MAY 2014
CCIIO/SEG

2015 QUALIFIED HEALTH PLAN APPLICATION REVIEW TOOLS USER GUIDE: MASTER REVIEW TOOL

FOR ISSUERS

Loading and Analyzing the Data

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QHP APPLICATION REVIEW TOOLS USER GUIDES

Introduction

The 2015 Qualified Health Plan (QHP) Application Review Tools are a set of Excel-based evaluation services that states can use to evaluate QHP applications for compliance with Federal certification standards. The QHP Application Review Tools set is comprised of eight tools: (1) Master Review Tool; (2) Cost Sharing Tool; (3) Essential Community Provider (ECP) Tool; (4) Meaningful Difference Tool ; (5) Non-Discrimination Benefits Review Tool; (6) Category Class Drug Count Tool; (7) Non-Discrimination Formulary Outlier Tool; and (8) Non-Discrimination Formulary Clinical Appropriateness Tool. The ability of a state to use the automated portions of these tools is contingent upon the state's use of the Federally developed standard data collection templates for its QHP applications (e.g., plans and benefits templates).

The QHP Application Review Tools are offered as one methodology for states performing plan management activities, regardless of Marketplace model, to review each of the required standards. The table below lists the QHP certification standards, indicates which standards can be evaluated by using the tools, and includes a list of the sources needed to perform each proposed review.

QHP Certification Standard	Proposed Approach for Reviewing QHP Certification Standard	Master	Stand-Alone	Proposed Sources for Reviews
Accreditation	Ensure compliance with accreditation timeline. Collect and verify information on issuers' existing accreditation during issuer application period for use in determining if QHP meets accreditation requirement.	✓		• Issuer applications
Program Attestation	Accept issuer attestation of compliance with regulation (note that the Final Rule on the Establishment of Exchanges and Qualified Health Plans (Exchange Final Rule) (http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf) defers to existing state marketing laws) and conduct post-certification monitoring.	✓		• General issuer attestations
SHOP Participation	Confirm issuer compliance with Small Business Health Options Program (SHOP) participation provision; if non-compliant, confirm satisfactory justification has been provided.	✓		• SHOP participation provision (45 CFR 156.200(g)); provider SHOP participation justifications
Essential Health Benefits Standards	Confirm that the plan being reviewed complies with standards for the provision of essential health benefits (EHB) consistent with Federal rules. (States may use the EHB Checklist (https://servis.cms.gov/resources/document_detail?doc_detail_id=7b5c1b60-25e6-b0a9-b0df-53481439d8c7) to assist with this review.)	✓		• Plans and benefits templates or forms filing
Essential Community	Collect issuer data on ECPs included in each network. Verify whether the issuer's network meets the regulatory standard consistent with	✓	✓	• Service area templates; • ECP templates;

QHP Certification Standard	Proposed Approach for Reviewing QHP Certification Standard	Master	Stand-Alone	Proposed Sources for Reviews
Providers (ECP)	Federally-facilitated Marketplace (FFM) policies and a reasonable interpretation of the regulation.			• plans and benefits templates
Category Class Drug Count	Using the EHB Prescription Drug Crosswalk (https://servis.cms.gov/resources/document_detail?doc_detail_id=29fccde5-ae45-eb49-7296-538619f79e8a), count issuers' templates to verify if their drug lists meet the state's EHB benchmarks. The EHB Prescription Drug Crosswalk is embedded within the Category Class Drug Count Tool.	✓	✓	• Prescription drug templates; justification documents
Non-Discrimination Formulary Outliers	Identify plans with unusually large numbers of drugs subject to prior authorization and/or step therapy requirements in the following USP classes: insulin, antidiabetic agents, immunomodulators, immune suppressants, and anti-HIV agents	✓	✓	• Prescription drug templates-individual; • prescription drug templates-SHOP
Non-Discrimination Formulary Clinical Appropriateness	Analyze the availability, per plan, of drugs associated with four conditions: diabetes, rheumatoid arthritis, bipolar disorder, and schizophrenia. Ensure issuers are offering a sufficient number of drugs, as recommended by clinical guidelines, for effective treatment. Ensure issuers are not restricting access by lack of coverage or by inappropriate use of management techniques.	✓	✓	• Prescription drug templates-individual; • prescription drug templates-SHOP
Actuarial Value and Cost Sharing Reductions	Verify the QHP meets applicable actuarial value (AV) standards and cost-sharing reduction (CSR) requirements.	✓	✓	• Unified rate review templates; • plans and benefits templates
Meaningful Difference	Ensure QHP applications are "substantially different" from issuer's other applications so consumers can distinguish among the issuer's offerings.	✓	✓	• Plans and benefits templates
Discriminatory Benefit Design	Conduct plan-level analyses targeting areas where discrimination would most likely occur to ensure issuers do not employ benefit designs that discourage enrollment of individuals with significant health needs.	✓	✓	• Plans and benefits templates
Service Area	Verify that each service area meets geographic standards set forth in the Exchange Final Rule (http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf) and is nondiscriminatory (e.g., service areas of at least an entire county).	✓		• Service area templates
Network Adequacy	All issuers must attest to meeting network adequacy requirements as defined in 45 CFR 156.230. Additionally, all issuers must populate and submit the network adequacy template providing information about their in-network individual providers,			• Network adequacy section of QHP application

QHP Certification Standard	Proposed Approach for Reviewing QHP Certification Standard	Master	Stand-Alone	Proposed Sources for Reviews
	facilities and pharmacy for all their plans.			
Licensure and Solvency	Verify licensure and good standing with state Department of Insurance (DOI) or collect documentation from issuer.			

Using this Guide

The following characteristics are intended to focus the user to where actions are warranted:

- Items that appear in *italics* are features. (e.g., *Summary Review* tab)
- Items that are in **bold** type are functions. (e.g., **Click "Save." Click "Import Data from Master Review Tool."**)
- For space considerations, screenshots of Excel worksheets may not include the full data picture.

QHP Application Review Tools Overview

The tools listed and described in the table below offer one methodology for reviewing the required standards. You may use any, all, none, or only portions of the review tools. If using any of the stand-alone tools described above, it is recommended that you review the validation steps located within the Master Review Tool to better understand the logic behind the tool and see where justifications may be submitted.

Each tool contains detailed instructions on how to operate it, and which issuer templates are used as data input. For the tools to run, it is imperative that the user not change the worksheet names, format, and overall structure (e.g., adding or deleting rows or column, changing field names, copying or deleting worksheets), as this could impact the functioning of the tool macros. However, filters have been added to the table headings in many of the stand-alone tools and these may be used without disrupting tool use.

These tools can be run for the following plan types: plans offered on the Marketplace, plans offered off the Marketplace, or for all submitted standard plans, both on and off the Marketplace. All of these review standards apply to plans that are on the Marketplace, but not all of them apply to plans that are off the Marketplace. The Master Review Tool will gray-out reviews when they are not applicable on the *Review Summary* tab, and the off-Marketplace plans will not be listed on the review tabs of the standards which are not applicable.

Tool	Function
Master Review Tool	• Aggregates data from the plans and benefits, service area, and ECP templates and serves as a data input file to the stand-alone tools (described below). • Serves as a guide to performing the reviews for several certification standards. • Contains proposed step-by-step review processes for each standard.

Tool	Function
	• Includes additional direction when a stand-alone tool may help with a particular review.
Essential Community Providers (ECP) Tool	• Calculates the total ECPs an issuer has in each plan's network. • Compares the total ECP number to the ECPs available in that service area. • Confirms if the percent of ECPs covered meets a given threshold.
Meaningful Difference Tool	• Performs the "Supporting Informed Consumer Choice" review as discussed in regulation and the 2015 Letter to Issuers (http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf). • Compares all plans an issuer offers to identify multiple, essentially identical plans that are offered in the same counties.
Non-Discrimination Benefit Review Tool	• Cross-checks all state plans against predetermined benefits. • Note: This tool requires data from all issuers in a state, and will not yield meaningful results if run by a single issuer.
Cost Sharing Tool	• Conducts three cost-sharing standards analyses (when applicable to the specific plan): • Out-of-pocket maximum (OOPM) review. • Cost-sharing reduction (CSR) review. • Catastrophic plan review.
Category Class Drug Count Tool	• Compares the count of unique, chemically distinct drugs in each USPv5 category and class for each drug list with the benchmark.
Non-Discrimination Formulary Outlier Tool	• Identifies and flags as outliers those plans that have unusually large numbers of drugs subject to prior authorization and/or step therapy requirements in the following USP classes: – Antivirals/anti-HIV agents, non-nucleoside reverse transcriptase inhibitors. – Antivirals/anti-HIV agents, nucleoside and nucleotide reverse transcriptase inhibitors. – Antivirals/anti-HIV agents, protease inhibitors. – Antivirals/anti-HIV agents, other. – Blood glucose regulators/antidiabetic agents. – Blood glucose regulators/insulins. – Immunological agents/immunomodulators. – Immunological agents/immune suppressants. • Note: This tool requires data from all issuers in a state, and will not yield meaningful results if run by a single issuer.
Non-Discrimination Clinical Appropriateness Tool	• Analyzes the availability of drugs associated with four conditions: – Diabetes. – Rheumatoid arthritis. – Bipolar disorder. – Schizophrenia. • Ensures issuers are offering a sufficient number of drugs, as recommended in clinical guidelines, needed to effectively treat these

Tool	Function
	conditions.
Data Integrity Tool (DIT)	• Provides a method for issuers to check that the data contained in their templates is in the correct format. • Provides issuers with feedback immediately and should reduce resubmissions. • Serves as a companion to the review tools for states. • The DIT is a separate tool that is not encompassed by the User Guides.

DOWNLOADING AND SAVING THE QHP APPLICATION REVIEW TOOLS

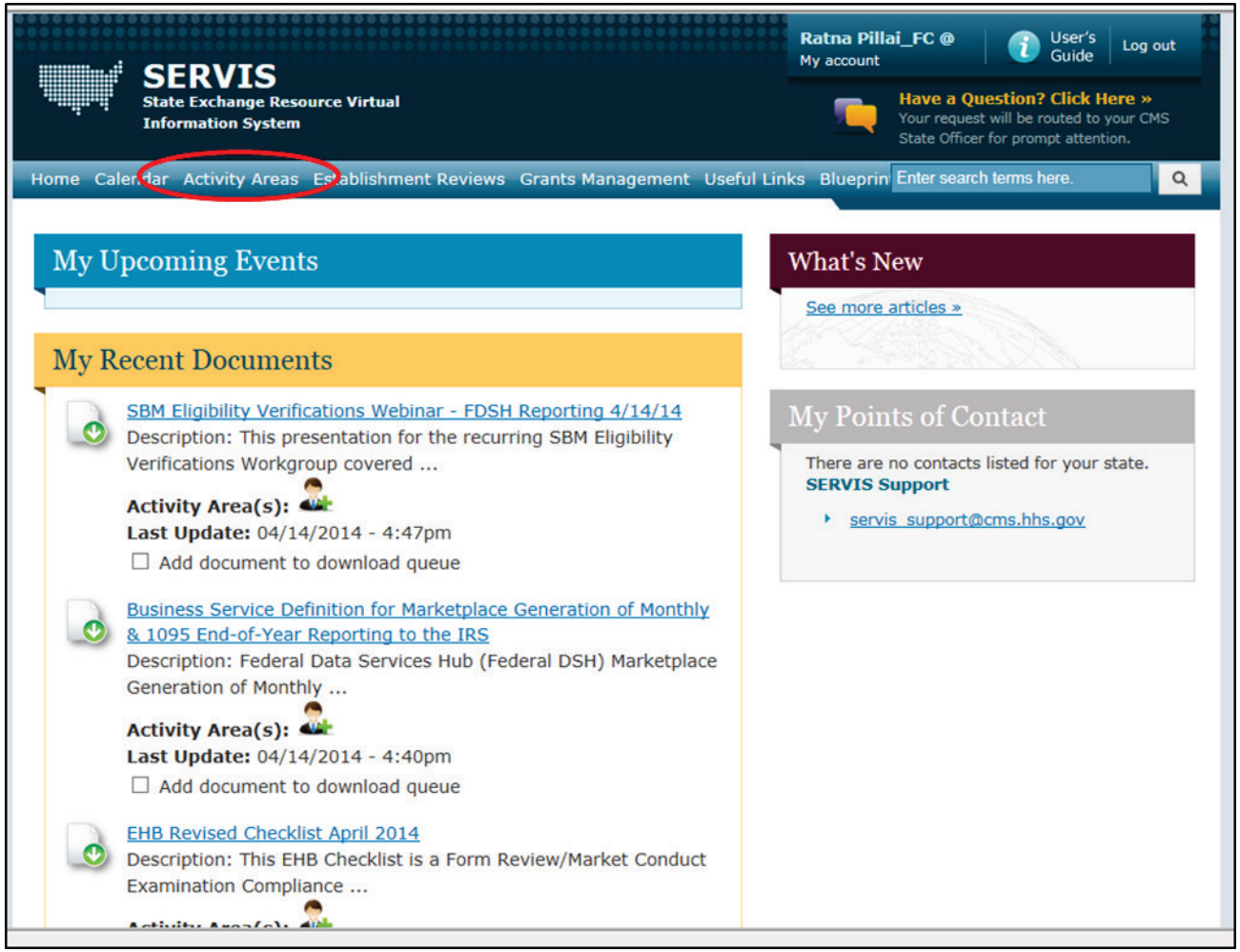
Note: Accessing the 2015 QHP Application Review Tools from SERVIS requires a CALT username and password. If you need a CALT username or need to reset your CALT password to access SERVIS, send an email request to the CALT support team (cms_support@cms.hhs.gov). For a password reset, include your CALT username in your email, and request to have your CALT password reset and your SERVIS account unlocked. For general questions about SERVIS, contact the SERVIS help desk (cms_feps@cms.hhs.gov).

Note: The 2015 QHP Application Review Tools and User Guides are also available for state regulators within the state regulator section of SERFF. To access them, log into your SERFF account and navigate to the "Online Help" section."

Using the SERVIS Homepage to Access and Download the Tools

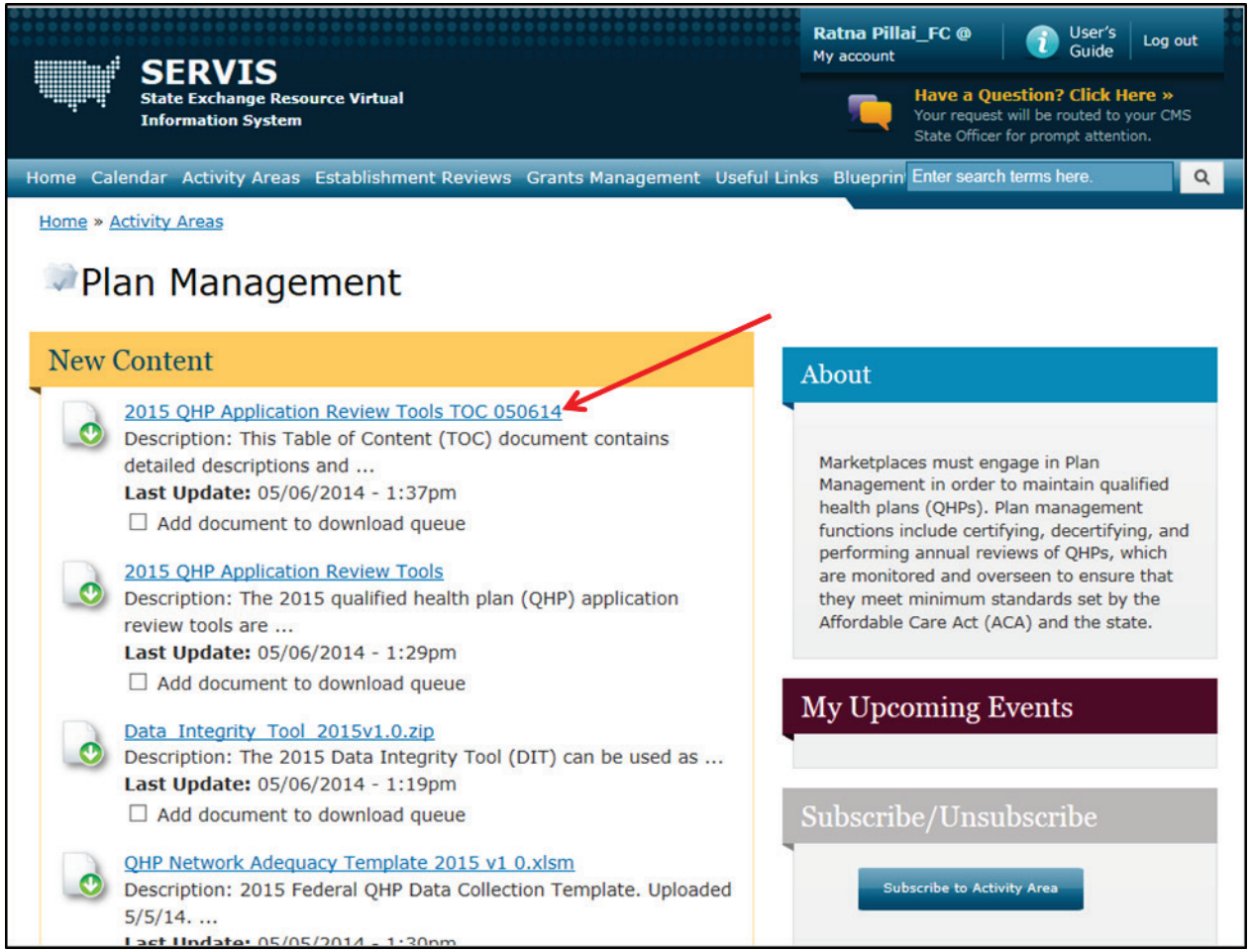
1. **Open** your web browser, navigate to the SERVIS portal (https://servis.cms.gov/resources). **Log in** using your CALT username and password.

2. After the SERVIS homepage opens, **locate** *Activity Areas* in the top toolbars.

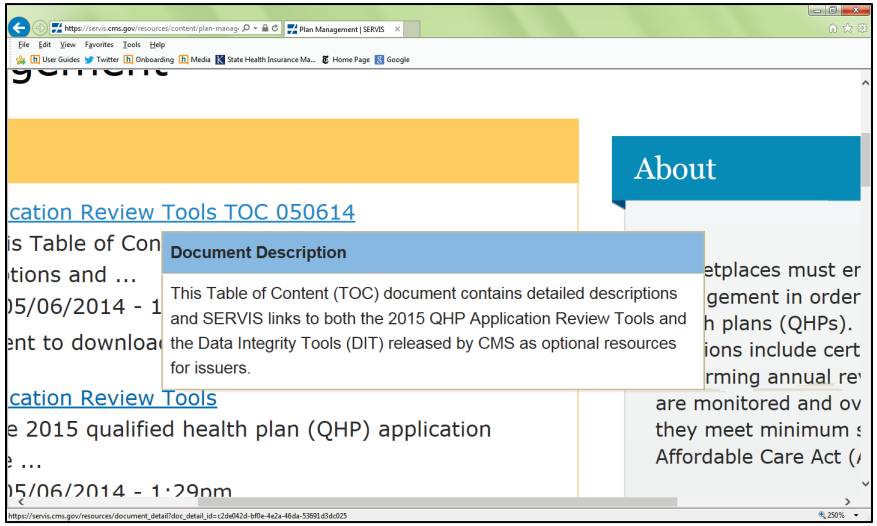


3. **Click** *Activity Areas* to see the drop down for linking pages. Click *Plan Management.*

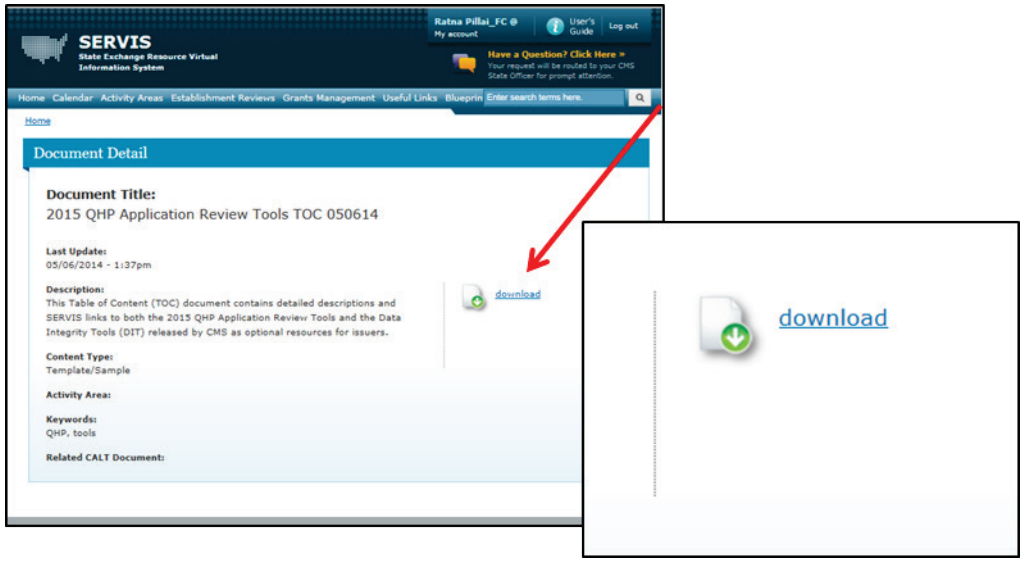
4. **Click** the *2015 QHP Application Review Tools TOC 050614* link.



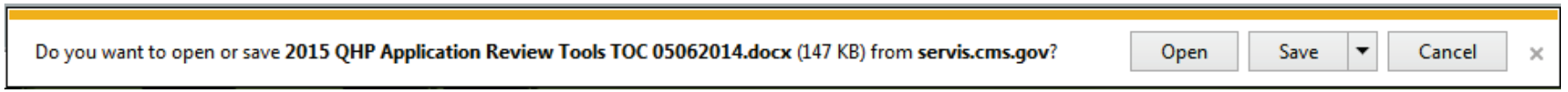
Note: Hovering the cursor over the link will activate the pop-up descriptor.



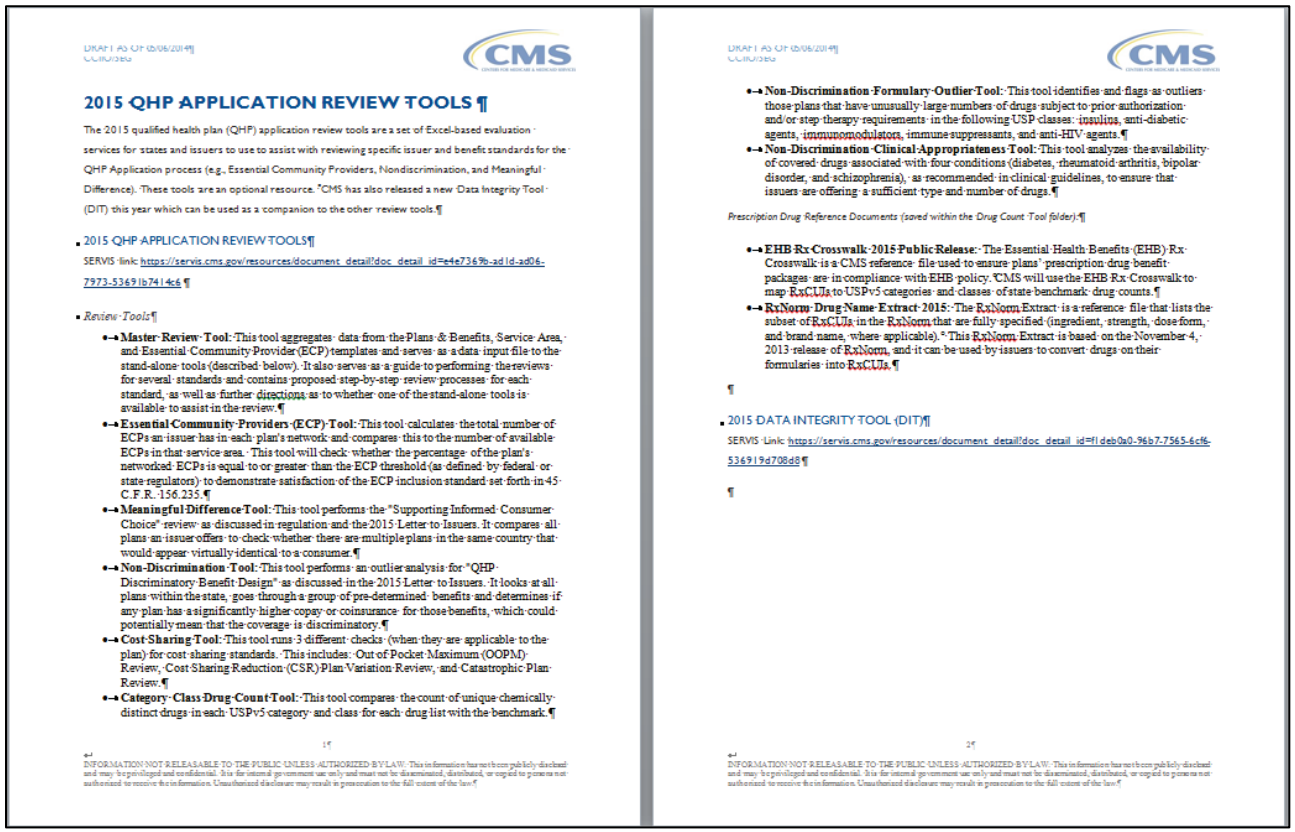
5. SERVIS will open up the *Document Detail* page for the 2015 QHP Application Review Tools. **Click** *download* on the right side of the page.



6. **Click** either "Open" or "Save" to open the 2015 QHP Application Review Tool TOC.



7. The overview of the 2015 QHP Application Tools will open. This document provides an overview of the review tools, information on the individual tools, and links to tools and the Data Integrity Tool.



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2015 QHP APPLICATION REVIEW TOOLS

The 2015 qualified health plan (QHP) application review tools are a set of Excel-based evaluation services for states and issuers to use to assist with reviewing specific issuer and benefit standards for the QHP Application process (e.g., Essential Community Providers, Nondiscrimination, and Meaningful Difference). These tools are an optional resource. CMS has also released a new Data Integrity Tool (DIT) this year which can be used as a companion to the other review tools.

