the addition of Provider Tier and Provider Cost Sharing data elements to the Network Adequacy Template. Recommends removing the proposed data fields to capture the network of providers and facilities and the costs associated with the tier.	Network Adequacy/Essential Community Providers Template	We appreciate the comment; however, we believe collecting the provider/facility tier information will provide additional transparency to consumers.
12	Data collected	Recommends removing the proposed data fields to the "Facility ECP" and "Individual ECP" tabs in which issuers would have to indicate the number of contracted MDs, DOs, PAs, NPs, DMDs and DDSs authorized to independently treat and prescribe within a listed facility, or for individual providers, the number of contracted providers associated with such provider (e.g. contracted MD with physician extenders such as NPs and PAs).	Network Adequacy/Essential Community Providers Template	Issuers should submit the number of FTE contracted practitioners for each ECP that it enters on its ECP template. This will help CMS assess ECP availability in an issuer's provider network and make facility and FTE comparisons where necessary to justify ECP patterns for 2017. If the number of FTE contracted practitioners for an ECP is not yet available to the issuer for 2017, the issuer will enter a null value to complete template validation.
13	Data collected	Recommends collecting Network IDs on the Facilities and Pharmacies tab. This was in the 2016 template and is currently missing; it appears to be an oversight.	Network Adequacy/Essential Community Providers Template	Thank you for the comment; however, this was not an oversight. The "Create Network IDs" was intentionally removed and replaced with the "Import Network IDs" button.
14	Data collected	Requests additional information regarding the functionality of the planned embedded ECP provider list within the Network Adequacy Template, specifically that CMS include search functionality to determine whether an ECP provider is an individual or a facility.	Network Adequacy/Essential Community Providers Template	The embedded final ECP list includes a filter functionality that allows issuers to quickly identify their contracted ECPs from the list. We will consider this for the future as we prioritize IT needs.
15	Data collected	Requests that CMS clarify the definitions for "authorized" versus "contracted" MDs, DOs, PAs, NPs, DMDs, and DDSs. Requests	Network Adequacy/Essential Community	The number of authorized practitioners displayed within the embedded ECP list reflects the number of available practitioners at the

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		specific clarification of any difference between the two terms and the implications for the data collection.	Providers Template	provider site reported by the ECP via the ECP petition process. The number of contracted practitioners that the issuer must enter in its ECP template should reflect the number of practitioners at the provider site with whom the issuer has included in its provider network and made available to consumer enrollees in its QHP.
16	Data collected	Recommends organizing the Plans and Benefits Template by essential health benefits (EHB) category.	Plans and Benefits Template	EHB categories will not be included in updates for PY 2017, but we will consider this for the future as we prioritize IT needs.
17	Data collected	Supports CMS' proposal to make the "Plan Design Type" field optional.	Plans and Benefits Template – Benefits Package tab	Plan Design Type Field is optional because offering standardized options is optional.
18	Data collected	Recommends that CMS clarify the difference between the new "Care Plan Limit" data field and "Limit Quantity," and that CMS clarify what it intends to collect for this data field.	Plans and Benefits Template – Benefits Package tab	The new Care Plan Limit and Limit Quantity date fields will not be included in updates for PY 2017. An issuer may require a provider to submit a Care Plan after a certain number of visits. If a Care Plan is not provided, the issuer will not reimburse for visits until the care plan is received. Compare this to a visit limit, in which an issuer explicitly states that coverage is limited to a certain number of visits.
19	Data collected	Recommends that CMS clarify that the new data field "Mental Health Emergency Services" will not be implemented until 2018, along with all other data fields related to mental health parity.	Plans and Benefits Template – Benefits Package tab	The "Mental Health Emergency Services" category and "Care Plan Limit" and "Limit Quantity" associated with providing new tools to determine mental health parity will not be included in updates for PY 2017 Plans & Benefits Template, but will be reflected in any future year updates in instructions and other supporting materials. CMS will use other sources of information to evaluate MHPAPEA compliance.