- 2015 QHP APPLICATION REVIEW TOOLS

SERVIS link: https://servis.cms.gov/resources/document_detail?doc_detail_id=e4e7369b-ad1d-ad06-7973-53691b741c4c

- *Review Tools*
  - **Master Review Tool:** This tool aggregates data from the Plans & Benefits, Service Area, and Essential Community Provider (ECP) templates and serves as a data input file to the stand-alone tools (described below). It also serves as a guide to performing the reviews for several standards and contains proposed step-by-step review processes for each standard, as well as further directions as to whether one of the stand-alone tools is available to assist in the review.
  - **Essential Community Providers (ECP) Tool:** This tool calculates the total number of ECPs an issuer has in each plan's network and compares this to the number of available ECPs in that service area. This tool will check whether the percentage of the plan's networked ECPs is equal to or greater than the ECP threshold (as defined by federal or state regulators) to demonstrate satisfaction of the ECP inclusion standard set forth in 45 C.F.R. 156.235.
  - **Meaningful Difference Tool:** This tool performs the "Supporting Informed Consumer Choice" review as discussed in regulation and the 2015 Letter to Issuers. It compares all plans an issuer offers to check whether there are multiple plans in the same country that would appear virtually identical to a consumer.
  - **Non-Discrimination Tool:** This tool performs an outlier analysis for "QHP Discriminatory Benefit Design" as discussed in the 2015 Letter to Issuers. It looks at all plans within the state, goes through a group of pre-determined benefits and determines if any plan has a significantly higher copay or coinsurance for those benefits, which could potentially mean that the coverage is discriminatory.
  - **Cost Sharing Tool:** This tool runs 3 different checks (when they are applicable to the plan) for cost sharing standards. This includes: Out of Pocket Maximum (OOPM) Review, Cost Sharing Reduction (CSR) Plan Variation Review, and Catastrophic Plan Review.
  - **Category Class Drug Count Tool:** This tool compares the count of unique chemically distinct drugs in each USPv5 category and class for each drug list with the benchmark.

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- **Non-Discrimination Formulary Outlier Tool:** This tool identifies and flags as outliers those plans that have unusually large numbers of drugs subject to prior authorization and/or step therapy requirements in the following USP classes: insulins, anti-diabetic agents, immunomodulators, immune suppressants, and anti-HIV agents.
- **Non-Discrimination Clinical Appropriateness Tool:** This tool analyzes the availability of covered drugs associated with four conditions (diabetes, rheumatoid arthritis, bipolar disorder, and schizophrenia), as recommended in clinical guidelines, to ensure that issuers are offering a sufficient type and number of drugs.

Prescription Drug Reference Documents (saved within the Drug Count Tool folder):

- **EHB Rx Crosswalk 2015 Public Release:** The Essential Health Benefits (EHB) Rx Crosswalk is a CMS reference file used to ensure plans' prescription drug benefit packages are in compliance with EHB policy. CMS will use the EHB Rx Crosswalk to map RxCUIs to USPv5 categories and classes of state benchmark drug counts.
- **RxNorm Drug Name Extract 2015:** The RxNorm Extract is a reference file that lists the subset of RxCUIs in the RxNorm that are fully specified (ingredient, strength, dose form, and brand name, where applicable).[5] This RxNorm Extract is based on the November 4, 2013 release of RxNorm, and it can be used by issuers to convert drugs on their formularies into RxCUIs.

- 2015 DATA INTEGRITY TOOL (DIT)

SERVIS Link: https://servis.cms.gov/resources/document_detail?doc_detail_id=f1deb0a0-96b7-7565-6cf6-536919d708d8

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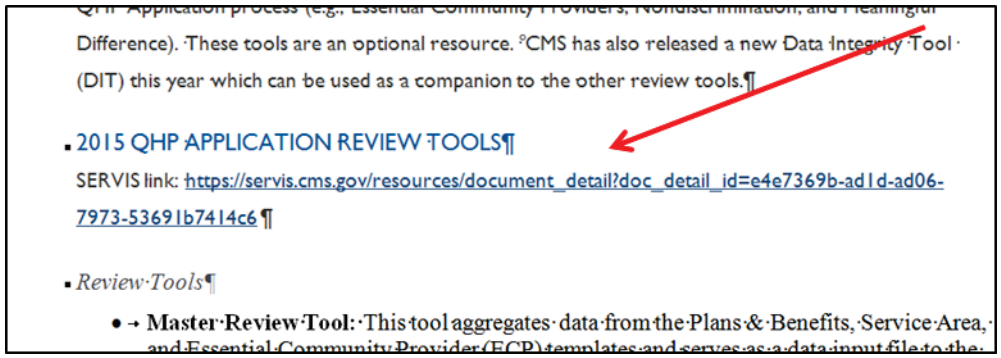
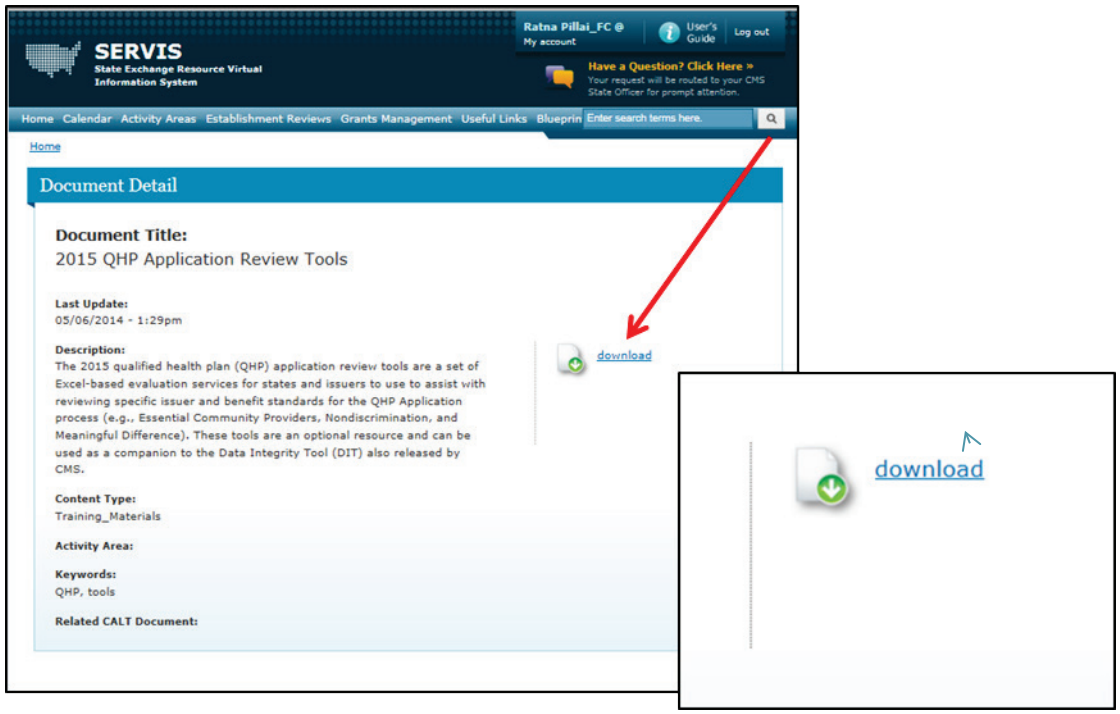
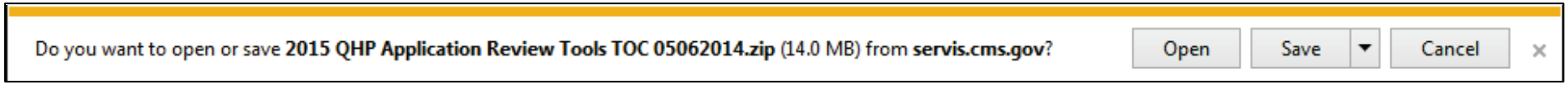
8. **CTRL+Click** the SERVIS link under 2015 QHP APPLICATION REVIEW TOOLS near the top of the page.



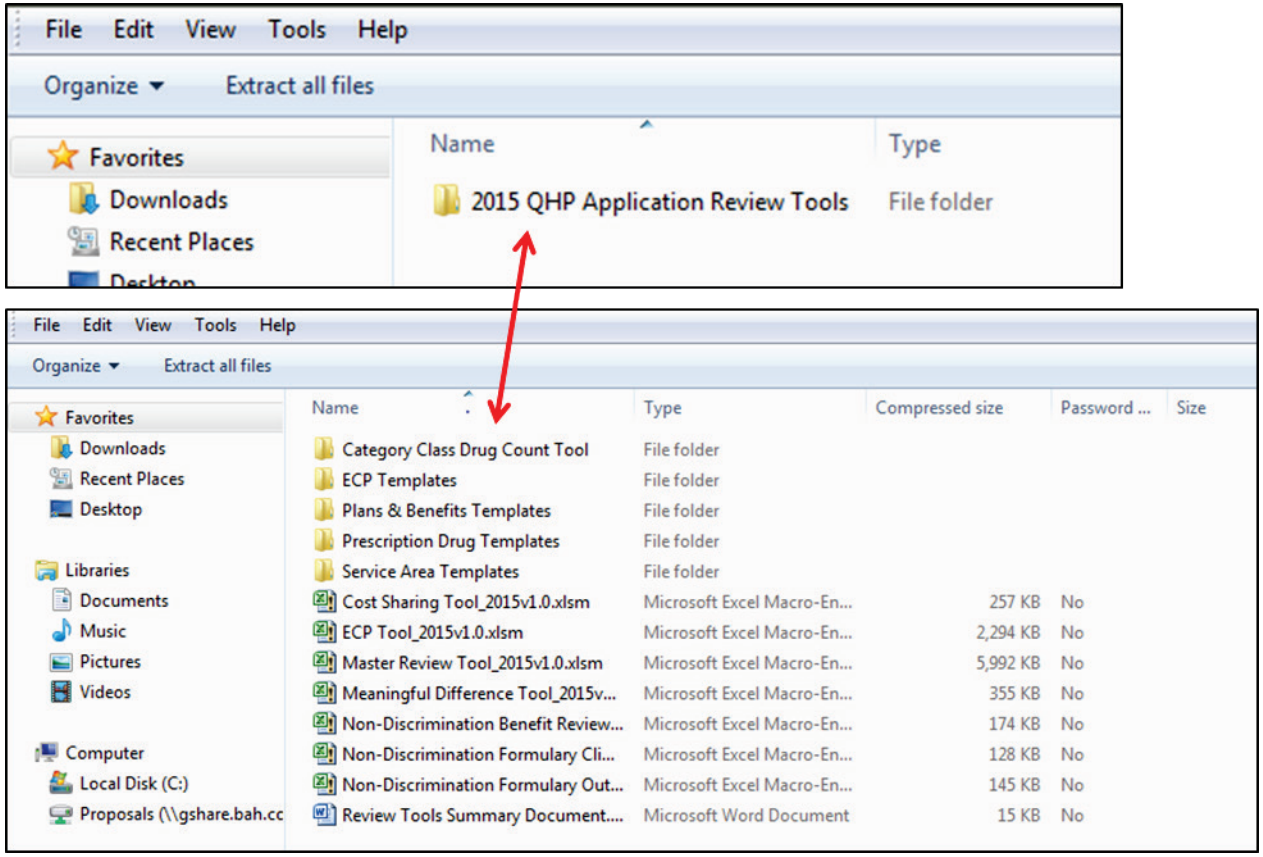
9. A SERVIS page, similar to the previous page opened, will appear. **Click** *download* again on the right side of the page.



10. **Click** either "Open" or "Save."



11. A compressed file will appear. If you have not saved this file on your computer, **save** it now to a location you can easily access. **Double click** on the compressed file to view all the tools and necessary accompanying folders necessary to operate them.



MASTER REVIEW TOOL AND DATA IMPORT

Use the Master Review Tool to evaluate all issuers' plan offerings submitted for QHP certification. The Master Review Tool pulls data from all issuers' plans and benefits templates, service area templates, and ECP templates and uses that data for further plan reviews (e.g., the benefit cost sharing review).

The Master Review Tool's overview summarizes the functionalities of the tools used collaboratively or independently of the Master Review Tool review summary and provides details on their use and limitations.

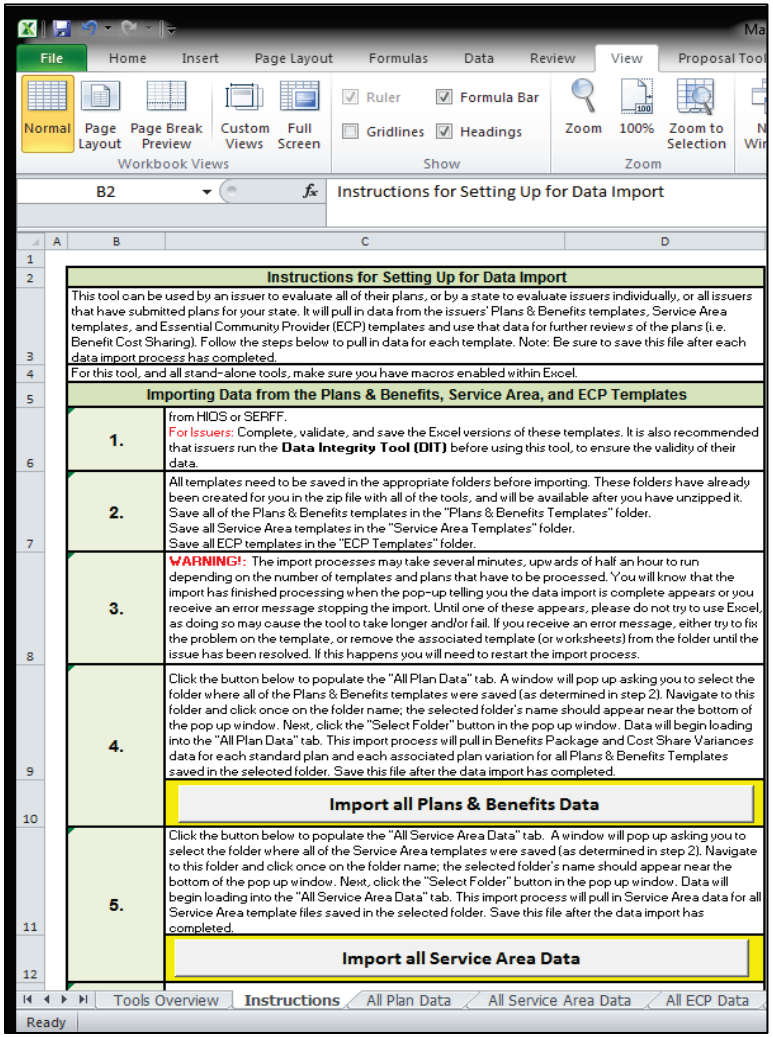
Master Review Tool Worksheets (Tabs)

There are a number of tabs in this workbook (as shown below); the table below lists each tab and explains the worksheet functions.

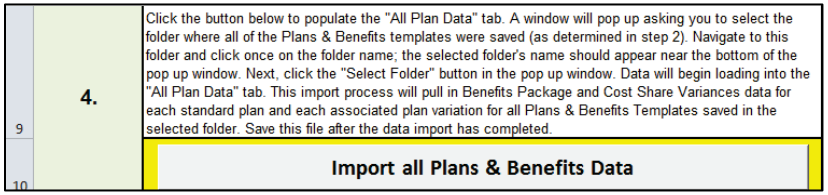
Worksheet (Tab)	Use/Explanation
All Plan Data	• Populated by the "Import all Plans and Benefits Data." • Contains one line for each standard plan and each associated plan variation and has columns detailing: – Basic plan data. – Maximum out-of-pocket maximum and deductible values. – Cost sharing for each of the benefits. • Populates the review summary and standard review tab headers. • Serves as an input to many of the stand-alone tools.
All Service Area Data	• Populated by the "Import all Service Area Data." • Contains issuer ID and same headers as the service area template. • Used for reference and input to perform the ECP and meaningful difference reviews using the stand-alone tools.
All ECP Data	• Populated by the "Import all ECP Data" button. • Contains column for the issuer ID and same headers as the ECP template. • Used for reference and an input to perform the ECP review using the stand-alone tool.
Review Summary	• Tracks whether each plan has met each of the standards. – Contains formulas that allow the "Met" or "Not Met" values to populate based on the results inputted to each of the standard review tabs. – Allows "Met" or "Not Met" compliance to be overwritten at reviewer's discretion.
Standard Review Tabs: Accreditation, Program Attestation, SHOP Participation, ECP, Category Class Drug Count, Formulary Outlier,	• Step-by-step validation steps for reviewing specific standards. – Stand-alone tools, where applicable, may be used for these analyses. – Allows "Met" or "Not Met" compliance to be entered at reviewer's discretion.

Worksheet (Tab)	Use/Explanation
Clinical Appropriateness, Benefit Cost Sharing, Meaningful Difference, Non-Discrimination Benefit, Actuarial Value (AV), Service Area	• Indicates level of review within each worksheet. – Reviewer changes auto-populate to the "Review Summary."
Tukey Outlier Overview	• Used to conduct the non-discrimination cost-sharing outlier review (see *Non-Discrimination Benefit* tab for more information) and the formulary outlier review (see *Formulary Outlier* tab for more information). • Includes more detail on methodology supplied within tab.
Maximum Out-of-Pocket (MOOP) Details	• Used as source for standards validation of benefit cost sharing. • Provides MOOP details for medical and drug EHB.
Non-Discrimination Guidance	• Clarifies non-discrimination standards. • Provides examples of benefit design that are potentially discriminatory under the Affordable Care Act (ACA).

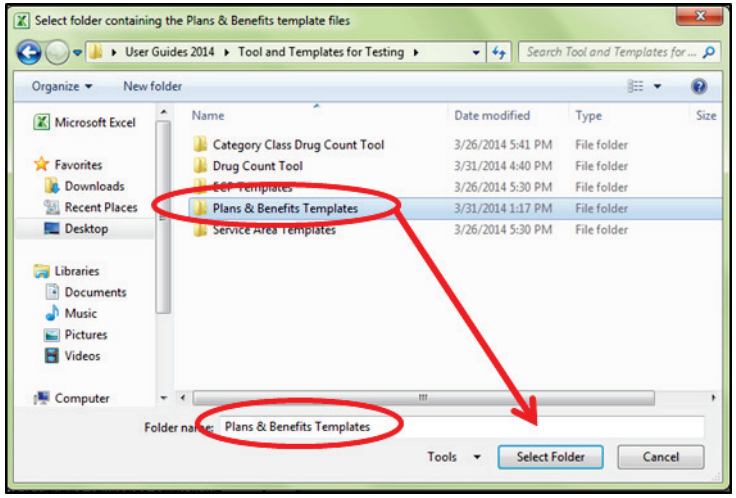
IMPORTING DATA FROM TEMPLATES



1. For issuers: **Complete, validate, and save** the Excel versions of templates. It is also recommended that issuers run the Data Integrity Tool (DIT) before using this tool, to ensure the validity of their data.
2. The first step in the Master Review Tool is to **import** data from issuers' plans and benefits, service area, and ECP templates. Most of the stand-alone tools, except for the drug tools, will then import data from this data in the Master Review Tool.
3. **Save** all templates in the appropriate folders before importing. These folders have already been created for you in the ZIP file with all of the tools, and will be available after you have unzipped it.
   a. **Save** all of the plans and benefits templates in the *Plans and Benefits Templates* folder.
   b. **Save** all service area templates in the *Service Area Templates* folder.
   c. **Save** all ECP templates in the *ECP Templates* folder.
4. Note the WARNING in the Master Review Tool instructions: the data import may take up several minutes, upwards of half an hour depending on the number of templates and plans to process.
5. **Click Import all Plan Data** in row 10.

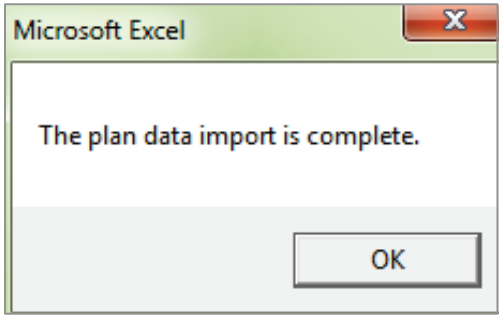


6. At the pop-up window, navigate to the folder where you saved all the plans and benefits templates (created in step 3).
   a. **Click** on the folder name once to highlight it; the folder name will appear in the folder name: field.
   b. **Click** Select Folder in the pop-up window.

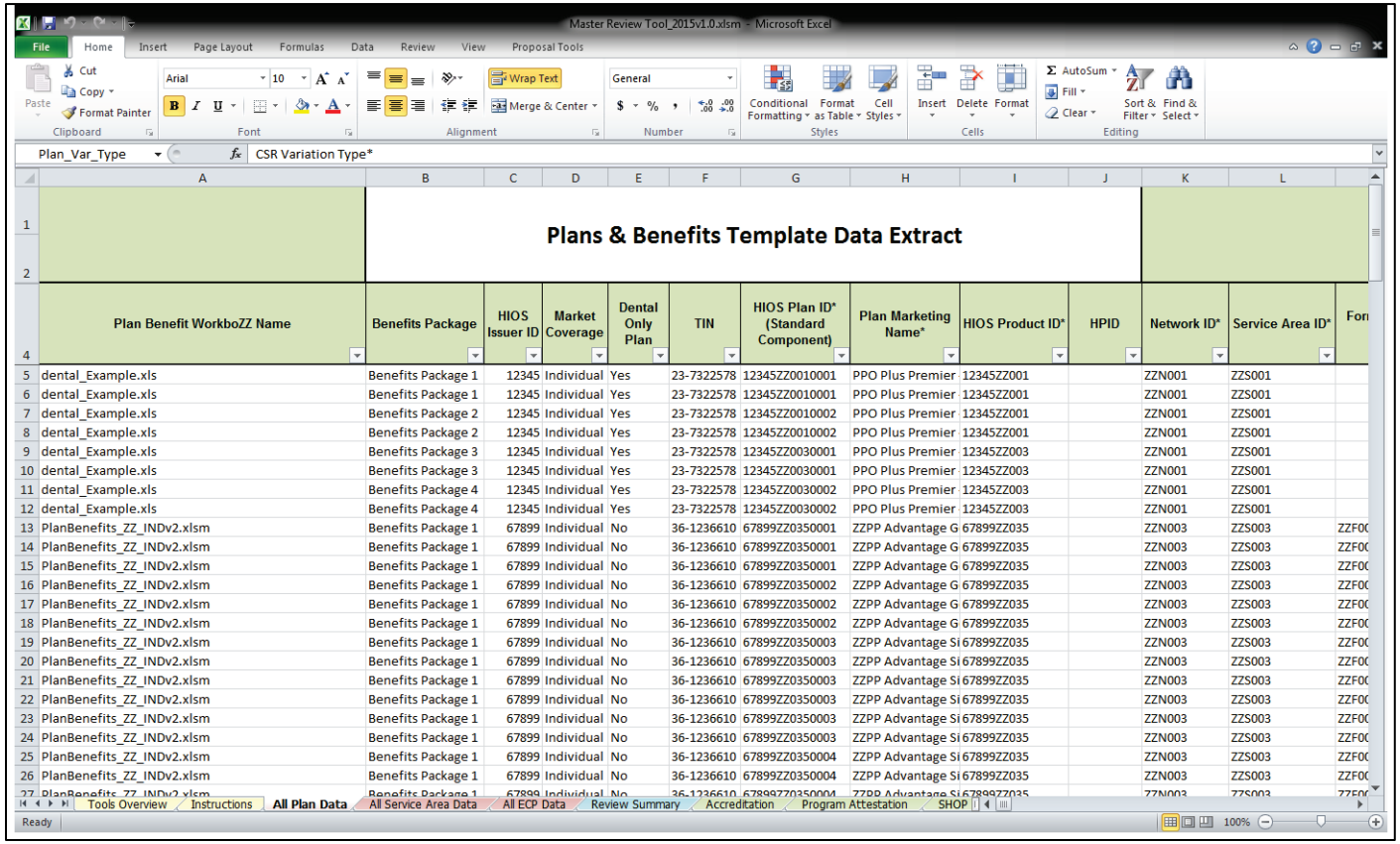


c. Data will begin loading into the *All Plan Data* tab, pulling in benefits package and cost share variances data (on a per plan variation level) from all plans and benefits templates in the plans and benefits folder.

d. **Click "OK"** when "The plan data import is complete" pops up.



7. **Click** the *All Plan Data* tab to see the populated worksheet.



Master Review Tool_2015v1.0.xlsm - Microsoft Excel

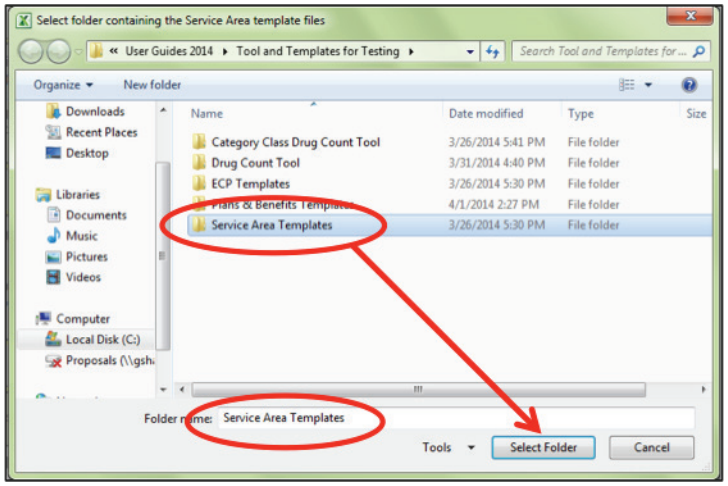
Plans & Benefits Template Data Extract

	Plan Benefit WorkboZZ Name	Benefits Package	HIOS Issuer ID	Market Coverage	Dental Only Plan	TIN	HIOS Plan ID* (Standard Component)	Plan Marketing Name*	HIOS Product ID*	HPID	Network ID*	Service Area ID*	For
5	dental_Example.xls	Benefits Package 1	12345	Individual	Yes	23-7322578	12345ZZ0010001	PPO Plus Premier	12345ZZ001		ZZN001	ZZS001	
6	dental_Example.xls	Benefits Package 1	12345	Individual	Yes	23-7322578	12345ZZ0010001	PPO Plus Premier	12345ZZ001		ZZN001	ZZS001	
7	dental_Example.xls	Benefits Package 2	12345	Individual	Yes	23-7322578	12345ZZ0010002	PPO Plus Premier	12345ZZ001		ZZN001	ZZS001	
8	dental_Example.xls	Benefits Package 2	12345	Individual	Yes	23-7322578	12345ZZ0010002	PPO Plus Premier	12345ZZ001		ZZN001	ZZS001	
9	dental_Example.xls	Benefits Package 3	12345	Individual	Yes	23-7322578	12345ZZ0030001	PPO Plus Premier	12345ZZ003		ZZN001	ZZS001	
10	dental_Example.xls	Benefits Package 3	12345	Individual	Yes	23-7322578	12345ZZ0030001	PPO Plus Premier	12345ZZ003		ZZN001	ZZS001	
11	dental_Example.xls	Benefits Package 4	12345	Individual	Yes	23-7322578	12345ZZ0030002	PPO Plus Premier	12345ZZ003		ZZN001	ZZS001	
12	dental_Example.xls	Benefits Package 4	12345	Individual	Yes	23-7322578	12345ZZ0030002	PPO Plus Premier	12345ZZ003		ZZN001	ZZS001	
13	PlanBenefits_ZZ_INDv2.xlsm	Benefits Package 1	67899	Individual	No	36-1236610	67899ZZ0350001	ZZPP Advantage G	67899ZZ035		ZZN003	ZZS003	ZZF0
14	PlanBenefits_ZZ_INDv2.xlsm	Benefits Package 1	67899	Individual	No	36-1236610	67899ZZ0350001	ZZPP Advantage G	67899ZZ035		ZZN003	ZZS003	ZZF0
15	PlanBenefits_ZZ_INDv2.xlsm	Benefits Package 1	67899	Individual	No	36-1236610	67899ZZ0350001	ZZPP Advantage G	67899ZZ035		ZZN003	ZZS003	ZZF0
16	PlanBenefits_ZZ_INDv2.xlsm	Benefits Package 1	67899	Individual	No	36-1236610	67899ZZ0350002	ZZPP Advantage G	67899ZZ035		ZZN003	ZZS003	ZZF0
17	PlanBenefits_ZZ_INDv2.xlsm	Benefits Package 1	67899	Individual	No	36-1236610	67899ZZ0350002	ZZPP Advantage G	67899ZZ035		ZZN003	ZZS003	ZZF0
18	PlanBenefits_ZZ_INDv2.xlsm	Benefits Package 1	67899	Individual	No	36-1236610	67899ZZ0350002	ZZPP Advantage G	67899ZZ035		ZZN003	ZZS003	ZZF0
19	PlanBenefits_ZZ_INDv2.xlsm	Benefits Package 1	67899	Individual	No	36-1236610	67899ZZ0350003	ZZPP Advantage Si	67899ZZ035		ZZN003	ZZS003	ZZF0
20	PlanBenefits_ZZ_INDv2.xlsm	Benefits Package 1	67899	Individual	No	36-1236610	67899ZZ0350003	ZZPP Advantage Si	67899ZZ035		ZZN003	ZZS003	ZZF0
21	PlanBenefits_ZZ_INDv2.xlsm	Benefits Package 1	67899	Individual	No	36-1236610	67899ZZ0350003	ZZPP Advantage Si	67899ZZ035		ZZN003	ZZS003	ZZF0
22	PlanBenefits_ZZ_INDv2.xlsm	Benefits Package 1	67899	Individual	No	36-1236610	67899ZZ0350003	ZZPP Advantage Si	67899ZZ035		ZZN003	ZZS003	ZZF0
23	PlanBenefits_ZZ_INDv2.xlsm	Benefits Package 1	67899	Individual	No	36-1236610	67899ZZ0350003	ZZPP Advantage Si	67899ZZ035		ZZN003	ZZS003	ZZF0
24	PlanBenefits_ZZ_INDv2.xlsm	Benefits Package 1	67899	Individual	No	36-1236610	67899ZZ0350003	ZZPP Advantage Si	67899ZZ035		ZZN003	ZZS003	ZZF0
25	PlanBenefits_ZZ_INDv2.xlsm	Benefits Package 1	67899	Individual	No	36-1236610	67899ZZ0350004	ZZPP Advantage Si	67899ZZ035		ZZN003	ZZS003	ZZF0
26	PlanBenefits_ZZ_INDv2.xlsm	Benefits Package 1	67899	Individual	No	36-1236610	67899ZZ0350004	ZZPP Advantage Si	67899ZZ035		ZZN003	ZZS003	ZZF0

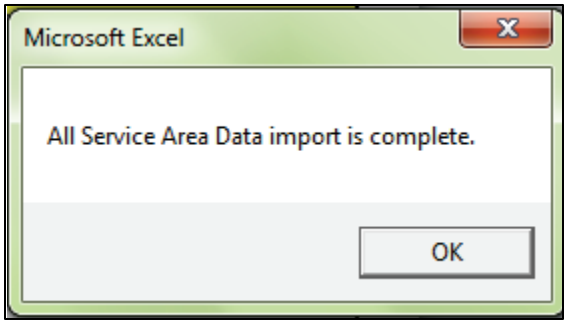
Tools Overview | Instructions | All Plan Data | All Service Area Data | All ECP Data | Review Summary | Accreditation | Program Attestation | SHOP

8. **Save** the Master Review Tool workbook after the data import has completed.
9. **Click Import all Service Area Data** in row 12.

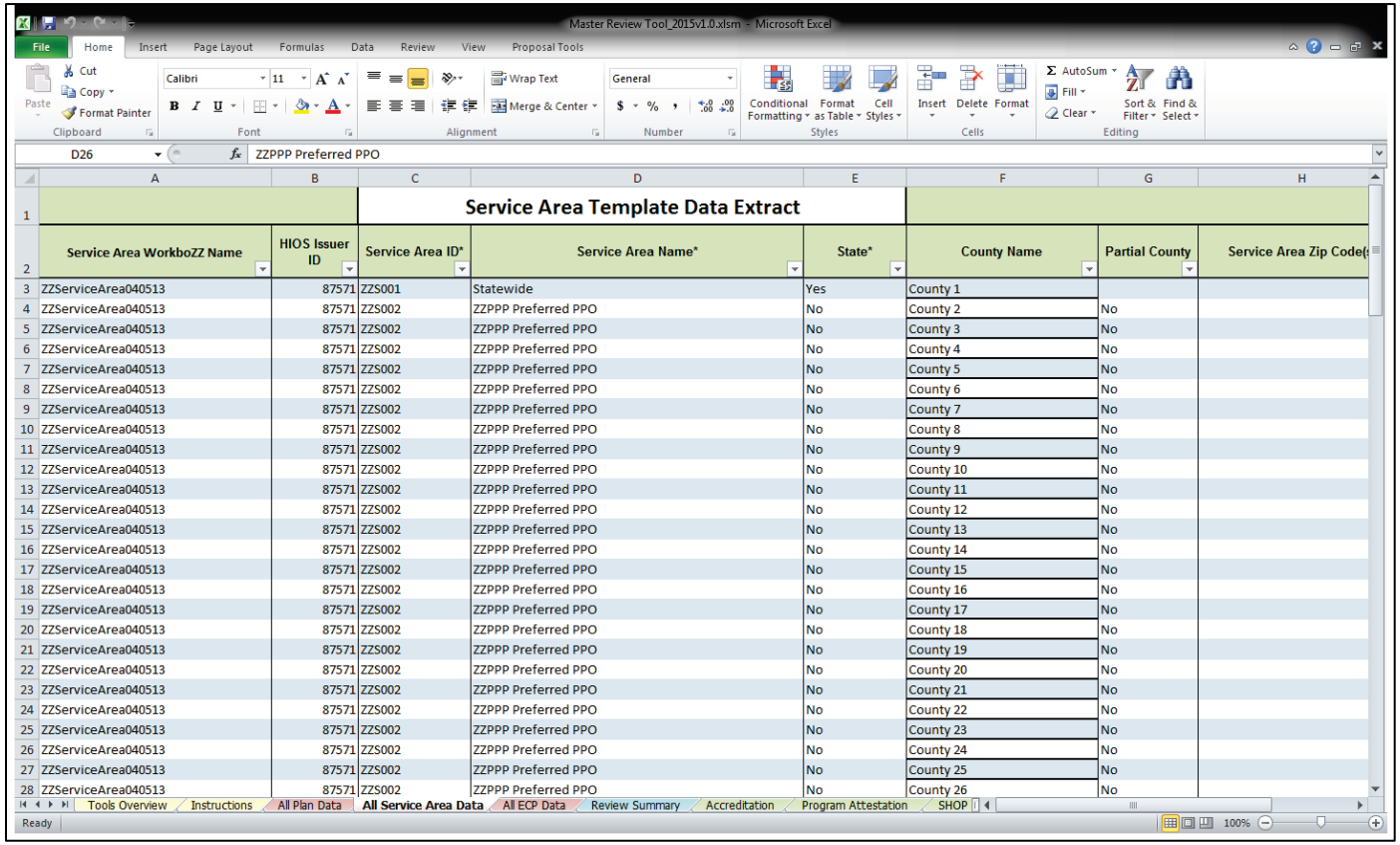
10. At the pop-up window, navigate to the folder where you saved all the service area templates (created in step 3).
    a. **Click** on the folder name once to highlight it; the folder name will appear in the *Folder name*: field.
    b. **Click** Select Folder in the pop-up window; data will begin loading into the *All Service Area Data* tab.



    c. **Click "OK"** when "All Service Area Data import is complete" pops up.

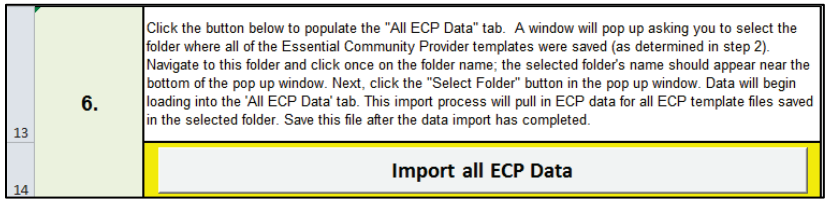


11. **Click** the *All Service Area Data* tab to see the populated worksheet.

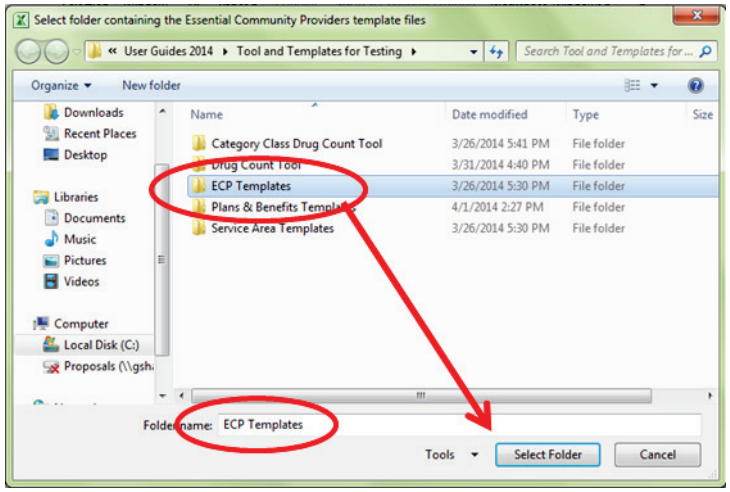


	Service Area WorkboZZ Name	HIOS Issuer ID	Service Area ID*	Service Area Name*	State*	County Name	Partial County	Service Area Zip Code
3	ZZServiceArea040513	87571	ZZS001	Statewide	Yes	County 1		
4	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 2	No	
5	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 3	No	
6	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 4	No	
7	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 5	No	
8	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 6	No	
9	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 7	No	
10	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 8	No	
11	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 9	No	
12	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 10	No	
13	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 11	No	
14	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 12	No	
15	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 13	No	
16	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 14	No	
17	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 15	No	
18	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 16	No	
19	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 17	No	
20	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 18	No	
21	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 19	No	
22	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 20	No	
23	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 21	No	
24	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 22	No	
25	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 23	No	
26	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 24	No	
27	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 25	No	
28	ZZServiceArea040513	87571	ZZS002	ZZPPP Preferred PPO	No	County 26	No	

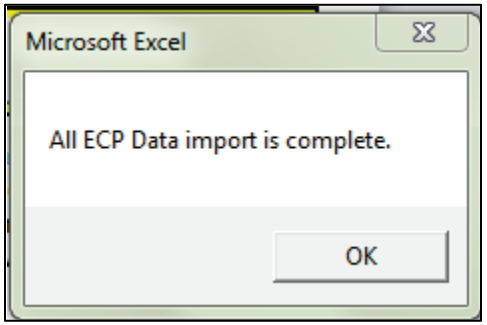
12. **Save** the Master Review Tool workbook again after the data import is complete.
13. Click "Import all ECP Data" in row 14.



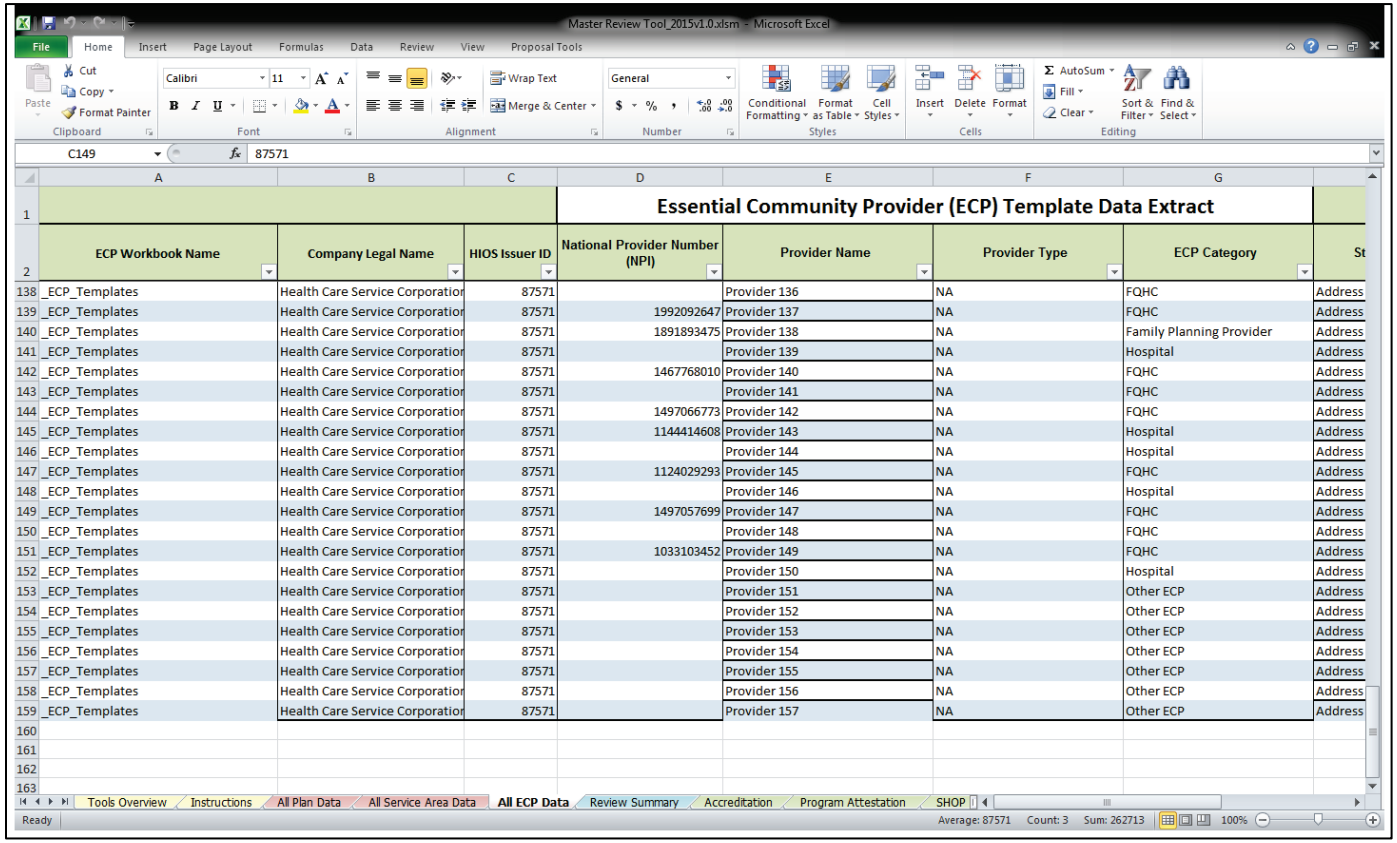
14. At the pop-up window, **navigate** to the folder where you saved all the ECP templates (created in step 3).
    a. **Click** once on the folder name. (The folder name should appear near the bottom of the pop-up window.)
    b. **Click Select Folder** in the pop-up window; data will begin loading into the *All ECP Data* tab.



15. When "All ECP Data import is complete" pops up, **click "OK."**



16. **Click** the *All ECP Data* tab to see the populated worksheet.



Master Review Tool_2015v1.0.xlsm - Microsoft Excel

Essential Community Provider (ECP) Template Data Extract

	ECP Workbook Name	Company Legal Name	HIOS Issuer ID	National Provider Number (NPI)	Provider Name	Provider Type	ECP Category	St
138	_ECP_Templates	Health Care Service Corporation	87571		Provider 136	NA	FQHC	Address
139	_ECP_Templates	Health Care Service Corporation	87571	1992092647	Provider 137	NA	FQHC	Address
140	_ECP_Templates	Health Care Service Corporation	87571	1891893475	Provider 138	NA	Family Planning Provider	Address
141	_ECP_Templates	Health Care Service Corporation	87571		Provider 139	NA	Hospital	Address
142	_ECP_Templates	Health Care Service Corporation	87571	1467768010	Provider 140	NA	FQHC	Address
143	_ECP_Templates	Health Care Service Corporation	87571		Provider 141	NA	FQHC	Address
144	_ECP_Templates	Health Care Service Corporation	87571	1497066773	Provider 142	NA	FQHC	Address
145	_ECP_Templates	Health Care Service Corporation	87571	1144414608	Provider 143	NA	Hospital	Address
146	_ECP_Templates	Health Care Service Corporation	87571		Provider 144	NA	Hospital	Address
147	_ECP_Templates	Health Care Service Corporation	87571	1124029293	Provider 145	NA	FQHC	Address
148	_ECP_Templates	Health Care Service Corporation	87571		Provider 146	NA	Hospital	Address
149	_ECP_Templates	Health Care Service Corporation	87571	1497057699	Provider 147	NA	FQHC	Address
150	_ECP_Templates	Health Care Service Corporation	87571		Provider 148	NA	FQHC	Address
151	_ECP_Templates	Health Care Service Corporation	87571	1033103452	Provider 149	NA	FQHC	Address
152	_ECP_Templates	Health Care Service Corporation	87571		Provider 150	NA	Hospital	Address
153	_ECP_Templates	Health Care Service Corporation	87571		Provider 151	NA	Other ECP	Address
154	_ECP_Templates	Health Care Service Corporation	87571		Provider 152	NA	Other ECP	Address
155	_ECP_Templates	Health Care Service Corporation	87571		Provider 153	NA	Other ECP	Address
156	_ECP_Templates	Health Care Service Corporation	87571		Provider 154	NA	Other ECP	Address
157	_ECP_Templates	Health Care Service Corporation	87571		Provider 155	NA	Other ECP	Address
158	_ECP_Templates	Health Care Service Corporation	87571		Provider 156	NA	Other ECP	Address
159	_ECP_Templates	Health Care Service Corporation	87571		Provider 157	NA	Other ECP	Address

17. **Save** the Master Review Tool workbook again after the data import has completed.

18. **Go back** to the Master Review Tool *Instructions* tab and determine if you want to evaluate plans offered inside the Marketplace only, plans offered outside the Marketplace only, or both plans offered inside and outside the Marketplace.

19. Once you decide which plans to evaluate, using the drop down in row 16, **click** the option you have chosen.

15	7.	Select if you'd like to use this tool to evaluate on exchange plans only, off exchange plans only, or both on and off exchange plans. Please note that not all of the reviews are applicable to off exchange plans. The "Review Summary" tab will grey out the cells for reviews that are not applicable and those plans will not be on the tabs corresponding to the not applicable standards.	Select which plans you would like to review
16			**Both On and Off Exchange Plans**

20. **Go back** to the Master Review Tool *Instructions* tab and **click "Populate Worksheet Headers"** in row 18.

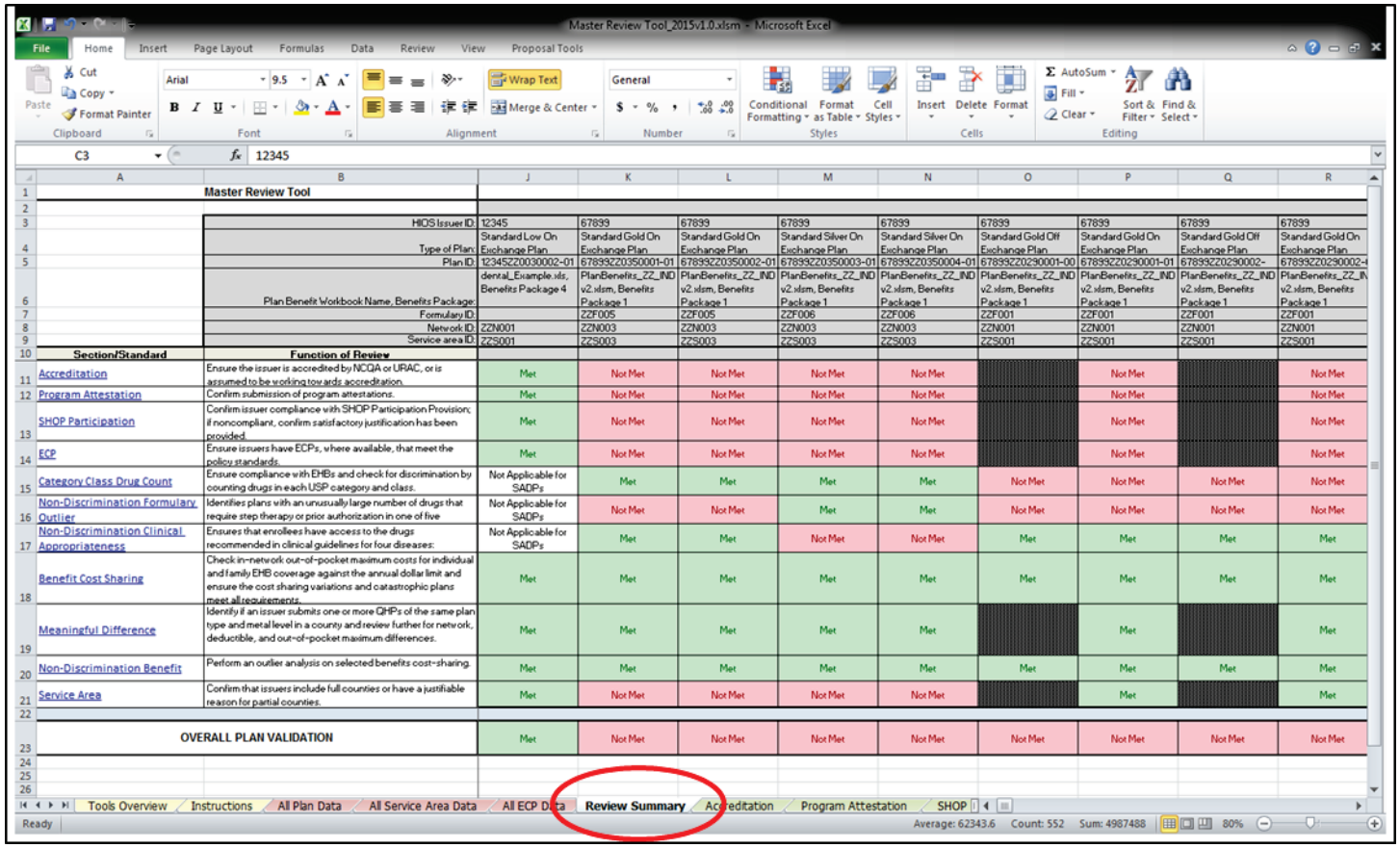
17	8.	Once the "All Plan Data" worksheet has been populated, you can use the button below to populate the headers of the "Review Summary" tab and all other review tabs based on the specific data in the "All Plan Data" tab.	
18		**Populate Worksheet Headers**	

21. **Click** the Master Review Tool *Review Summary* tab to see the populated worksheet headers.