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20	Data collected	Recommends that CMS clarify the purpose and definition of the EHB category data field citing its need when evaluating mental health parity.	Plans and Benefits Template – Benefits Package tab	See prior comment #19.
21	Data collected	Requests that CMS clarify the definition of the new “All Other Mental Health/Substance Use Outpatient Visits” benefit on the benefits list, as well as whether this benefit will always be required to be populated.	Plans and Benefits Template – Benefits Package tab	See prior comment #19. This benefit will not populate in the PY 2017 Plans & Benefits Template. When this benefit is implemented, we will provide additional guidance through the Template Instructions and other supporting materials.
22	Data collected	Suggest that template instructions for “Benchmark Used” clarify the purpose and definition of this field, including acceptable ways to populate it.	Plans and Benefits Template – Benefits Package tab	The “Benchmark Used” field will not be included in updates for the PY 2017 Plans & Benefits Template. We will however take your recommendation into account as we make future year updates in instructions and other supporting materials.
23	Data collected	Suggest that template instructions for “Plan Design Type” clarify whether this is meant only as an indicator to identify standardized plans or if it would be used to identify the product type (e.g., HMO, PPO).	Plans and Benefits Template – Benefits Package tab	It is meant as an indicator to identify standardized plans as well as an indicator to identify how many standardized options an issuer plans to offer at each metal level (i.e. one silver HMO standardized options and one silver PPO standardized option; in this case, the template would just note that there is a standardized plan one and a standardized plan two, it would not indicate “HMO” “PPO” explicitly).
24	Data collected	Recommends that CMS pre-populate the EHB Category field for each benefit for the appropriate category and provide the option for issuers to change that value to ensure accurate reporting.	Plans and Benefits Template – Benefits Package tab	The standardized options add-in will do this for the standardized plans.
25	Data collected	Recommend that the “Care Plan Limit” header be labeled to refer to prior authorization requirements, if this is	Plans and Benefits Template – Benefits Package	See comment #19.

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		<p>accurate. If this is representing another value, this field name needs to be clarified. Recommend that the “Number of Visits before Care Plan Limit Applies” field is labeled such that it refers to the number of visits that can be received before a prior authorization is required, if this is accurate. If this is representing another value, this field name needs to be clarified. Additionally, recommends that this field align with the limit fields and refer to them as “units” rather than “visits.”</p>	tab	
26	Data collected	<p>Recommends that CMS has a process in place to support fact-based exceptions to the review of benefits under the Mental Health Parity Act (MHPAEA) that may be more rigid than the existing framework that issuers use, and are permitted to use under MHPAEA.</p>	<p>Plans and Benefits Template – Benefits Package tab Mental Health</p>	<p>We will take this comment into account when defining operational processes to implement any reviews associated with MHPAEA in future years. However, please note fields associated with mental health parity/MHPAEA will not be included in updates for PY 2017 Plans &amp; Benefits Template, but will be reflected in any future year updates in instructions and other supporting materials.</p>
27	Data collected	<p>Recommends that CMS align the dates for adding the “Number of Visits before Cost Sharing Begins and “Number of Copays before Deductible/Coinsurance Begins” so that those changes occur in 2017.</p>	<p>Plans and Benefits Template – Cost Share Variances tab</p>	<p>The current “AV Calculator Additional Benefit Design” options are moving to the Cost Variance worksheet for 2017, but the new fields on “Which Benefits Begin Cost-Sharing After a Set Number of Visits?” will not be added in 2017 as the 2017 AV Calculator does not include these fields. Please refer to the 2017 AV Calculator Methodology document for additional information at: <a href="https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-AVC-Methodology-012016.pdf">https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-AVC-Methodology-012016.pdf</a></p>