MASTER REVIEW TOOL: ANALYSIS

Review Summary

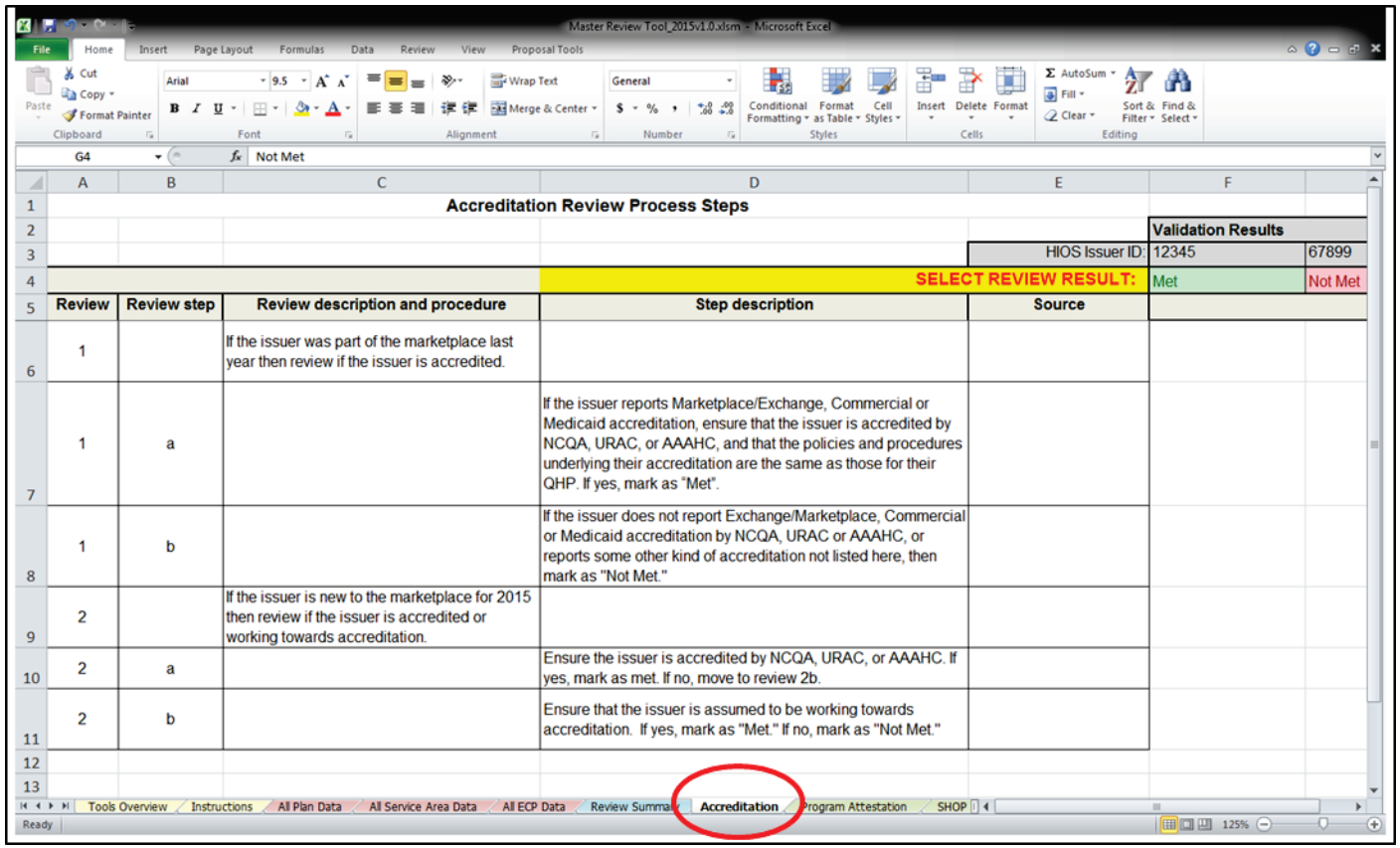
The Master Review Tool *Review Summary* tab tracks whether each plan has met its applicable QHP standards. You can work directly in this tab or use the information auto-populated based on the information input from the other review tabs. The Master Review Tool is just one option for plan and issuer evaluation. State regulators may use the Master Review Tool *Review Summary* results as they see fit, regardless of whether a plan meets or does not meet its applicable standard(s).



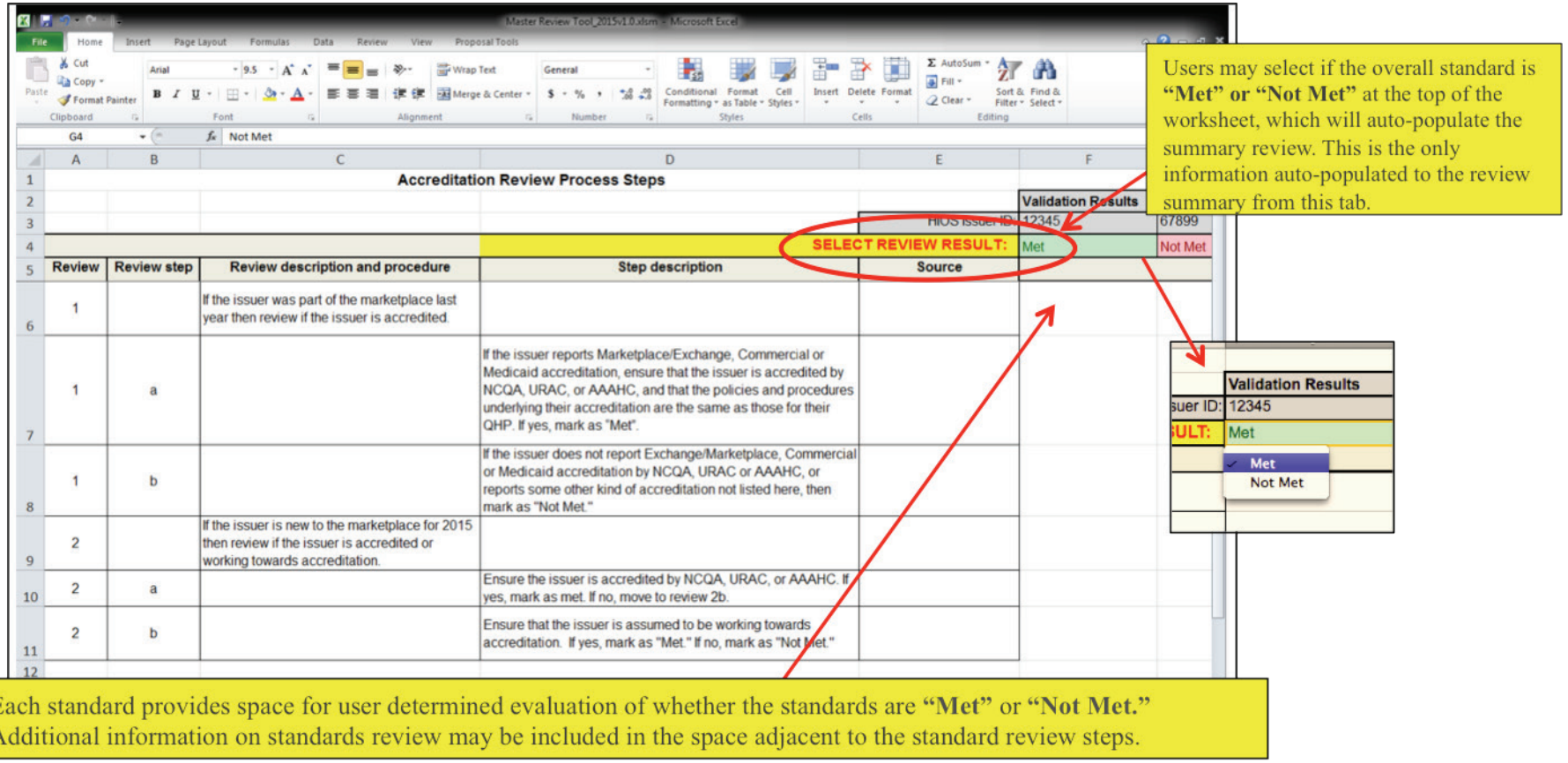
Accreditation Review

The accreditation review ensures the issuer is accredited by the National Committee for Quality Assurance (NCQA), URAC, or the Accreditation Association for Ambulatory Health Care (AAAHC), or is working toward accreditation. Accreditation is reviewed at the issuer level rather than the plan level.

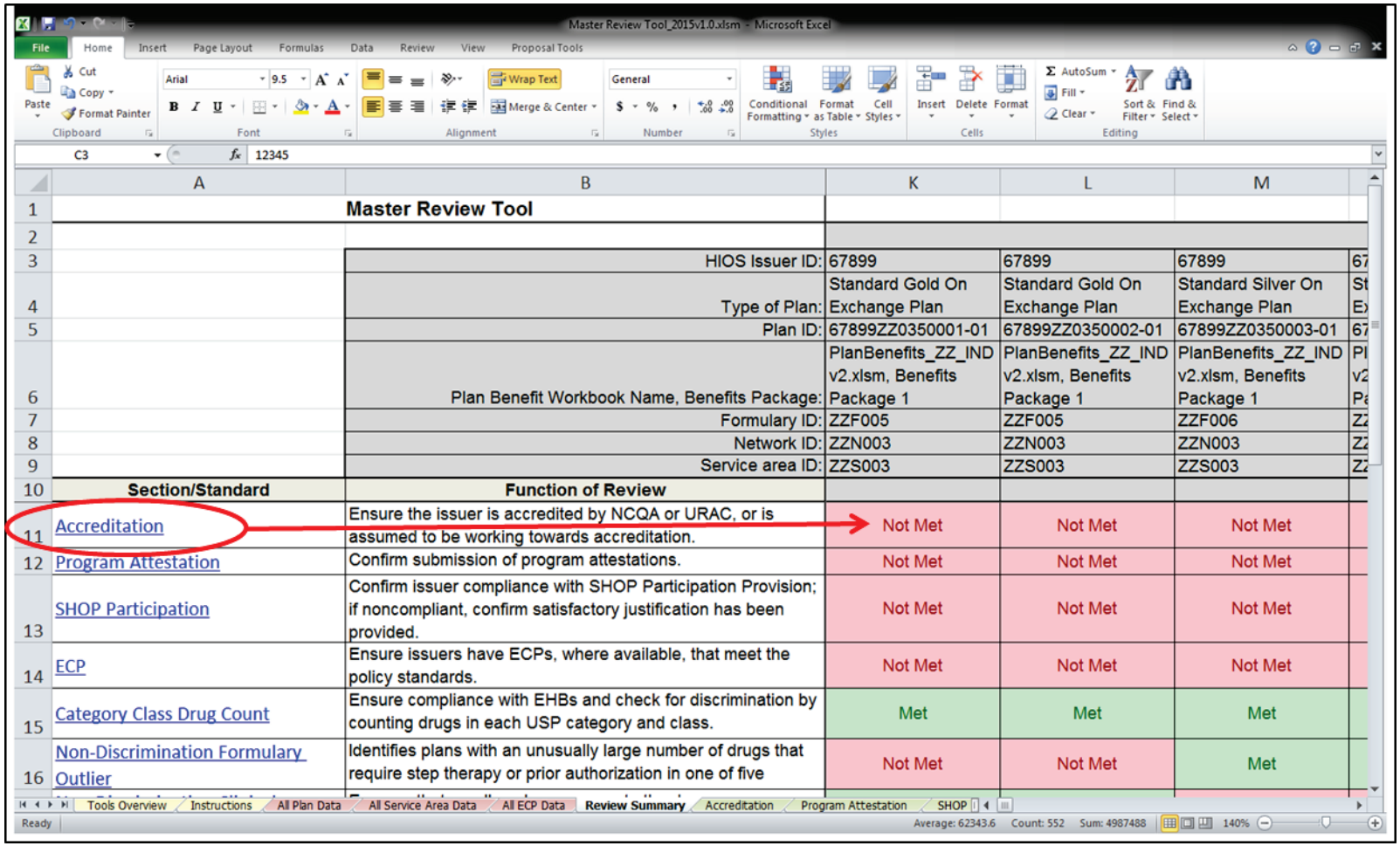
1. Review issuer accreditation to determine if the provider is accredited by NCQA, URAC, or AAAHC using the issuer application.
2. **Open** the *Accreditation* tab in the Master Review Tool.



3. Using the drop down in row 4 next to SELECT REVIEW RESULTS, **choose "Met"** or **"Not Met"** for each issuer listed.



4. After you have populated **"Met"** or **"Not Met"** for each issuer's plan in the Master Review Tool *Accreditation* tab, **open** the Master Review Tool *Review Summary tab* to see the auto-populated results in row 11.



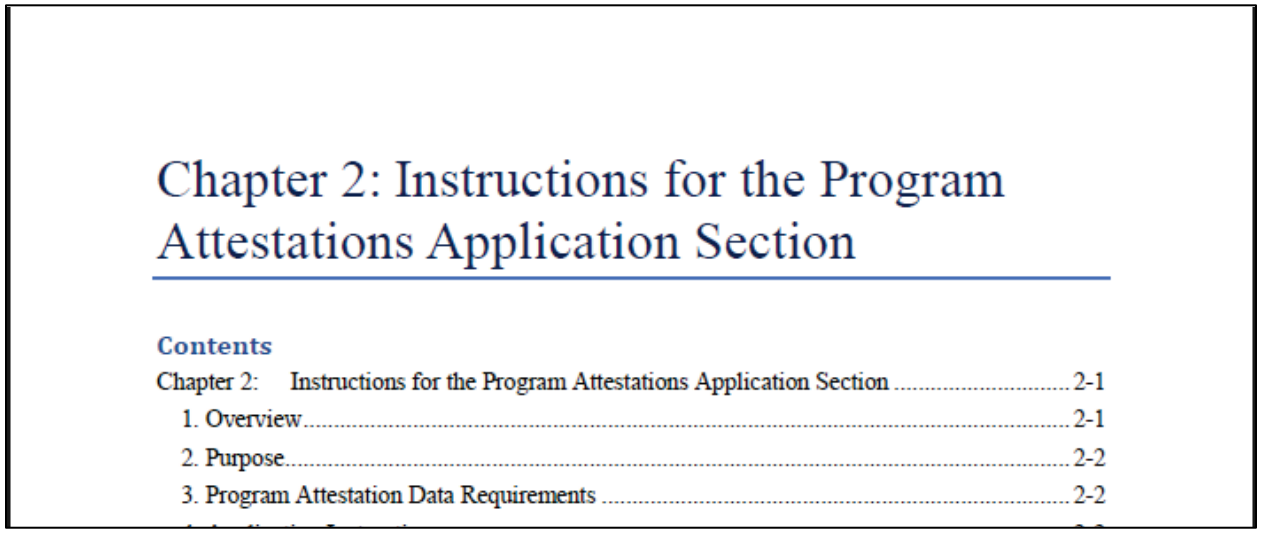
	A	B	K	L	M
1		**Master Review Tool**			
2					
3		HIOS Issuer ID:	67899	67899	67899
4		Type of Plan:	Standard Gold On Exchange Plan	Standard Gold On Exchange Plan	Standard Silver On Exchange Plan
5		Plan ID:	67899ZZ0350001-01	67899ZZ0350002-01	67899ZZ0350003-01
6		Plan Benefit Workbook Name, Benefits Package:	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1
7		Formulary ID:	ZZF005	ZZF005	ZZF006
8		Network ID:	ZZN003	ZZN003	ZZN003
9		Service area ID:	ZZS003	ZZS003	ZZS003
10	**Section/Standard**	**Function of Review**			
11	Accreditation	Ensure the issuer is accredited by NCQA or URAC, or is assumed to be working towards accreditation.	Not Met	Not Met	Not Met
12	Program Attestation	Confirm submission of program attestations.	Not Met	Not Met	Not Met
13	SHOP Participation	Confirm issuer compliance with SHOP Participation Provision; if noncompliant, confirm satisfactory justification has been provided.	Not Met	Not Met	Not Met
14	ECP	Ensure issuers have ECPs, where available, that meet the policy standards.	Not Met	Not Met	Not Met
15	Category Class Drug Count	Ensure compliance with EHBs and check for discrimination by counting drugs in each USP category and class.	Met	Met	Met
16	Non-Discrimination Formulary Outlier	Identifies plans with an unusually large number of drugs that require step therapy or prior authorization in one of five	Not Met	Not Met	Met

5. **Save** the Master Review Tool after you have completed the accreditation review.

Program Attestation Review

The program attestation review evaluates QHP applications for completed issuer attestation. The QHP instructions document for program attestations (http://cciio.cms.gov/programs/exchanges/qhp.html) lists the attestations for which a "No" answer is acceptable.

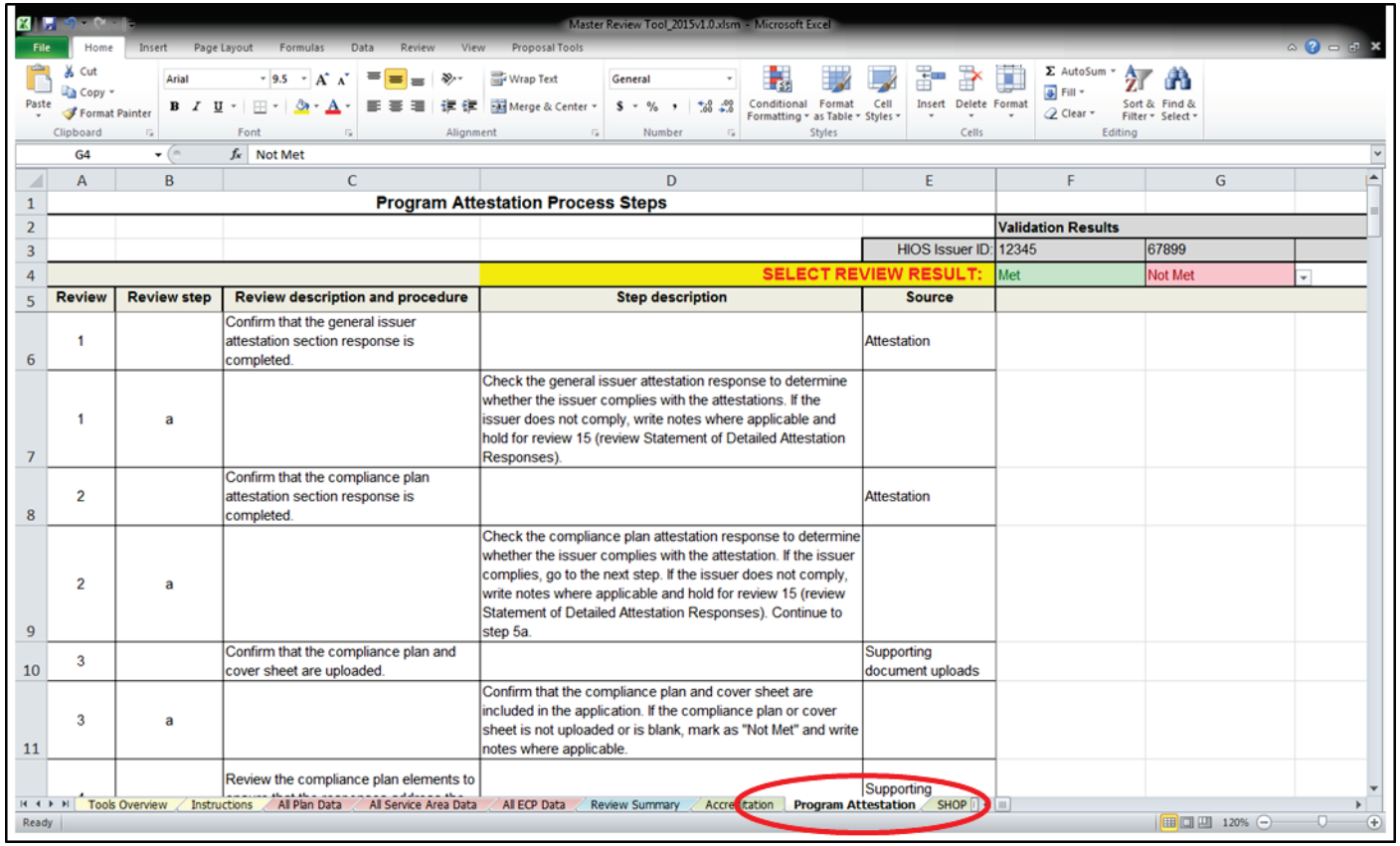
1. **Use** the general issuer attestation to determine the program attestation review.



Chapter 2: Instructions for the Program Attestations Application Section

Contents

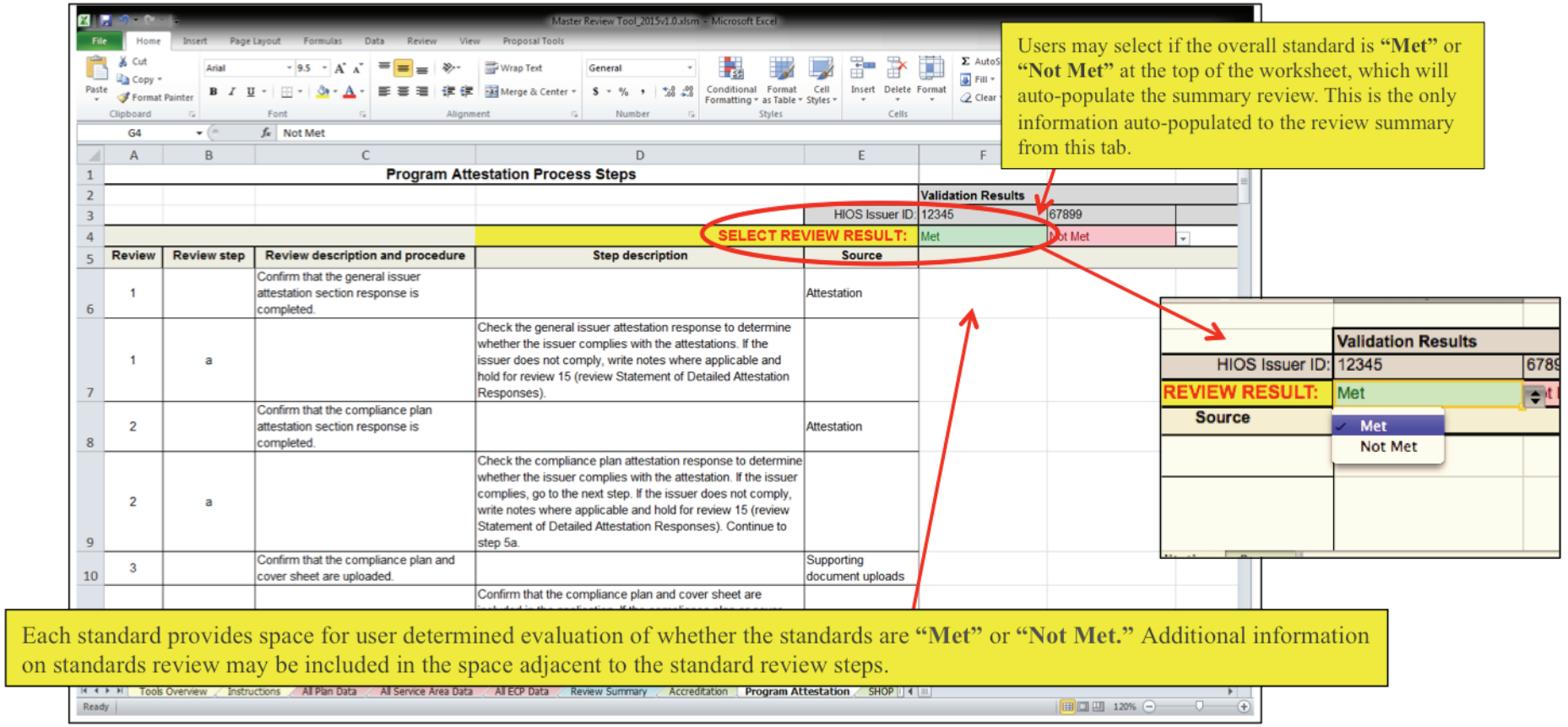
2. **Open** the Master Review Tool *Program Attestation* tab.



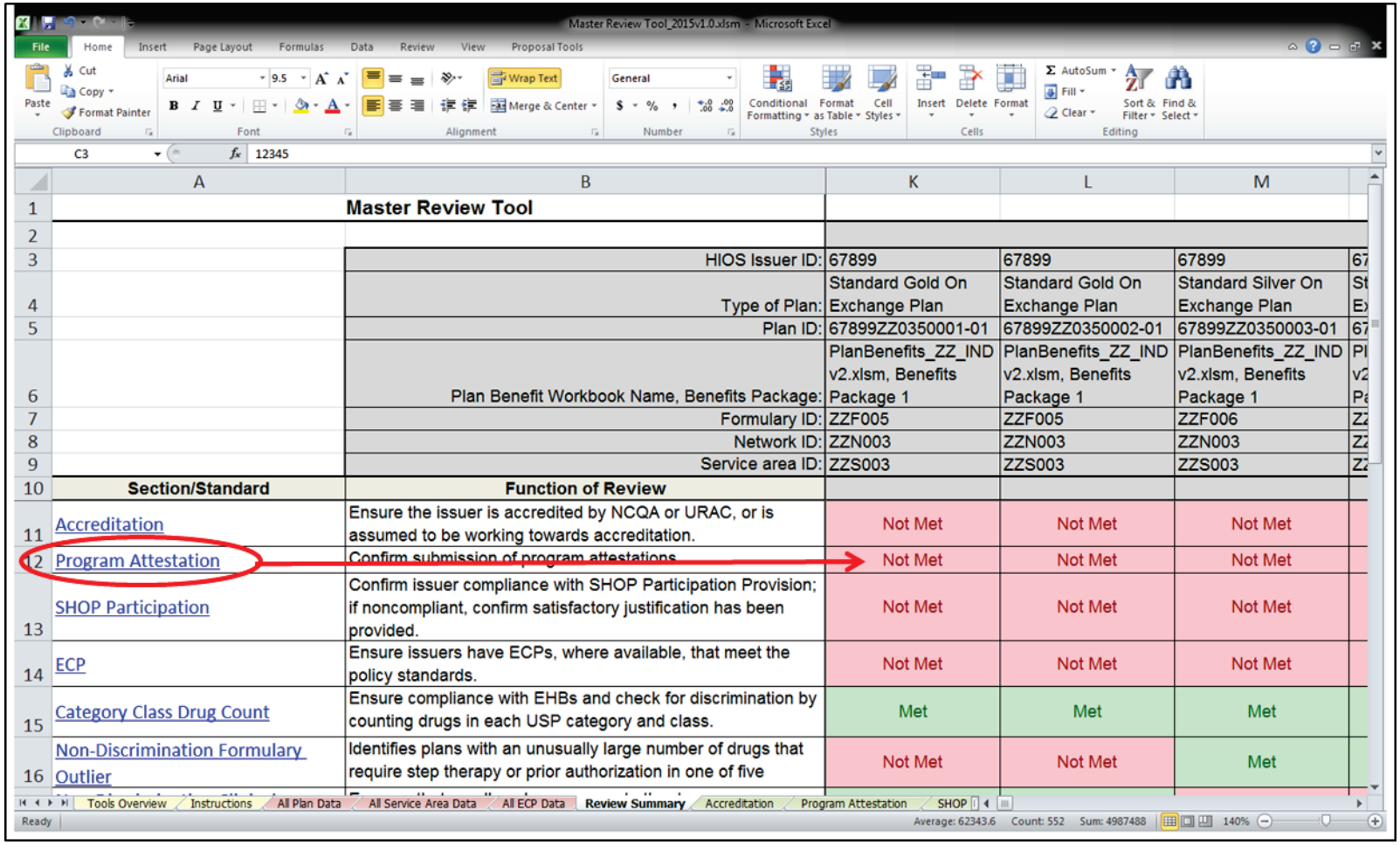
Program Attestation Process Steps

					Validation Results	
				HIOS Issuer ID:	12345	67899
			SELECT REVIEW RESULT:		Met	Not Met
Review	Review step	Review description and procedure	Step description	Source		
1		Confirm that the general issuer attestation section response is completed.		Attestation		
1	a		Check the general issuer attestation response to determine whether the issuer complies with the attestations. If the issuer does not comply, write notes where applicable and hold for review 15 (review Statement of Detailed Attestation Responses).			
2		Confirm that the compliance plan attestation section response is completed.		Attestation		
2	a		Check the compliance plan attestation response to determine whether the issuer complies with the attestation. If the issuer complies, go to the next step. If the issuer does not comply, write notes where applicable and hold for review 15 (review Statement of Detailed Attestation Responses). Continue to step 5a.			
3		Confirm that the compliance plan and cover sheet are uploaded.		Supporting document uploads		
3	a		Confirm that the compliance plan and cover sheet are included in the application. If the compliance plan or cover sheet is not uploaded or is blank, mark as "Not Met" and write notes where applicable.			
		Review the compliance plan elements to		Supporting		

3. **Manually populate**, in the SELECT REVIEW RESULT row, **"Met"** or **"Not Met"** from the drop-down menus of each column for each issuer's plan.



4. **Open** the Master Review Tool *Review Summary* tab to see the auto-populated results.



Master Review Tool_2015v1.0.xlsm - Microsoft Excel

	A	B	K	L	M
1		**Master Review Tool**			
2					
3		HIOS Issuer ID:	67899	67899	67899
4		Type of Plan:	Standard Gold On Exchange Plan	Standard Gold On Exchange Plan	Standard Silver On Exchange Plan
5		Plan ID:	67899ZZ0350001-01	67899ZZ0350002-01	67899ZZ0350003-01
6		Plan Benefit Workbook Name, Benefits Package:	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1
7		Formulary ID:	ZZF005	ZZF005	ZZF006
8		Network ID:	ZZN003	ZZN003	ZZN003
9		Service area ID:	ZZS003	ZZS003	ZZS003
10	**Section/Standard**	**Function of Review**			
11	Accreditation	Ensure the issuer is accredited by NCQA or URAC, or is assumed to be working towards accreditation.	Not Met	Not Met	Not Met
12	Program Attestation	Confirm submission of program attestations	Not Met	Not Met	Not Met
13	SHOP Participation	Confirm issuer compliance with SHOP Participation Provision; if noncompliant, confirm satisfactory justification has been provided.	Not Met	Not Met	Not Met
14	ECP	Ensure issuers have ECPs, where available, that meet the policy standards.	Not Met	Not Met	Not Met
15	Category Class Drug Count	Ensure compliance with EHBs and check for discrimination by counting drugs in each USP category and class.	Met	Met	Met
16	Non-Discrimination Formulary Outlier	Identifies plans with an unusually large number of drugs that require step therapy or prior authorization in one of five	Not Met	Not Met	Met

Tools Overview | Instructions | All Plan Data | All Service Area Data | All ECP Data | Review Summary | Accreditation | Program Attestation | SHOP

Ready — Average: 62343.6 Count: 552 Sum: 4987488 140%

5. **Save** the Master Review Tool after you have completed the accreditation review.

SHOP Participation Review

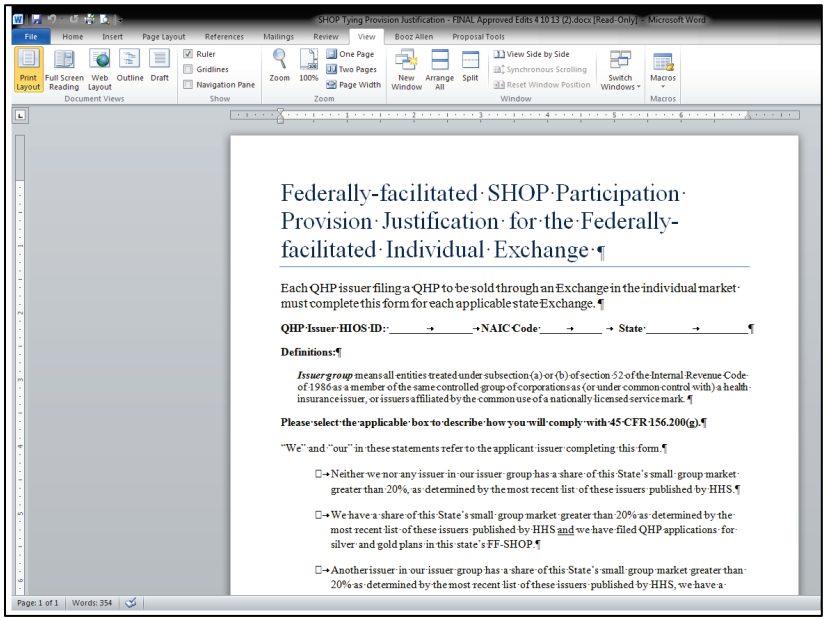
1. **Use the SHOP participation provision (45 CFR §156.200(g)), the list of issuers subject to the SHOP participation provision, and the provider SHOP participation justifications to complete the *SHOP participation* review** (in the Master Review Tool *SHOP participation* tab) with **"Met" or "Not Met"** accordingly**.**

   § 156.200 QHP issuer participation standards

   (g) *Certification standard specific to a Federally-facilitated Marketplace (FFM).* A FFM may certify a QHP in the individual market of a FFM only if the QHP issuer meets one of the conditions below:

   (1) The QHP issuer also offers through a Federally-facilitated SHOP serving that state at least one small group market QHP at the silver level of coverage and one at the gold level of coverage as described in section 1302(d) of the Affordable Care Act.
   (2) The QHP issuer does not offer small group market products in that state, but another issuer in the same issuer group offers through a Federally-facilitated SHOP serving that state at least one small group market QHP at the silver level of coverage and one at the gold level of coverage.

   (3) Neither the issuer nor any other issuer in the same issuer group has a share of the small group market, as determined by U.S. Department of Health and Human Services (HHS), greater than 20 percent, based on the earned premiums submitted by all issuers in the state's small group market, under § 158.110 of this subchapter, on the reporting date immediately preceding the due date of the application for QHP certification.



Federally-facilitated SHOP Participation Provision Justification for the Federally-facilitated Individual Exchange

Each QHP issuer filing a QHP to be sold through an Exchange in the individual market must complete this form for each applicable state Exchange.

QHP Issuer HIOS ID: _____ → NAIC Code: _____ → State: _____

Definitions:

Issuer group means all entities treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations as (or under common control with) a health insurance issuer, or issuers affiliated by the common use of a nationally licensed service mark.

Please select the applicable box to describe how you will comply with 45 CFR 156.200(g).

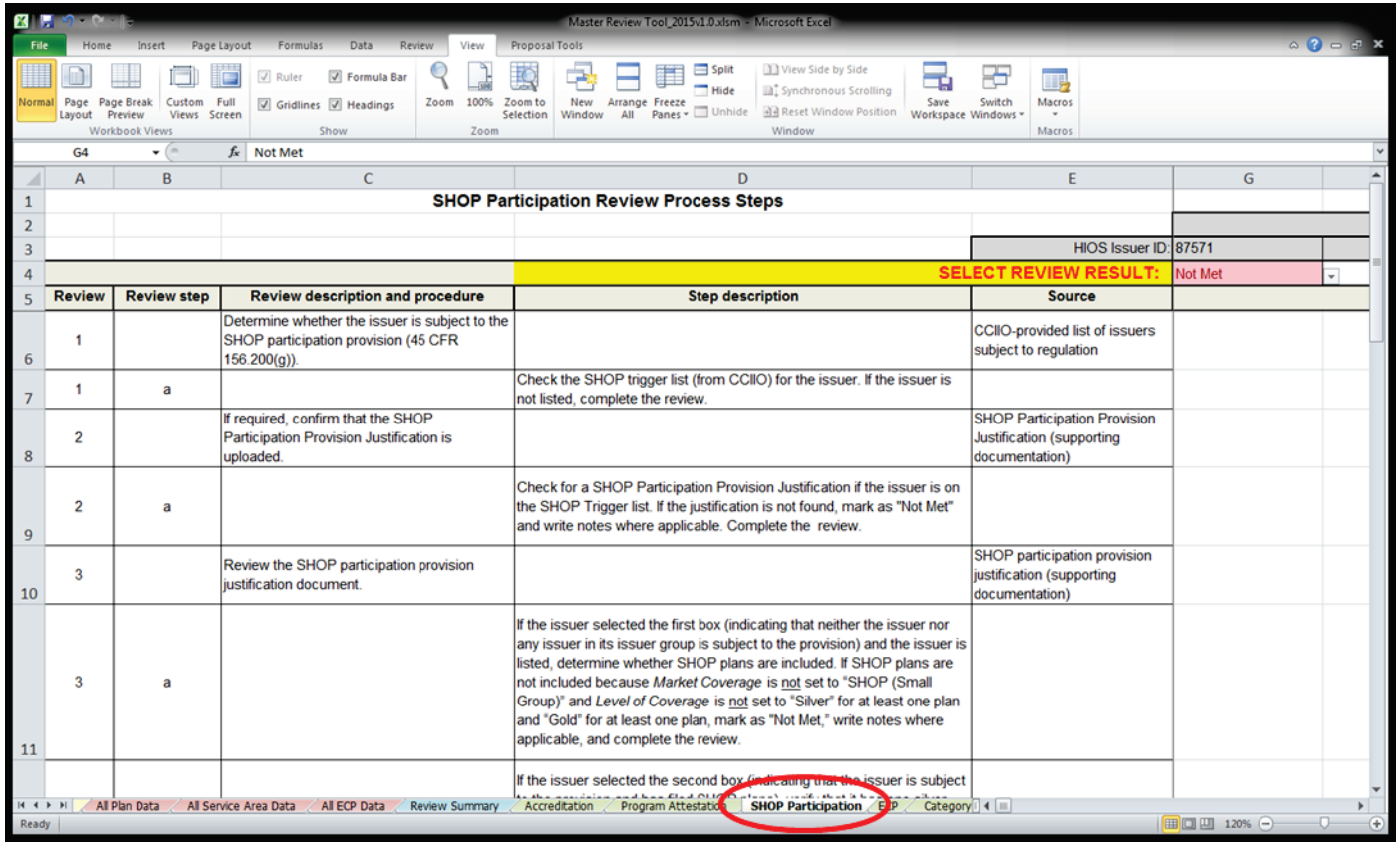
"We" and "our" in these statements refer to the applicant issuer completing this form.

☐ → Neither we nor any issuer in our issuer group has a share of this State's small group market greater than 20%, as determined by the most recent list of these issuers published by HHS.

☐ → We have a share of this State's small group market greater than 20% as determined by the most recent list of these issuers published by HHS and we have filed QHP applications for silver and gold plans in this state's FF-SHOP.

☐ → Another issuer in our issuer group has a share of this State's small group market greater than 20% as determined by the most recent list of these issuers published by HHS, we have a

2. **Open** the Master Review Tool and then open the *SHOP Participation* tab.



Master Review Tool_2015v1.0.xlsm - Microsoft Excel

G4: Not Met

SHOP Participation Review Process Steps

HIOS Issuer ID: 87571

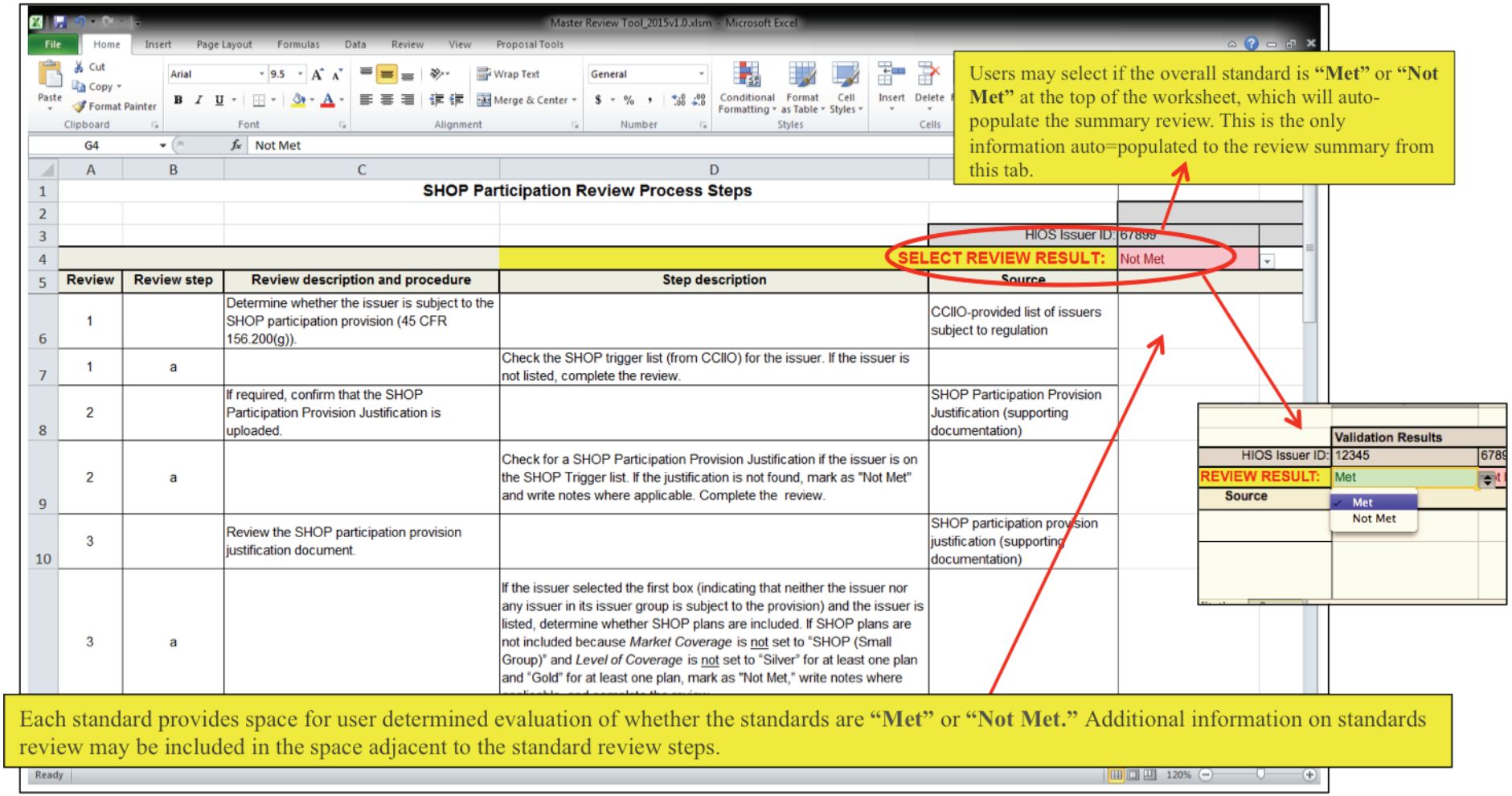
SELECT REVIEW RESULT: Not Met

Review	Review step	Review description and procedure	Step description	Source
1		Determine whether the issuer is subject to the SHOP participation provision (45 CFR 156.200(g)).		CCIIO-provided list of issuers subject to regulation
1	a		Check the SHOP trigger list (from CCIIO) for the issuer. If the issuer is not listed, complete the review.	
2		If required, confirm that the SHOP Participation Provision Justification is uploaded.		SHOP Participation Provision Justification (supporting documentation)
2	a		Check for a SHOP Participation Provision Justification if the issuer is on the SHOP Trigger list. If the justification is not found, mark as "Not Met" and write notes where applicable. Complete the review.	
3		Review the SHOP participation provision justification document.		SHOP participation provision justification (supporting documentation)
3	a		If the issuer selected the first box (indicating that neither the issuer nor any issuer in its issuer group is subject to the provision) and the issuer is listed, determine whether SHOP plans are included. If SHOP plans are not included because *Market Coverage* is not set to "SHOP (Small Group)" and *Level of Coverage* is not set to "Silver" for at least one plan and "Gold" for at least one plan, mark as "Not Met," write notes where applicable, and complete the review.	
			If the issuer selected the second box (indicating that the issuer is subject	

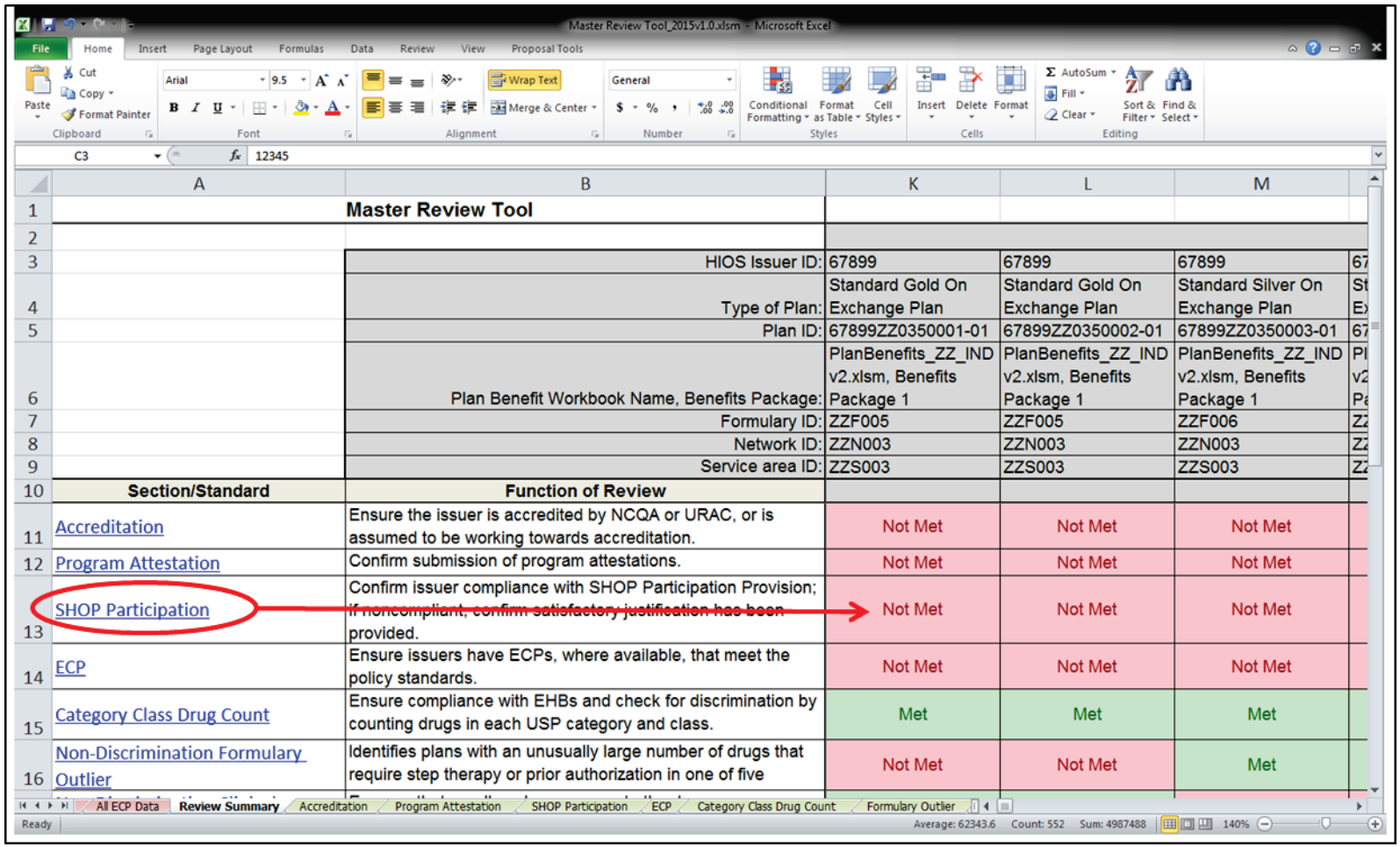
All Plan Data | All Service Area Data | All ECP Data | Review Summary | Accreditation | Program Attestation | SHOP Participation | EHB | Category

3. **Read** the *SHOP Participation* validation step descriptions carefully as subsequent *SHOP Participation* validation steps are conditional based on previous *SHOP Participation* validation steps' **"Met"** or **"Not Met"** compliance.

4. In the *SHOP Participation* tab, **manually populate "Met"** or **"Not Met"** from the drop-down menus at the top of each column in the SELECT REVIEW RESULT row for each issuer.



5. **Open** the Master Review Tool *Review Summary* tab to see the auto-populated results.



Master Review Tool_2015v1.0.xlsm - Microsoft Excel

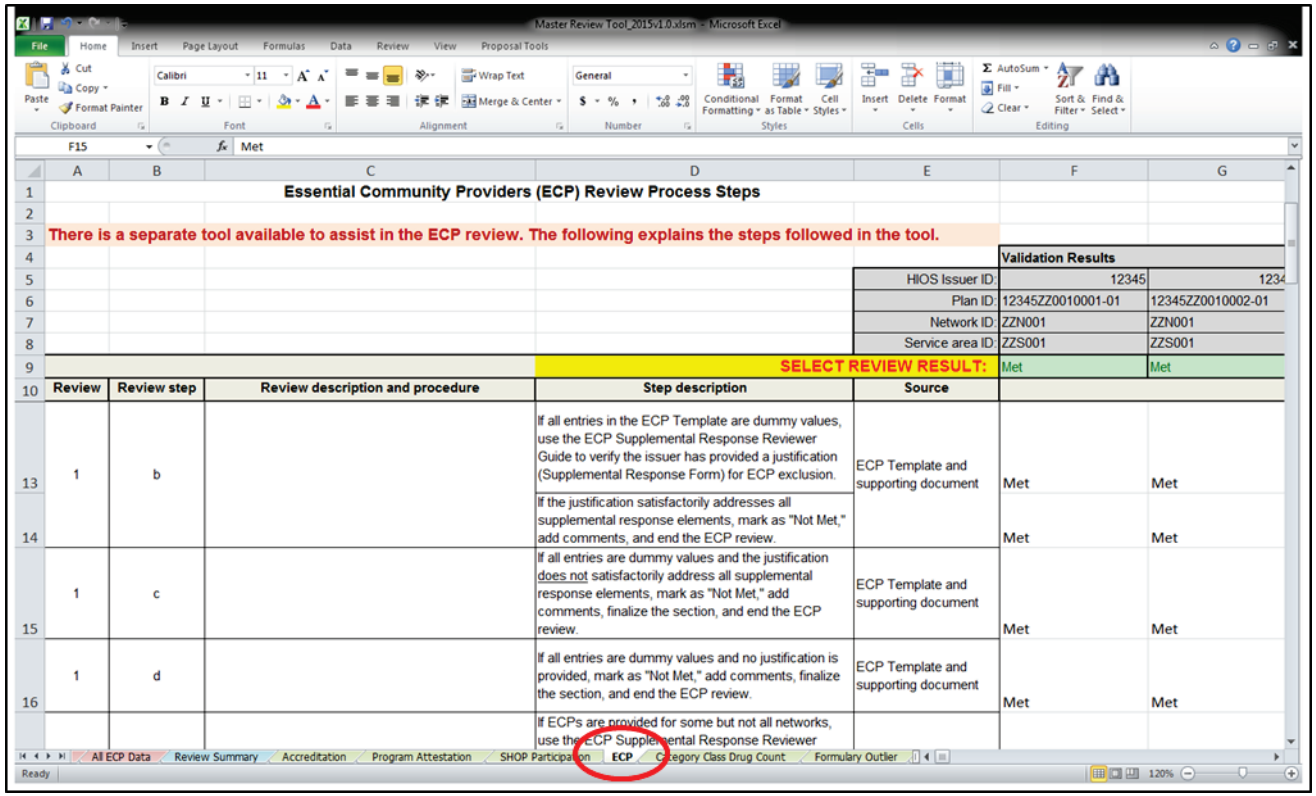
	A	B	K	L	M
1		**Master Review Tool**			
2					
3		HIOS Issuer ID:	67899	67899	67899
4		Type of Plan:	Standard Gold On Exchange Plan	Standard Gold On Exchange Plan	Standard Silver On Exchange Plan
5		Plan ID:	67899ZZ0350001-01	67899ZZ0350002-01	67899ZZ0350003-01
6		Plan Benefit Workbook Name, Benefits Package:	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1
7		Formulary ID:	ZZF005	ZZF005	ZZF006
8		Network ID:	ZZN003	ZZN003	ZZN003
9		Service area ID:	ZZS003	ZZS003	ZZS003
10	**Section/Standard**	**Function of Review**			
11	Accreditation	Ensure the issuer is accredited by NCQA or URAC, or is assumed to be working towards accreditation.	Not Met	Not Met	Not Met
12	Program Attestation	Confirm submission of program attestations.	Not Met	Not Met	Not Met
13	SHOP Participation	Confirm issuer compliance with SHOP Participation Provision; if noncompliant, confirm satisfactory justification has been provided.	Not Met	Not Met	Not Met
14	ECP	Ensure issuers have ECPs, where available, that meet the policy standards.	Not Met	Not Met	Not Met
15	Category Class Drug Count	Ensure compliance with EHBs and check for discrimination by counting drugs in each USP category and class.	Met	Met	Met
16	Non-Discrimination Formulary Outlier	Identifies plans with an unusually large number of drugs that require step therapy or prior authorization in one of five	Not Met	Not Met	Met

6. **Save** the Master Review Tool after you have completed the SHOP participation review.