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28	Data collected	Requests clarification on whether the changes related to Mental Health Emergency Services will be implemented for Plan Year 2017 or 2018.	Plans and Benefits Template – Cost Share Variances tab	The changes related to Mental Health Emergency Services will be implemented for Plan Year 2018 or after.
29	Data collected	Recommends that additional options are added to the “Which Benefits Begin Cost-Sharing After a Set Number of Visits?” field and that the Mental Health and Substance Abuse benefits are broken into more detail if additional benefits for these services are added in 2018. Additionally, suggests that issuers have the ability to select multiple values for this field.	Plans and Benefits Template – Cost Share Variances tab	We are considering additional options for “Which Benefits Begin Cost-Sharing After a Set Number of Visits?” for Mental/Behavior Health Substance Abuse Disorder Outpatient Services. A discussion on these options is included in the Overview of Updates section of the 2017 AV Calculator Methodology at: <a href="https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-AVC-Methodology-012016.pdf">https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-AVC-Methodology-012016.pdf</a>
30	Data collected	Suggests adding minimum and maximum fields for employer’s HSA/HRA contributions.	Plans and Benefits Template – Cost Share Variances tab AV Calculator	The input in the Plans and Benefits Template to the employer’s HSA/HRA contribution is mapped to the AV Calculator and impacts the AV calculation. Therefore, the user can only have one number as there is only one AV for a plan.
31	Data collected	Recommends collecting data from issuers regarding compliance with the new 2016 Payment Parameters Final Rule requirements.	Prescription Drug Template	The Prescription Drug Template is intended to collect information on which drugs an issuer covers and at this time has not specifically been developed or designed as an oversight tool for the P&T Committee requirements established in the 2016 Payment Notice.
32	Data collected	Requests additional clarification and examples regarding CMS’ response to 60-day comments that the new data elements in the Prescription Drug Template are industry standards.	Prescription Drug Template	Quantity Limit refers to the maximum number of unit a drug (i.e., maximum number of tablets or capsules a prescription drug is covered) is allowed per dispensing. Fill Limit refers to the maximum number of dispensing a drug is allowed. Pharmacy restriction refers to when a prescription can only be filled at a particular pharmacy.

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33	Data collected	Recommends not limiting plan reviews and outlier analyses to the annual certification processes to maximize the detection of discriminatory plan benefit designs.	Prescription Drug Template	We will consider this for the future.
34	Data collected	Requests clarification on where information regarding mail order benefits will be collected for display on healthcare.gov.	Prescription Drug Template	The information collected to display on Healthcare.gov regarding mail order benefit is at the 3 Month In Network Mail Order Pharmacy Benefit Offered? field.
35	Data collected	Recommends continuing to include "Specialty" and "Medical" tiers in the drop down values for "Drug Tier Type."	Prescription Drug Template - Formulary tab	We will consider this for the future as we prioritize IT needs.
36	Data collected	Recommends that CMS continue to provide the same options for drug tier type that were allowed in previous years, including specialty drugs, zero cost share preventative drugs, and medical service drugs. These have been removed from the drug tier type drop down list.	Prescription Drug Template - Formulary tab	We will consider this for the future as we prioritize IT needs.
37	Data collected	Requests clarification on whether one line per formulary ID is expected in the Formulary tab.	Prescription Drug Template - Formulary tab	Currently, the Prescription Drug Template allows one line per formulary ID in the Formulary Tab of the template.
38	Data collected	Requests further definition of "Quantity Limits" and "Fill Limits," beyond the indication that these are standard pharmacy terms.	Prescription Drug Template - Drug Lists tab	Quantity Limit refers to the number of unit a drug (i.e., maximum number of tablets or capsules a prescription drug is covered) is allowed per dispensing. Fill limit refers to the maximum number of dispensing a drug is allowed.
39	Data collected	Requests that the Prior Authorization, Step Therapy, Quantity Limit, Fill Limit, Pharmacy Restriction, and Over-the-Counter Step Therapy Protocol fields are required for each RxCUI unless the Tier Level is N/A or the tier designated for	Prescription Drug Template - Drug Lists tab	The proposed limit fields are required at each RXCUI unless the tier level is N/A.

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		medical drugs.		
40	Out of scope	Many comments were out of scope and related to network adequacy, ECP, and EHB policy.	N/A	We have recently addressed network adequacy, ECP, and EHB policy in the 2017 Notice of Benefit and Payment Parameters Proposed Rule and 2017 Draft Letter to Issuers. We intend to also address these topics in the final Payment Notice and Letter to Issuers.