Essential Community Provider (ECP) Review

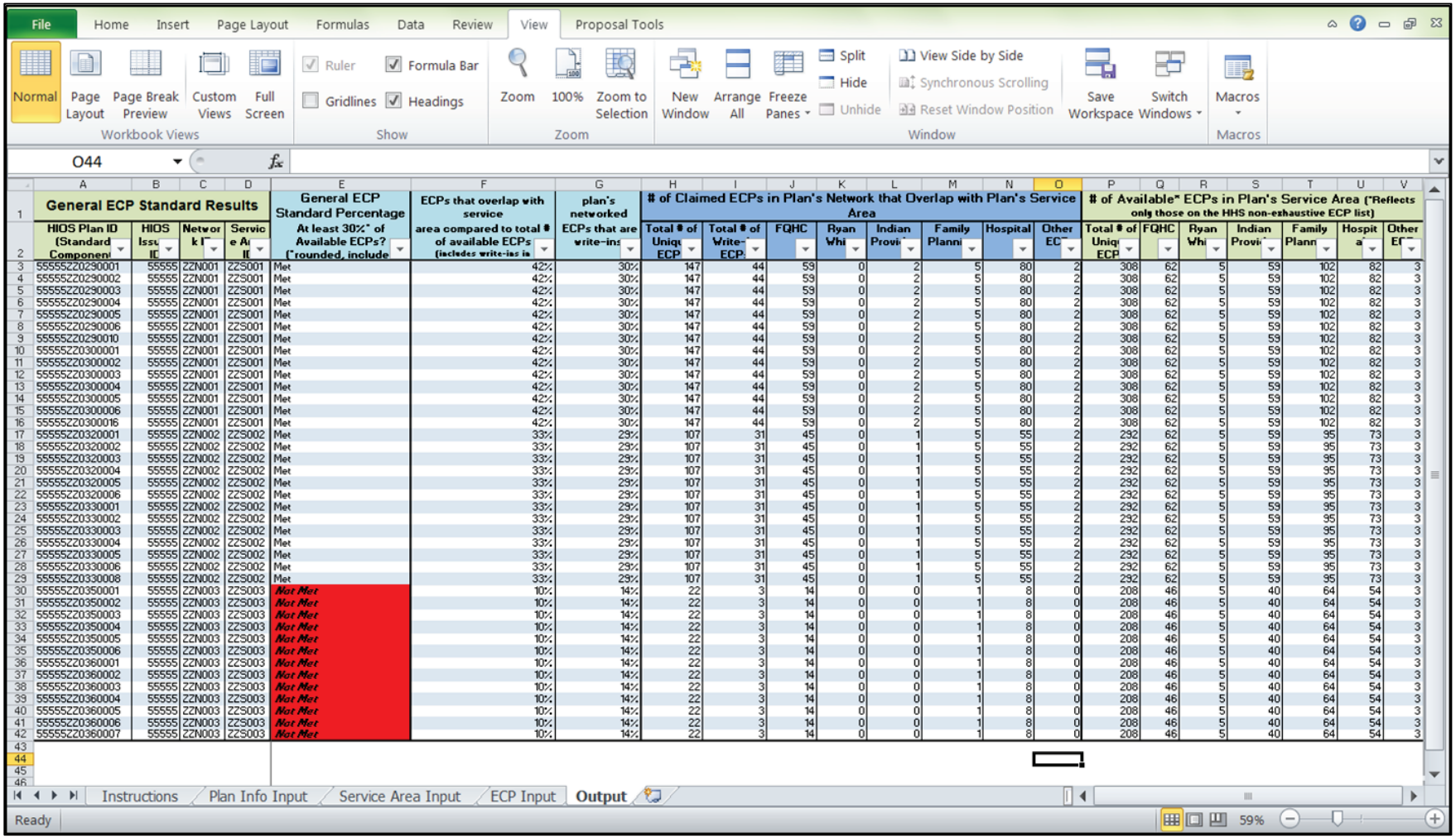
The ECP review process in the Master Review Tool determines whether issuers have networked with an adequate number and geographic distribution of ECPs, where available, to satisfy the 30 percent ECP standard.

1. Open the QHP application review tools folder and run the ECP Tool for all the issuers' plans you wish to evaluate. You must run the ECP Tool only one issuer at a time, so be sure to save each completed ECP Tool with a unique filename, e.g., by issuer ID. *See the ECP Tool User Guide for instructions.*
2. If you decide to use the ECP stand-alone tool, review the validation steps in the Master Review Tool *ECP* tab to better understand the logic behind the ECP Tool or to see where you can submit justifications.
3. **Open** the Master Review Tool and then **open** the *ECP* tab.

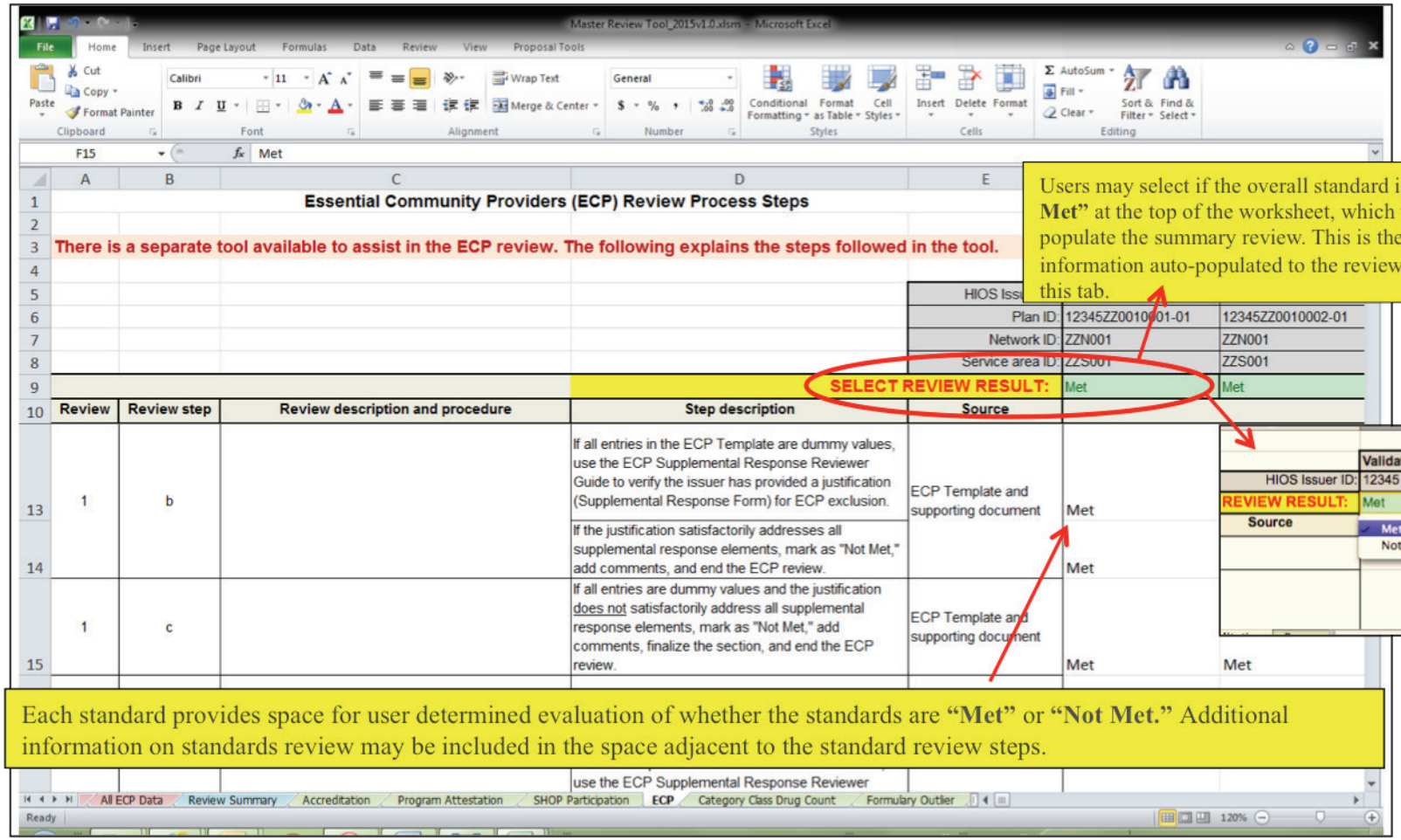


4. **Open** the *ECP Tool output* tab to see the issuer's plans you wish to review.

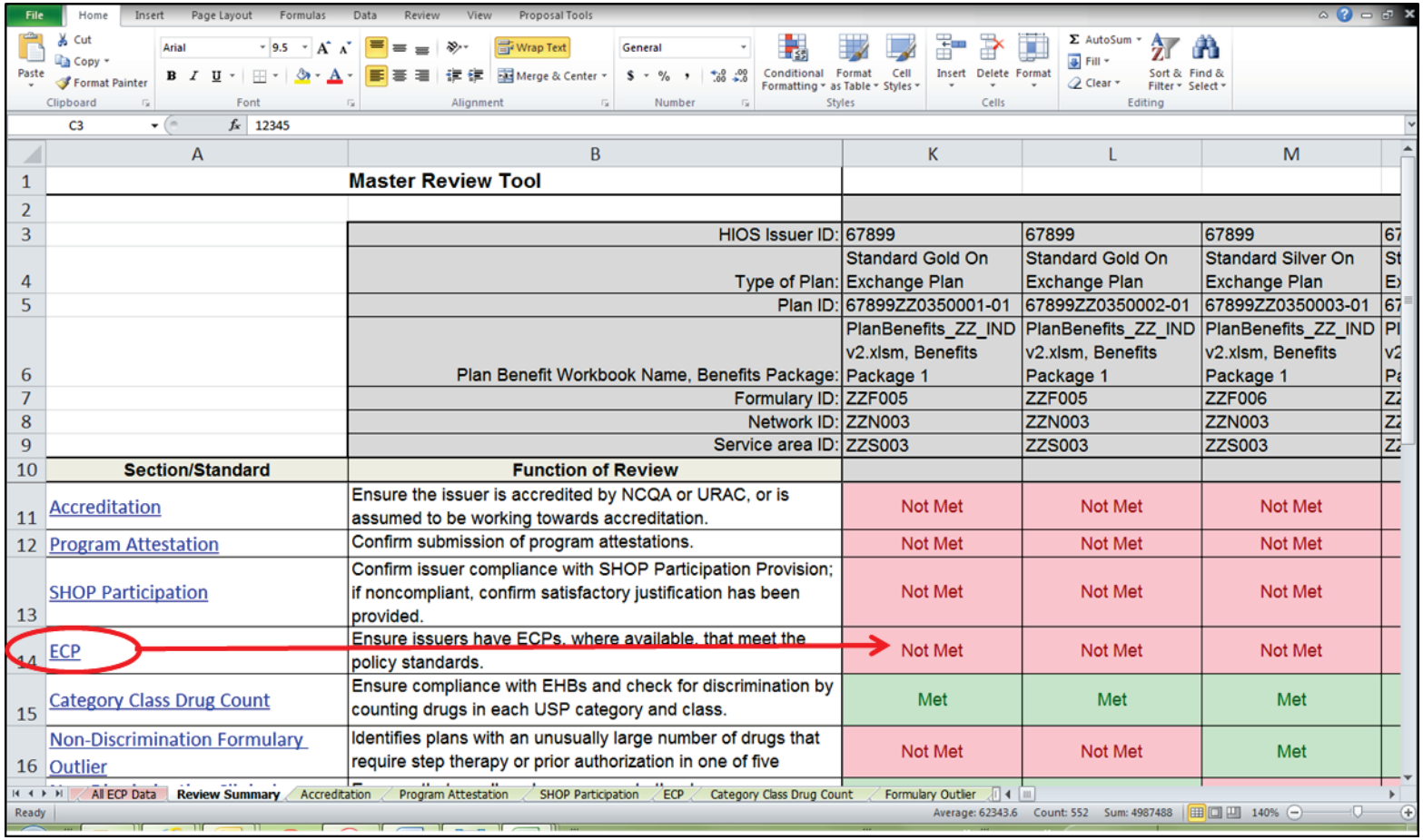
Note: If the issuer has selected categories for both Provider Type and ECP Category (column C and D) in the ECP template, the ECP Tool will give you an error message. "NA" must be selected all the way down in either column C or column D for the tool to run correctly. For more information, refer to the ECP Tool User Guide.



5. Using the data in the ECP Tool Output tab, go to the Master Review Tool ECP tab and use the drop-down menus at the top of each column in the SELECT REVIEW RESULT row to indicate if an issuer's plan has met the 30 percent ECP standard.



6. **Open** the Master Review Tool *Review Summary* tab to see the auto-populated results.



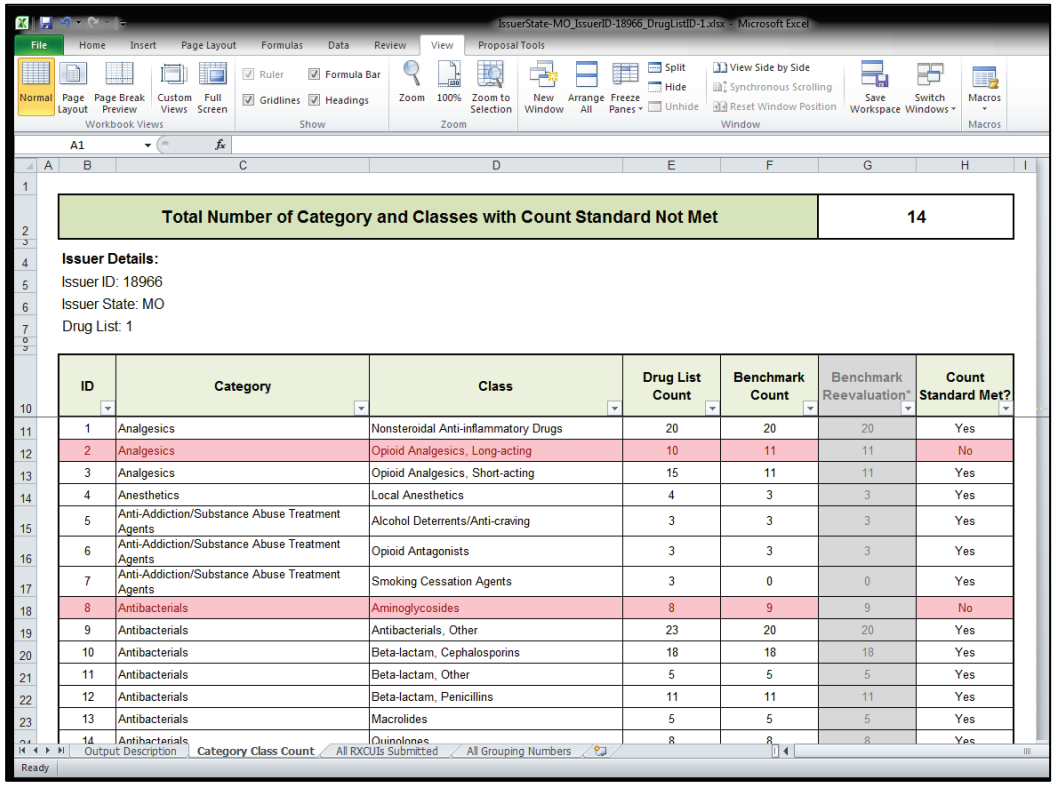
	A	B	K	L	M
1		**Master Review Tool**			
2					
3		HIOS Issuer ID:	67899	67899	67899
4		Type of Plan:	Standard Gold On Exchange Plan	Standard Gold On Exchange Plan	Standard Silver On Exchange Plan
5		Plan ID:	67899ZZ0350001-01	67899ZZ0350002-01	67899ZZ0350003-01
6		Plan Benefit Workbook Name, Benefits Package:	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1
7		Formulary ID:	ZZF005	ZZF005	ZZF006
8		Network ID:	ZZN003	ZZN003	ZZN003
9		Service area ID:	ZZS003	ZZS003	ZZS003
10	**Section/Standard**	**Function of Review**			
11	Accreditation	Ensure the issuer is accredited by NCQA or URAC, or is assumed to be working towards accreditation.	Not Met	Not Met	Not Met
12	Program Attestation	Confirm submission of program attestations.	Not Met	Not Met	Not Met
13	SHOP Participation	Confirm issuer compliance with SHOP Participation Provision; if noncompliant, confirm satisfactory justification has been provided.	Not Met	Not Met	Not Met
14	ECP	Ensure issuers have ECPs, where available, that meet the policy standards.	Not Met	Not Met	Not Met
15	Category Class Drug Count	Ensure compliance with EHBs and check for discrimination by counting drugs in each USP category and class.	Met	Met	Met
16	Non-Discrimination Formulary Outlier	Identifies plans with an unusually large number of drugs that require step therapy or prior authorization in one of five	Not Met	Not Met	Met

7. **Save** the Master Review Tool after you have completed the ECP review.

Category Class Drug Count

The formulary review process in the Master Review Tool ensures compliance with EHB and checks for discrimination by counting drugs in each USP category and class.

1. **Open** the QHP Application Review Tools folder and **run** the Category Class Drug Count Tool for the drug lists you wish to evaluate. *See the Category Class Drug Count Tool User Guide for instructions.*
2. **Open** the Category Class Drug Count *Prescription Drug List Output* for the issuer's drug list you wish to evaluate.



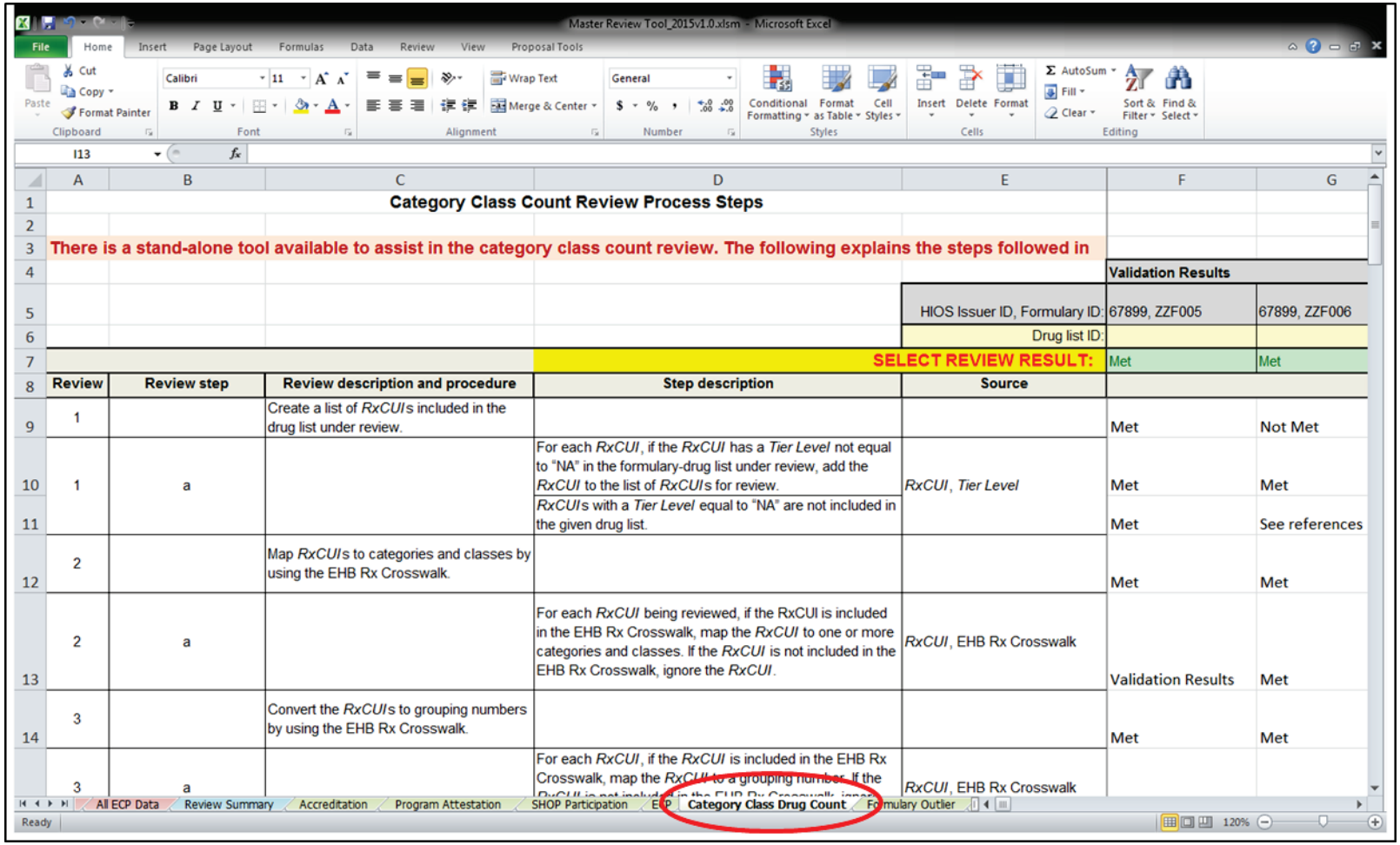
IssuerState-MO_IssuerID-18966_DrugListID-1.xlsx - Microsoft Excel

Total Number of Category and Classes with Count Standard Not Met	14

Issuer Details:
Issuer ID: 18966
Issuer State: MO
Drug List: 1

ID	Category	Class	Drug List Count	Benchmark Count	Benchmark Reevaluation*	Count Standard Met?
1	Analgesics	Nonsteroidal Anti-inflammatory Drugs	20	20	20	Yes
2	Analgesics	Opioid Analgesics, Long-acting	10	11	11	No
3	Analgesics	Opioid Analgesics, Short-acting	15	11	11	Yes
4	Anesthetics	Local Anesthetics	4	3	3	Yes
5	Anti-Addiction/Substance Abuse Treatment Agents	Alcohol Deterrents/Anti-craving	3	3	3	Yes
6	Anti-Addiction/Substance Abuse Treatment Agents	Opioid Antagonists	3	3	3	Yes
7	Anti-Addiction/Substance Abuse Treatment Agents	Smoking Cessation Agents	3	0	0	Yes
8	Antibacterials	Aminoglycosides	8	9	9	No
9	Antibacterials	Antibacterials, Other	23	20	20	Yes
10	Antibacterials	Beta-lactam, Cephalosporins	18	18	18	Yes
11	Antibacterials	Beta-lactam, Other	5	5	5	Yes
12	Antibacterials	Beta-lactam, Penicillins	11	11	11	Yes
13	Antibacterials	Macrolides	5	5	5	Yes
14	Antibacterials	Quinolones	8	8	8	Yes

3. **Open** the Master Review Tool and then open the *Category Class Drug Count* tab.



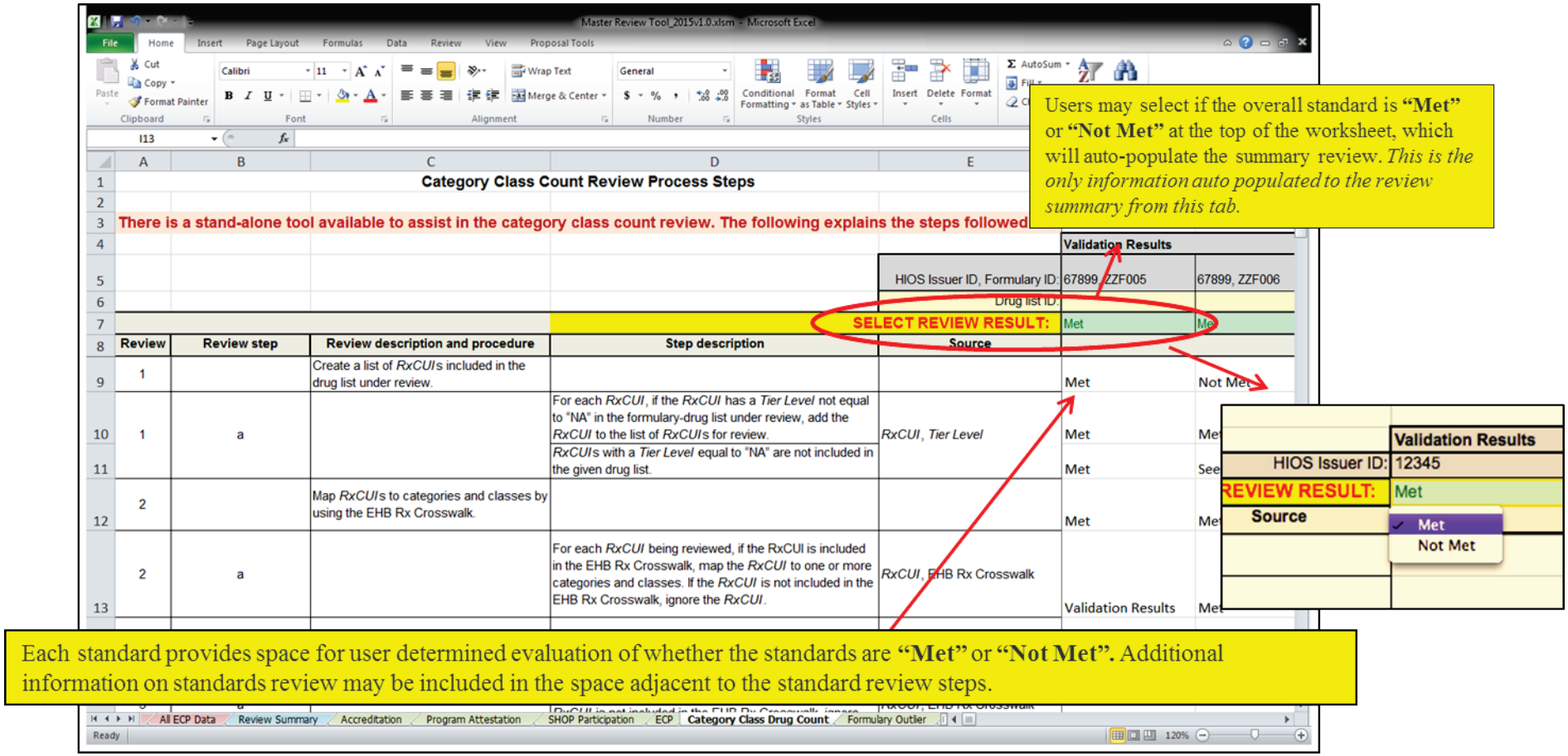
Master Review Tool_2015v1.0.xlsm - Microsoft Excel

	A	B	C	D	E	F	G
1				**Category Class Count Review Process Steps**			
2							
3	**There is a stand-alone tool available to assist in the category class count review. The following explains the steps followed in**						
4						**Validation Results**	
5					HIOS Issuer ID, Formulary ID:	67899, ZZF005	67899, ZZF006
6					Drug list ID:		
7				**SELECT REVIEW RESULT:**		Met	Met
8	**Review**	**Review step**	**Review description and procedure**	**Step description**	**Source**		
9	1		Create a list of *RxCUI*s included in the drug list under review.			Met	Not Met
10	1	a		For each *RxCUI*, if the *RxCUI* has a *Tier Level* not equal to "NA" in the formulary-drug list under review, add the *RxCUI* to the list of *RxCUI*s for review.	*RxCUI*, *Tier Level*	Met	Met
11				*RxCUI*s with a *Tier Level* equal to "NA" are not included in the given drug list.		Met	See references
12	2		Map *RxCUI*s to categories and classes by using the EHB Rx Crosswalk.			Met	Met
13	2	a		For each *RxCUI* being reviewed, if the RxCUI is included in the EHB Rx Crosswalk, map the *RxCUI* to one or more categories and classes. If the *RxCUI* is not included in the EHB Rx Crosswalk, ignore the *RxCUI*.	*RxCUI*, EHB Rx Crosswalk	Validation Results	Met
14	3		Convert the *RxCUI*s to grouping numbers by using the EHB Rx Crosswalk.			Met	Met
	3	a		For each *RxCUI*, if the *RxCUI* is included in the EHB Rx Crosswalk, map the *RxCUI* to a grouping number. If the	*RxCUI*, EHB Rx Crosswalk		

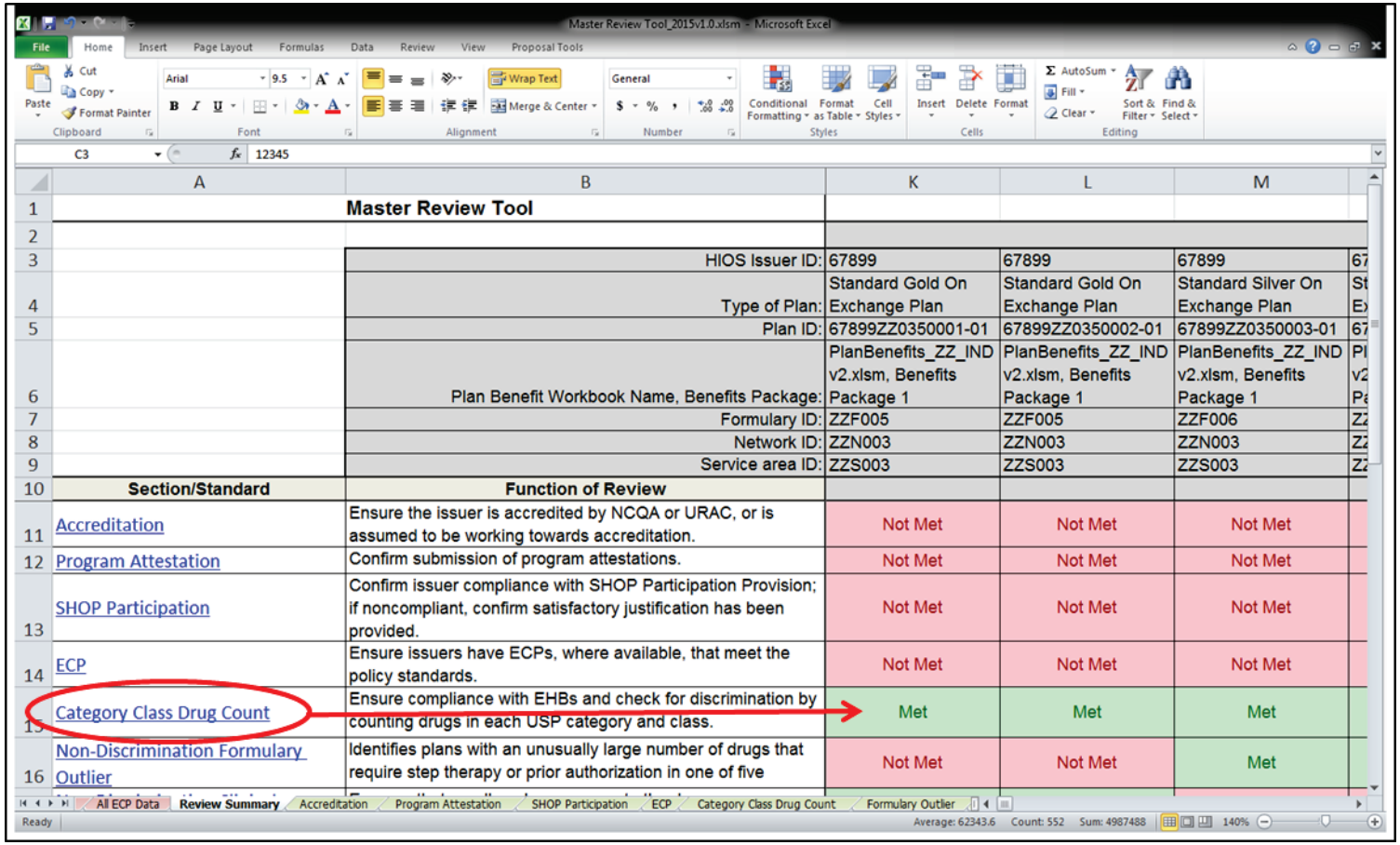
All ECP Data | Review Summary | Accreditation | Program Attestation | SHOP Participation | ECP | Category Class Drug Count | Formulary Outlier

Ready

4. Using the data in the *category class drug count prescription drug list outputs*, **go to** the Master Review Tool *Category Class Drug Count* tab to indicate if an issuer's drug lists have met the formulary requirement. **Populate** the **"Met"** or **"Not Met"** from the drop-down menus at the top of each column in the SELECT REVIEW RESULT row for each issuer's drug list.



5. **Open** the Master Review Tool *Review Summary* tab to see the auto-populated results in row 15.



Master Review Tool_2015v1.0.xlsm - Microsoft Excel

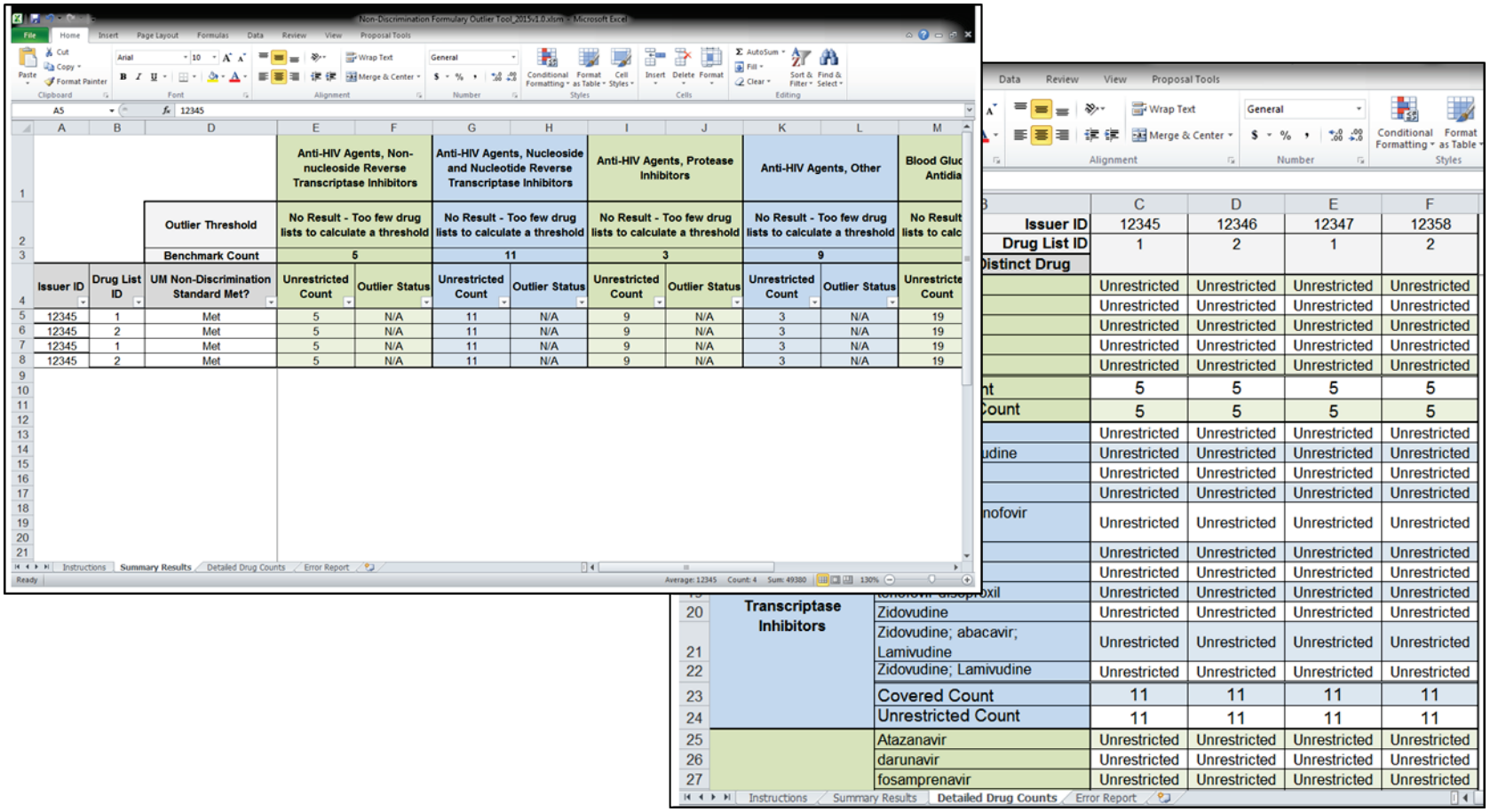
	A	B	K	L	M
1		**Master Review Tool**			
2					
3		HIOS Issuer ID:	67899	67899	67899
4		Type of Plan:	Standard Gold On Exchange Plan	Standard Gold On Exchange Plan	Standard Silver On Exchange Plan
5		Plan ID:	67899ZZ0350001-01	67899ZZ0350002-01	67899ZZ0350003-01
6		Plan Benefit Workbook Name, Benefits Package:	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1
7		Formulary ID:	ZZF005	ZZF005	ZZF006
8		Network ID:	ZZN003	ZZN003	ZZN003
9		Service area ID:	ZZS003	ZZS003	ZZS003
10	**Section/Standard**	**Function of Review**			
11	Accreditation	Ensure the issuer is accredited by NCQA or URAC, or is assumed to be working towards accreditation.	Not Met	Not Met	Not Met
12	Program Attestation	Confirm submission of program attestations.	Not Met	Not Met	Not Met
13	SHOP Participation	Confirm issuer compliance with SHOP Participation Provision; if noncompliant, confirm satisfactory justification has been provided.	Not Met	Not Met	Not Met
14	ECP	Ensure issuers have ECPs, where available, that meet the policy standards.	Not Met	Not Met	Not Met
15	Category Class Drug Count	Ensure compliance with EHBs and check for discrimination by counting drugs in each USP category and class.	Met	Met	Met
16	Non-Discrimination Formulary Outlier	Identifies plans with an unusually large number of drugs that require step therapy or prior authorization in one of five	Not Met	Not Met	Met

6. **Save** the Master Review Tool after you have completed the formulary review.

Non-Discrimination Formulary Outlier Tool

This tool identifies and flags as outliers those plans that have unusually large numbers of drugs subject to prior authorization and/or step therapy requirements in the following USP classes: insulins; anti-diabetic agents; immunomodulators; immune suppressants; antivirals/anti-HIV agents (non-nucleoside reverse transcriptase inhibitors); antivirals/anti-HIV agents (nucleoside and nucleotide reverse transcriptase inhibitors); and antivirals/anti-HIV agents (protease inhibitors).

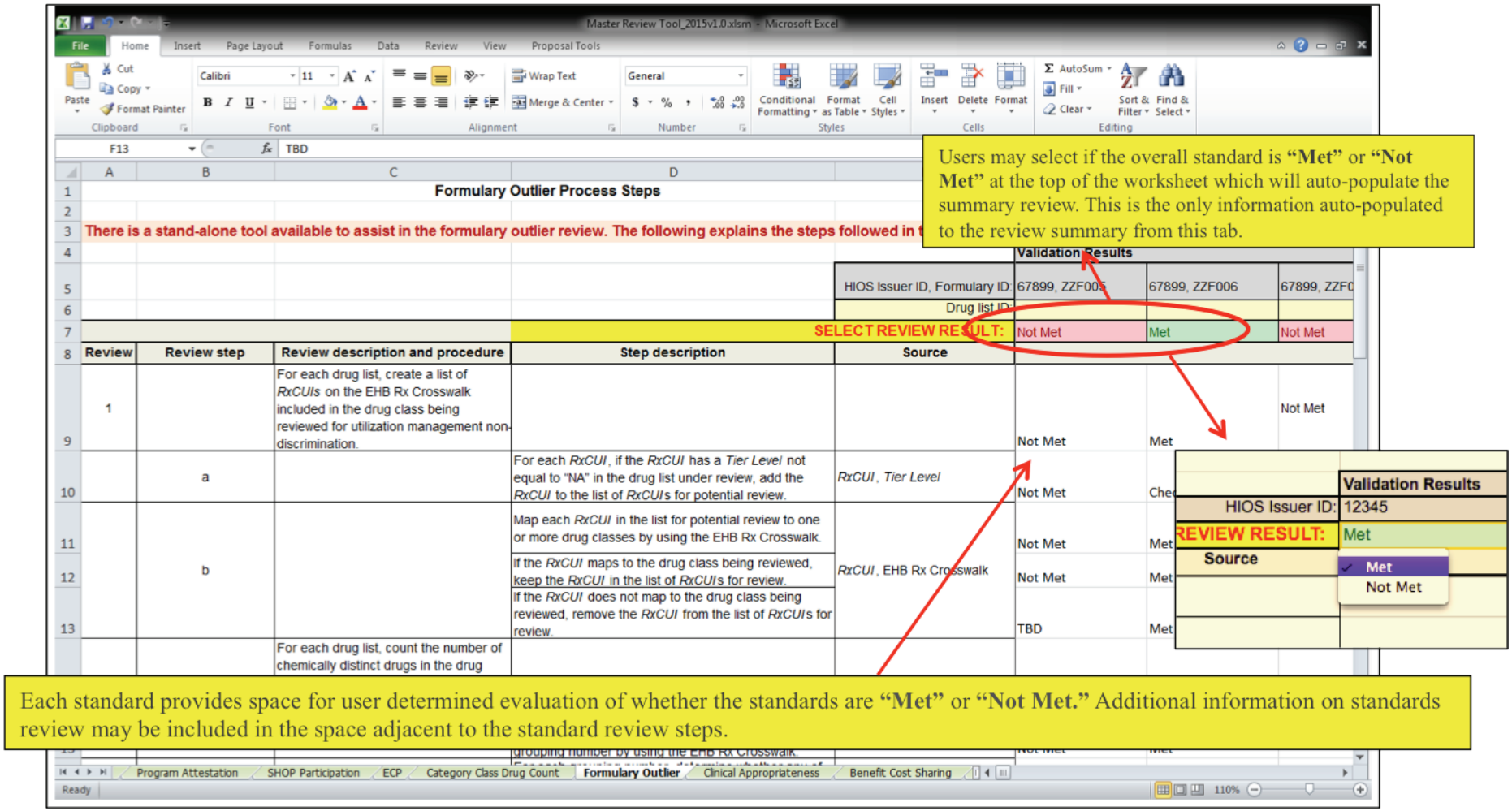
1. **Open** the QHP Application Review Tools folder and run the Non-Discrimination Formulary Outlier Tool for the drug lists you wish to evaluate. *See the Non-Discrimination Formulary Outliers Tool User Guide for instructions.*
2. **Open** the Non-Discrimination Formulary Outlier Tool tabs for the issuer's drug list you wish to evaluate.



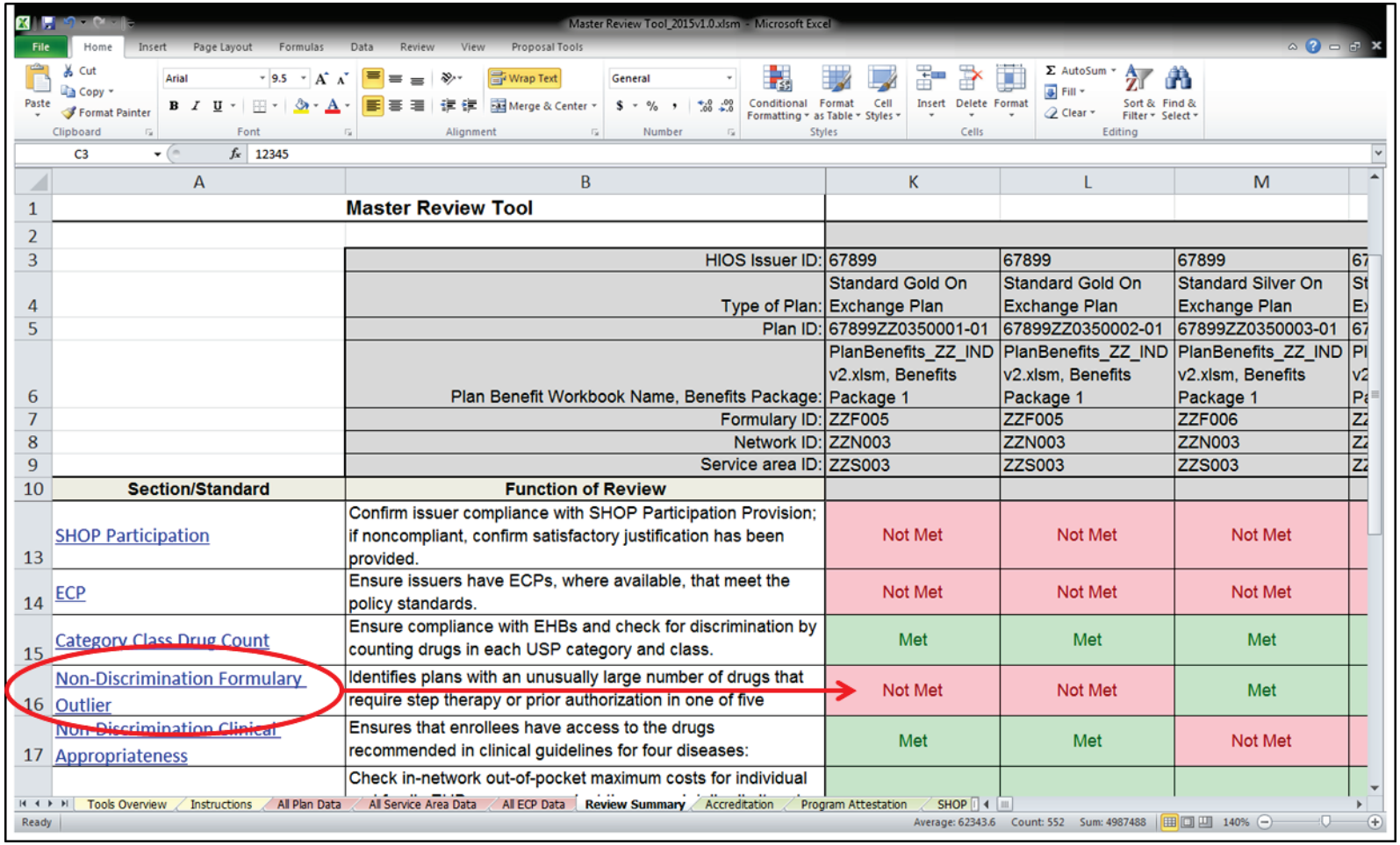
		Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors		Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors		Anti-HIV Agents, Protease Inhibitors		Anti-HIV Agents, Other		Blood Gluc Antidia
	Outlier Threshold	No Result - Too few drug lists to calculate a threshold		No Result - Too few drug lists to calculate a threshold		No Result - Too few drug lists to calculate a threshold		No Result - Too few drug lists to calculate a threshold		No Result lists to calc
	Benchmark Count	5		11		3		9		
Issuer ID	Drug List ID	UM Non-Discrimination Standard Met?	Unrestricted Count	Outlier Status	Unrestricted Count	Outlier Status	Unrestricted Count	Outlier Status	Unrestricted Count	Outlier Status	Unrestricte Count
12345	1	Met	5	N/A	11	N/A	9	N/A	3	N/A	19
12345	2	Met	5	N/A	11	N/A	9	N/A	3	N/A	19
12345	1	Met	5	N/A	11	N/A	9	N/A	3	N/A	19
12345	2	Met	5	N/A	11	N/A	9	N/A	3	N/A	19

			C	D	E	F
		Issuer ID	12345	12346	12347	12358
		Drug List ID	1	2	1	2
		Distinct Drug				
			Unrestricted	Unrestricted	Unrestricted	Unrestricted
			Unrestricted	Unrestricted	Unrestricted	Unrestricted
			Unrestricted	Unrestricted	Unrestricted	Unrestricted
			Unrestricted	Unrestricted	Unrestricted	Unrestricted
			Unrestricted	Unrestricted	Unrestricted	Unrestricted
		nt	5	5	5	5
		Count	5	5	5	5
			Unrestricted	Unrestricted	Unrestricted	Unrestricted
		udine	Unrestricted	Unrestricted	Unrestricted	Unrestricted
			Unrestricted	Unrestricted	Unrestricted	Unrestricted
			Unrestricted	Unrestricted	Unrestricted	Unrestricted
		nofovir	Unrestricted	Unrestricted	Unrestricted	Unrestricted
			Unrestricted	Unrestricted	Unrestricted	Unrestricted
			Unrestricted	Unrestricted	Unrestricted	Unrestricted
		oxil	Unrestricted	Unrestricted	Unrestricted	Unrestricted
20	Transcriptase Inhibitors	Zidovudine	Unrestricted	Unrestricted	Unrestricted	Unrestricted
21		Zidovudine; abacavir; Lamivudine	Unrestricted	Unrestricted	Unrestricted	Unrestricted
22		Zidovudine; Lamivudine	Unrestricted	Unrestricted	Unrestricted	Unrestricted
23		Covered Count	11	11	11	11
24		Unrestricted Count	11	11	11	11
25		Atazanavir	Unrestricted	Unrestricted	Unrestricted	Unrestricted
26		darunavir	Unrestricted	Unrestricted	Unrestricted	Unrestricted
27		fosamprenavir	Unrestricted	Unrestricted	Unrestricted	Unrestricted

3. Using the data in the *Non-Discrimination Formulary Outlier Tool Summary Results* tab, **go to** the Master Review Tool *Formulary Outlier* tab and indicate if an issuer's drug lists have met the formulary requirement. For each issuer's drug list, **populate "Met"** or **"Not Met"** from the drop-down menus at the top of each column in the SELECT REVIEW RESULT row.



4. **Open** the Master Review Tool *Review Summary* tab to see the auto-populated results in row 16.



Master Review Tool_2015v1.0.xlsm - Microsoft Excel

	A	B	K	L	M
1		**Master Review Tool**			
2					
3		HIOS Issuer ID:	67899	67899	67899
4		Type of Plan:	Standard Gold On Exchange Plan	Standard Gold On Exchange Plan	Standard Silver On Exchange Plan
5		Plan ID:	67899ZZ0350001-01	67899ZZ0350002-01	67899ZZ0350003-01
6		Plan Benefit Workbook Name, Benefits Package:	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1
7		Formulary ID:	ZZF005	ZZF005	ZZF006
8		Network ID:	ZZN003	ZZN003	ZZN003
9		Service area ID:	ZZS003	ZZS003	ZZS003
10	**Section/Standard**	**Function of Review**			
13	SHOP Participation	Confirm issuer compliance with SHOP Participation Provision; if noncompliant, confirm satisfactory justification has been provided.	Not Met	Not Met	Not Met
14	ECP	Ensure issuers have ECPs, where available, that meet the policy standards.	Not Met	Not Met	Not Met
15	Category Class Drug Count	Ensure compliance with EHBs and check for discrimination by counting drugs in each USP category and class.	Met	Met	Met
16	Non-Discrimination Formulary Outlier	Identifies plans with an unusually large number of drugs that require step therapy or prior authorization in one of five	Not Met	Not Met	Met
17	Non-Discrimination Clinical Appropriateness	Ensures that enrollees have access to the drugs recommended in clinical guidelines for four diseases:	Met	Met	Not Met
		Check in-network out-of-pocket maximum costs for individual			

Tools Overview | Instructions | All Plan Data | All Service Area Data | All ECP Data | Review Summary | Accreditation | Program Attestation | SHOP

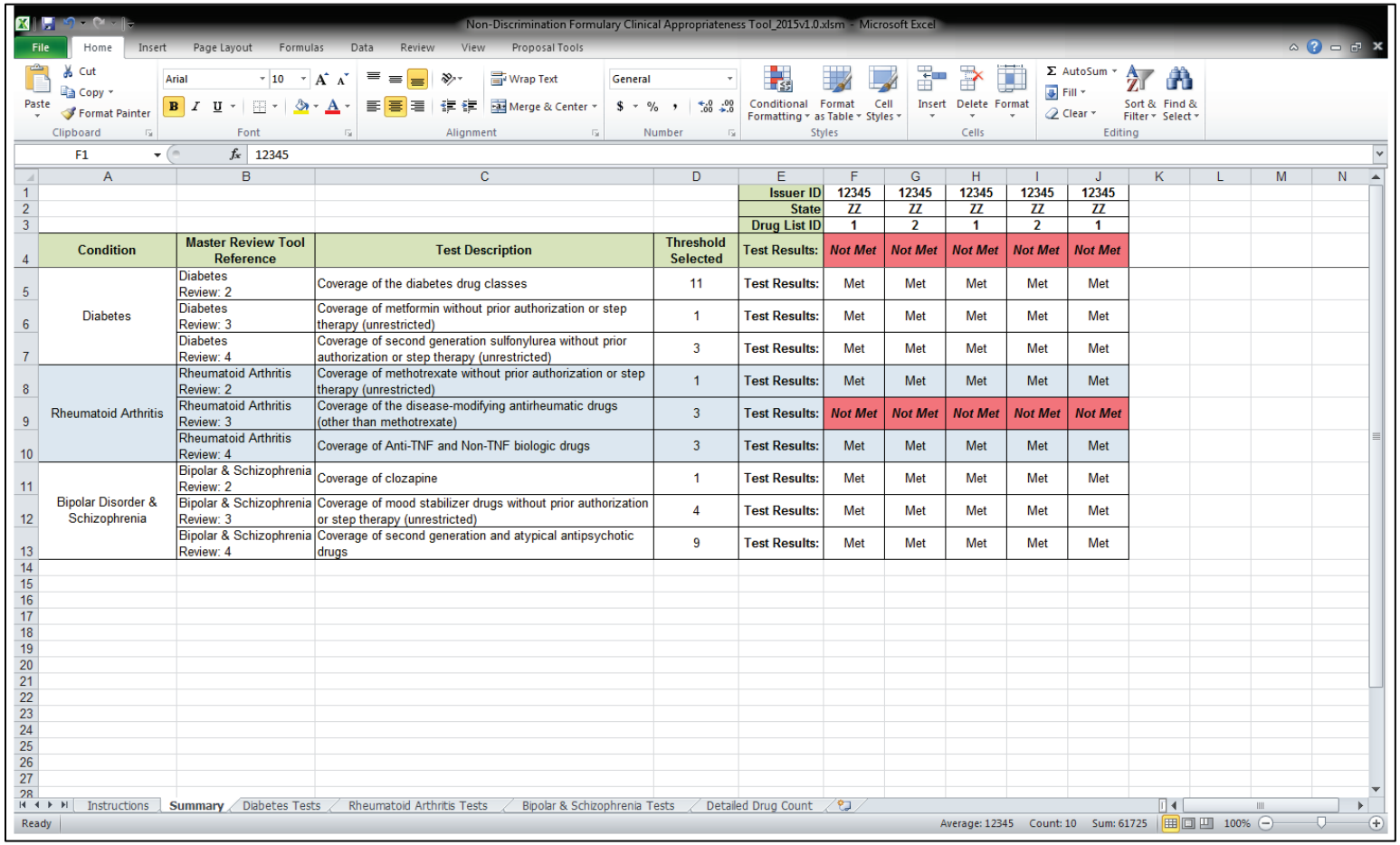
Ready — Average: 62343.6 Count: 552 Sum: 4987488 — 140%

5. **Save** the Master Review Tool after you have completed the formulary outlier review.

Non-Discrimination Formulary Clinical Appropriateness Tool

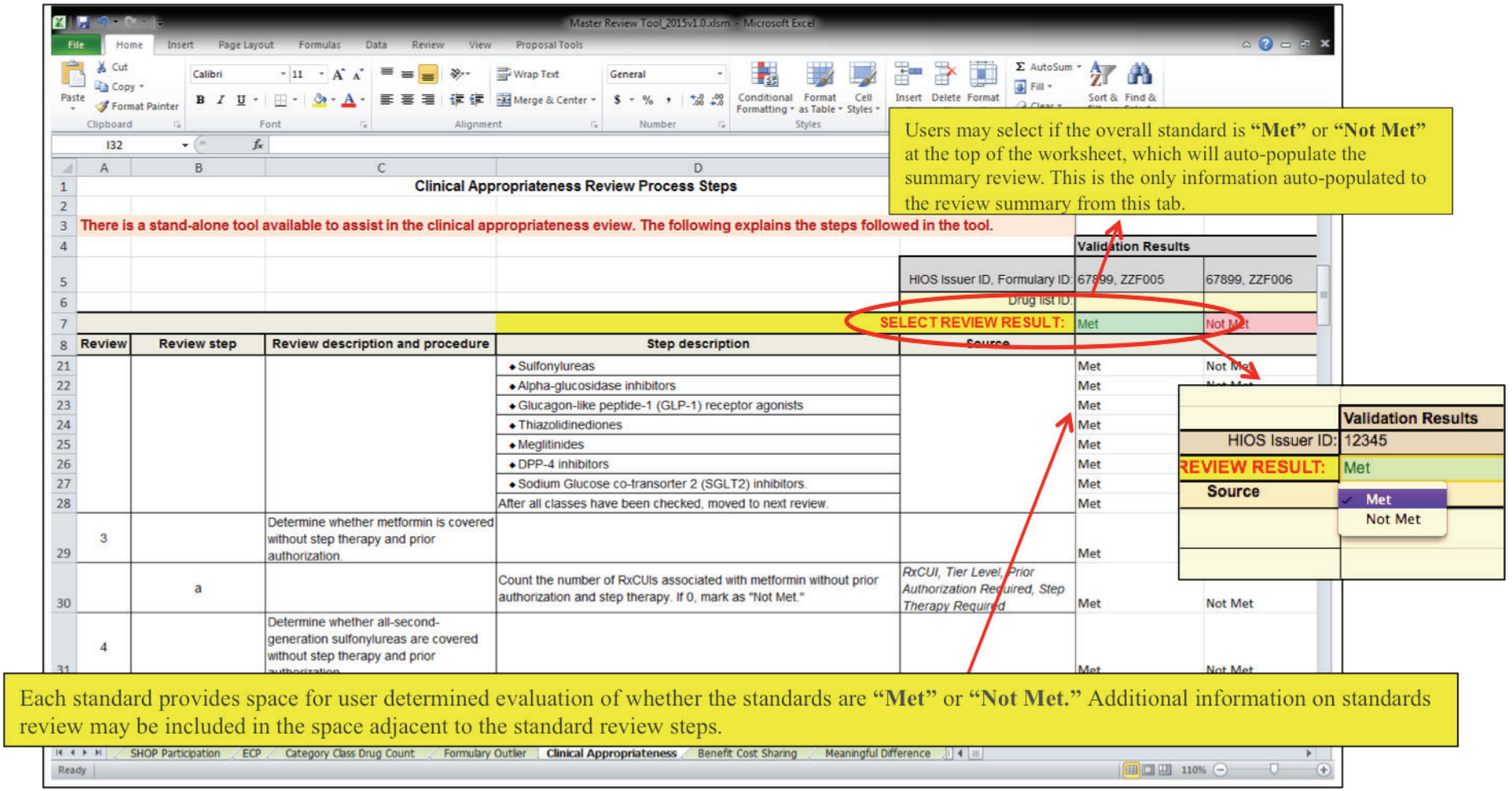
This tool analyzes the availability of covered drugs associated with four conditions (diabetes, rheumatoid arthritis, bipolar disorder, and schizophrenia), as recommended in clinical guidelines, to ensure issuers are offering a sufficient type and number of drugs.

1. **Open** the QHP Application Review Tools folder and **run** the Non-Discrimination Formulary Clinical Appropriateness Tool for the drug lists you wish to evaluate. *See the Non-Discrimination Formulary Clinical Appropriateness Tool User Guide for instructions.*
2. **Open** the Non-Discrimination Formulary Clinical Appropriateness Tool *Summary Results* tab for the issuer's drug list you wish to evaluate.

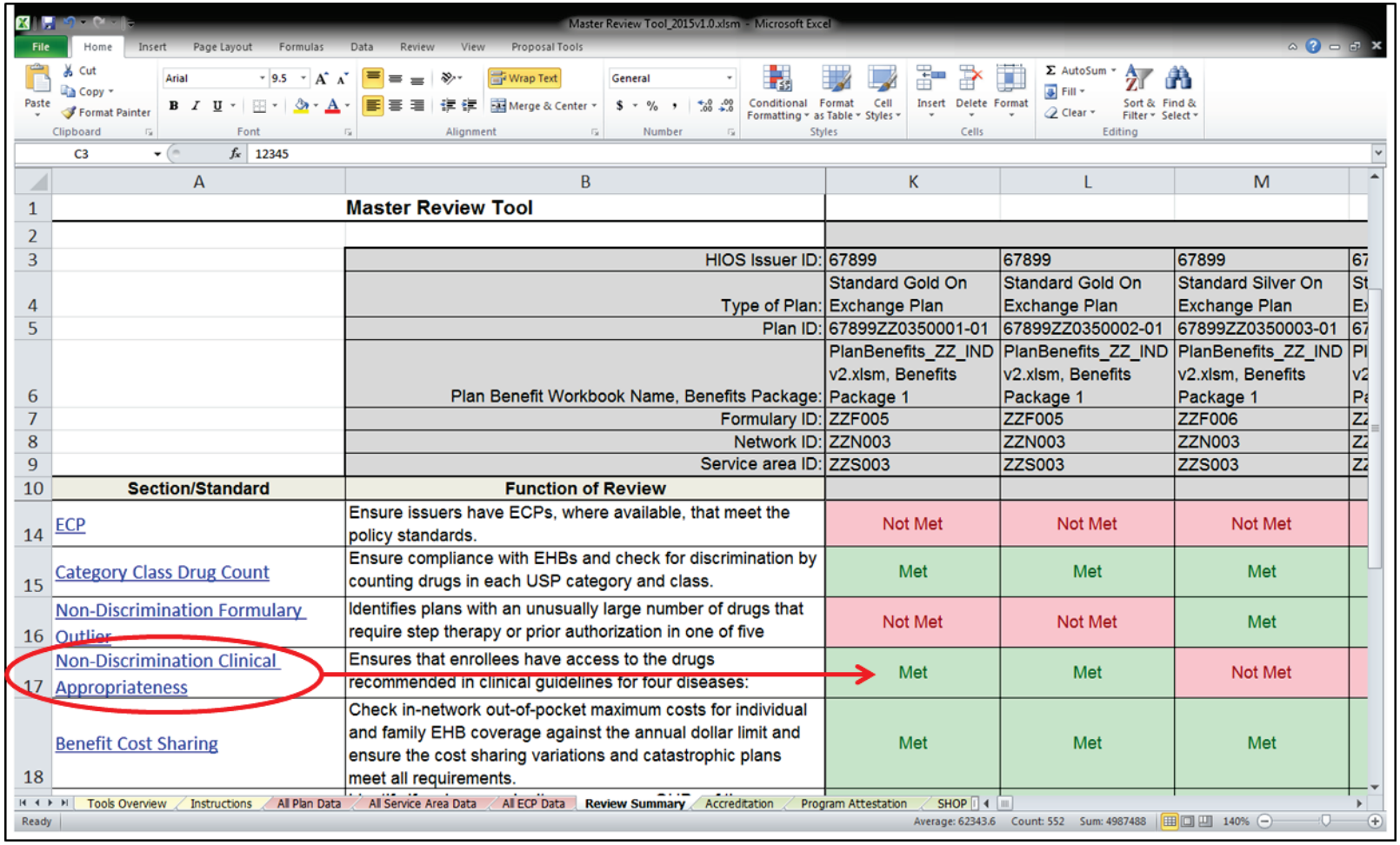


				Issuer ID	12345	12345	12345	12345	12345
				State	ZZ	ZZ	ZZ	ZZ	ZZ
				Drug List ID	1	2	1	2	1
Condition	Master Review Tool Reference	Test Description	Threshold Selected	Test Results:	Not Met	Not Met	Not Met	Not Met	Not Met
Diabetes	Diabetes Review: 2	Coverage of the diabetes drug classes	11	Test Results:	Met	Met	Met	Met	Met
	Diabetes Review: 3	Coverage of metformin without prior authorization or step therapy (unrestricted)	1	Test Results:	Met	Met	Met	Met	Met
	Diabetes Review: 4	Coverage of second generation sulfonylurea without prior authorization or step therapy (unrestricted)	3	Test Results:	Met	Met	Met	Met	Met
Rheumatoid Arthritis	Rheumatoid Arthritis Review: 2	Coverage of methotrexate without prior authorization or step therapy (unrestricted)	1	Test Results:	Met	Met	Met	Met	Met
	Rheumatoid Arthritis Review: 3	Coverage of the disease-modifying antirheumatic drugs (other than methotrexate)	3	Test Results:	Not Met	Not Met	Not Met	Not Met	Not Met
	Rheumatoid Arthritis Review: 4	Coverage of Anti-TNF and Non-TNF biologic drugs	3	Test Results:	Met	Met	Met	Met	Met
Bipolar Disorder & Schizophrenia	Bipolar & Schizophrenia Review: 2	Coverage of clozapine	1	Test Results:	Met	Met	Met	Met	Met
	Bipolar & Schizophrenia Review: 3	Coverage of mood stabilizer drugs without prior authorization or step therapy (unrestricted)	4	Test Results:	Met	Met	Met	Met	Met
	Bipolar & Schizophrenia Review: 4	Coverage of second generation and atypical antipsychotic drugs	9	Test Results:	Met	Met	Met	Met	Met

3. Using the data in Non-Discrimination Formulary Clinical Appropriateness Tool *Summary Results* tab, **go to** the Master Review Tool *Clinical Appropriateness* tab and indicate if an issuer's drug lists have met the formulary requirement. For each issuer's drug list, **populate "Met"** or **"Not Met"** from the drop-down menus at the top of each column in the SELECT REVIEW RESULT row.



4. When completed, **open** the Master Review Tool *Review Summary* tab to see the auto-populated results in row 17.



Master Review Tool_2015v1.0.xlsm - Microsoft Excel

	A	B	K	L	M
1		**Master Review Tool**			
2					
3		HIOS Issuer ID:	67899	67899	67899
4		Type of Plan:	Standard Gold On Exchange Plan	Standard Gold On Exchange Plan	Standard Silver On Exchange Plan
5		Plan ID:	67899ZZ0350001-01	67899ZZ0350002-01	67899ZZ0350003-01
6		Plan Benefit Workbook Name, Benefits Package:	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1
7		Formulary ID:	ZZF005	ZZF005	ZZF006
8		Network ID:	ZZN003	ZZN003	ZZN003
9		Service area ID:	ZZS003	ZZS003	ZZS003
10	**Section/Standard**	**Function of Review**			
14	ECP	Ensure issuers have ECPs, where available, that meet the policy standards.	Not Met	Not Met	Not Met
15	Category Class Drug Count	Ensure compliance with EHBs and check for discrimination by counting drugs in each USP category and class.	Met	Met	Met
16	Non-Discrimination Formulary Outlier	Identifies plans with an unusually large number of drugs that require step therapy or prior authorization in one of five	Not Met	Not Met	Met
17	Non-Discrimination Clinical Appropriateness	Ensures that enrollees have access to the drugs recommended in clinical guidelines for four diseases:	Met	Met	Not Met
18	Benefit Cost Sharing	Check in-network out-of-pocket maximum costs for individual and family EHB coverage against the annual dollar limit and ensure the cost sharing variations and catastrophic plans meet all requirements.	Met	Met	Met

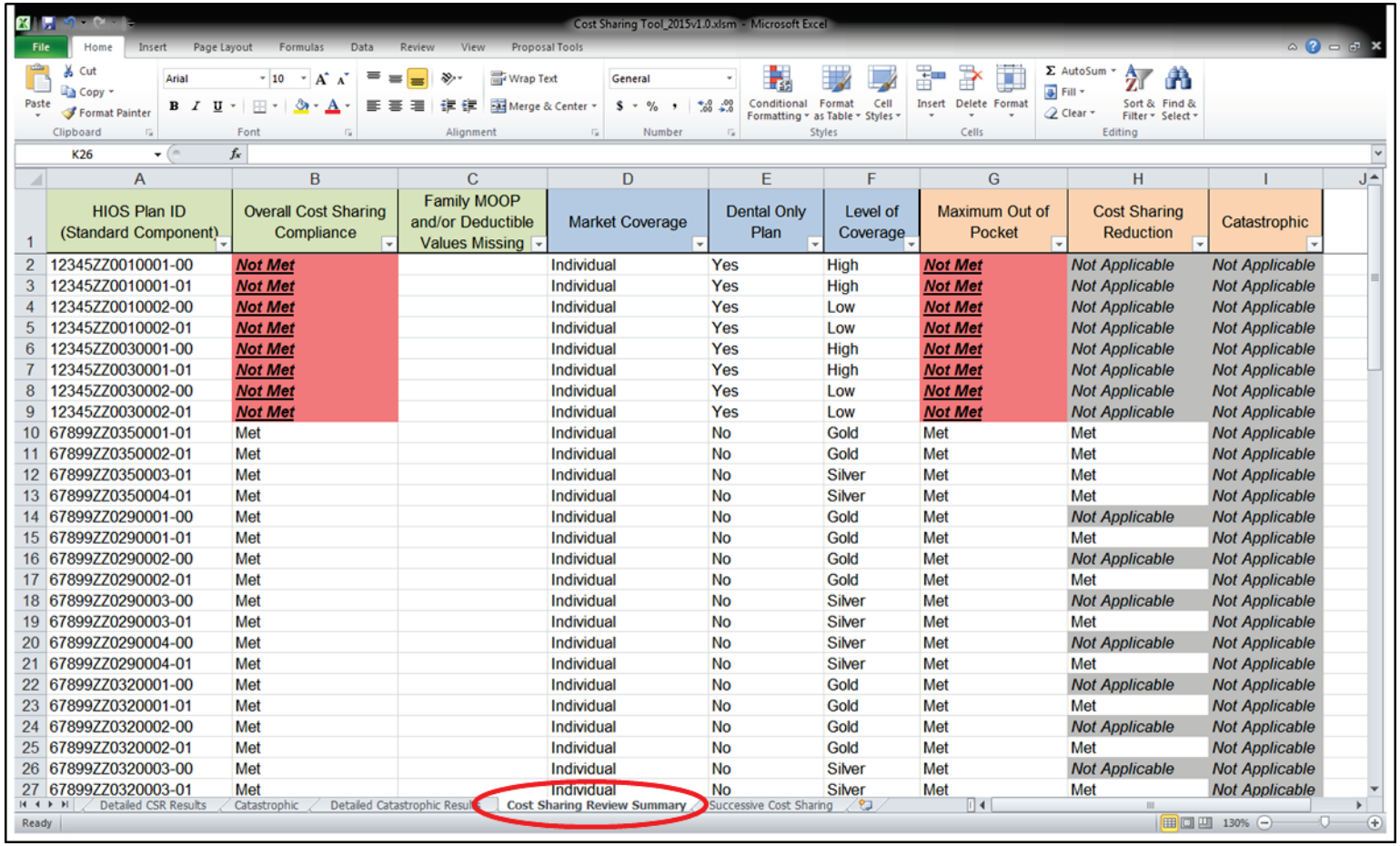
Tools Overview | Instructions | All Plan Data | All Service Area Data | All ECP Data | Review Summary | Accreditation | Program Attestation | SHOP

Ready — Average: 62343.6 Count: 552 Sum: 4987488 140%

5. **Save** the Master Review Tool after you have completed the clinical appropriateness review.

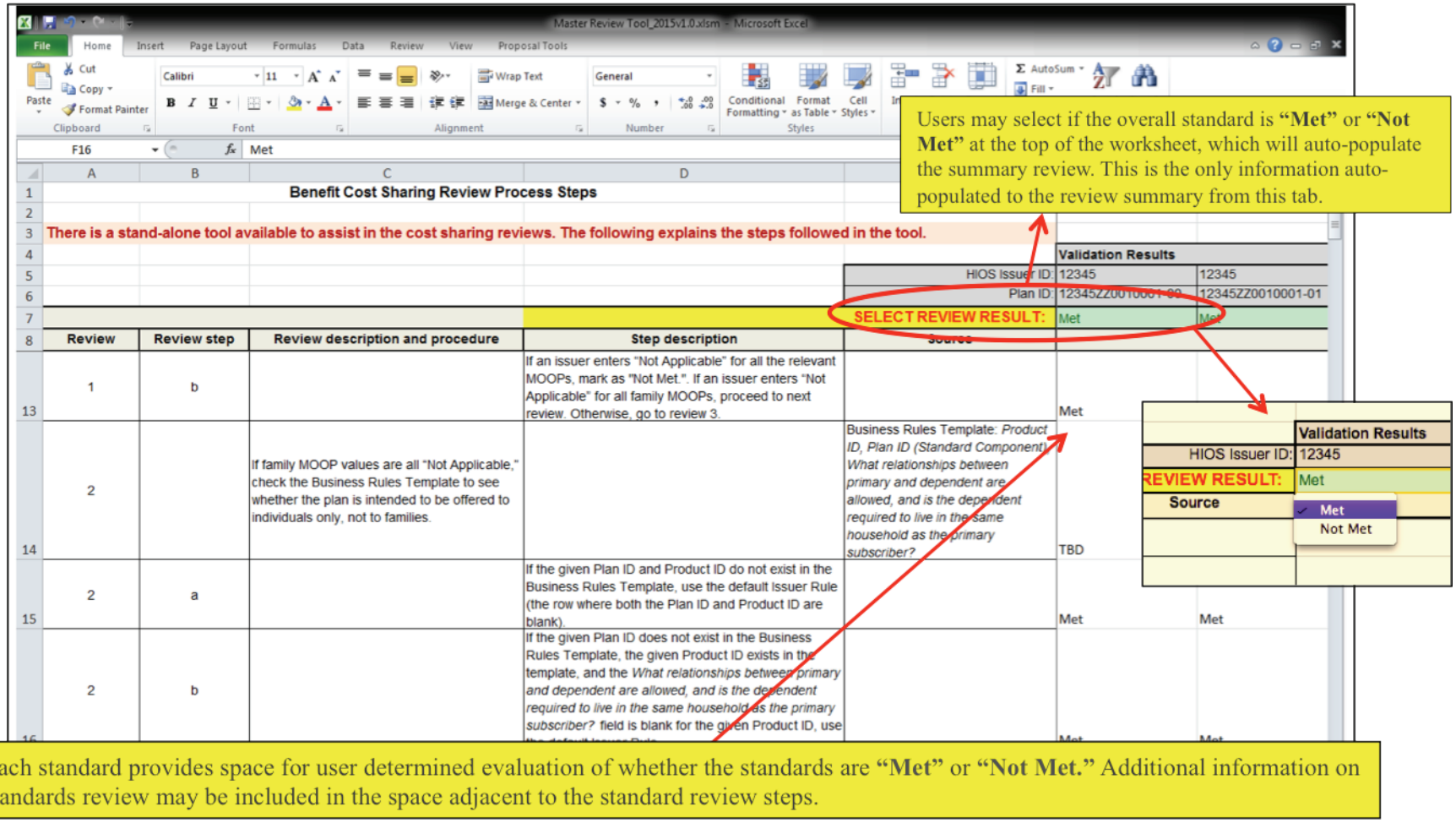
Benefit Cost Sharing Review

1. **Open** the QHP Application Review Tools folder and run the Cost Sharing Tool for all the plans you wish to evaluate. *See the Cost Sharing Tool User Guide for instructions.*
2. **Open** the Cost Sharing Tool Cost Sharing *Review Summary* tab to see the issuer's plans you wish to review.

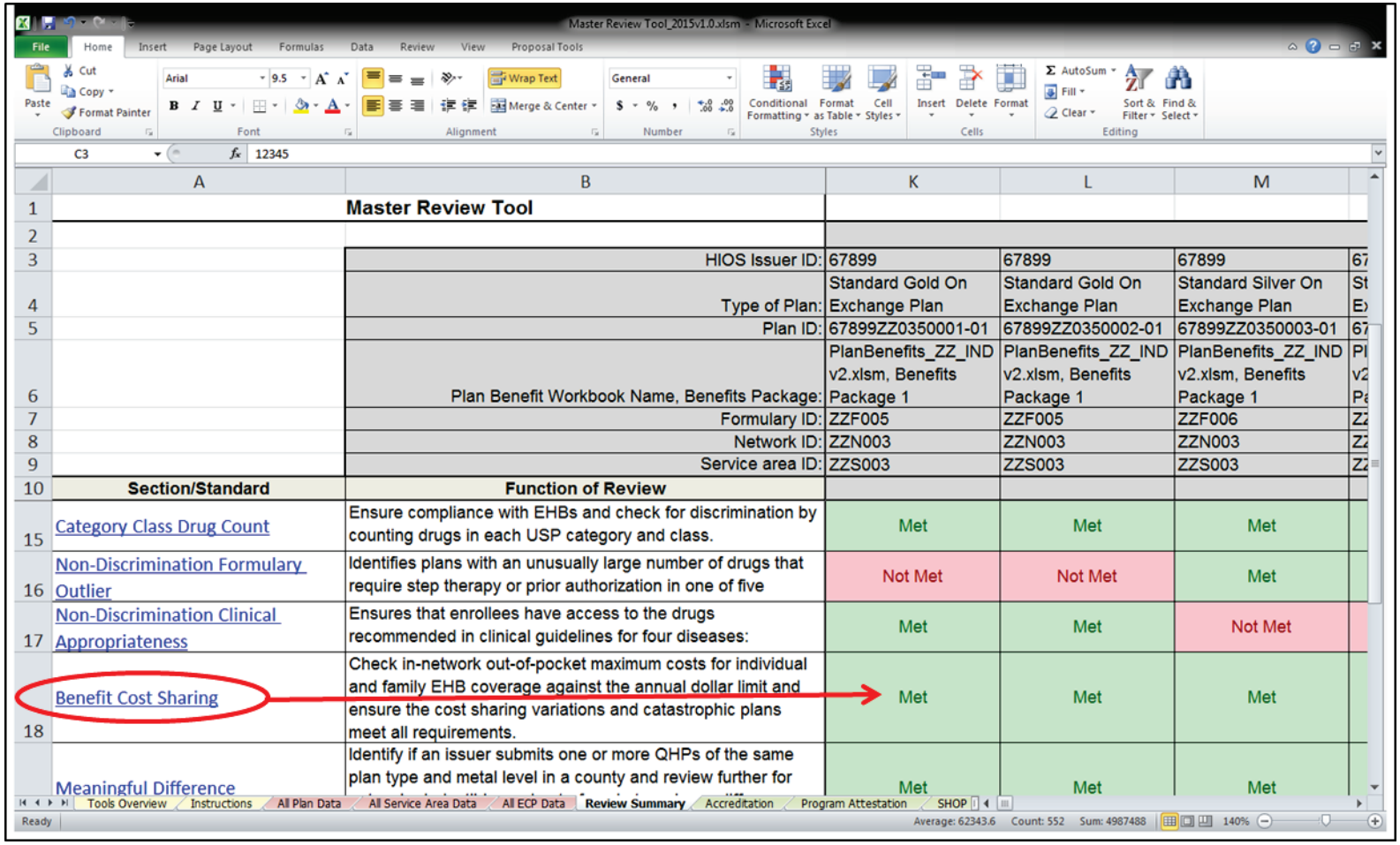


HIOS Plan ID (Standard Component)	Overall Cost Sharing Compliance	Family MOOP and/or Deductible Values Missing	Market Coverage	Dental Only Plan	Level of Coverage	Maximum Out of Pocket	Cost Sharing Reduction	Catastrophic
12345ZZ0010001-00	Not Met		Individual	Yes	High	Not Met	Not Applicable	Not Applicable
12345ZZ0010001-01	Not Met		Individual	Yes	High	Not Met	Not Applicable	Not Applicable
12345ZZ0010002-00	Not Met		Individual	Yes	Low	Not Met	Not Applicable	Not Applicable
12345ZZ0010002-01	Not Met		Individual	Yes	Low	Not Met	Not Applicable	Not Applicable
12345ZZ0030001-00	Not Met		Individual	Yes	High	Not Met	Not Applicable	Not Applicable
12345ZZ0030001-01	Not Met		Individual	Yes	High	Not Met	Not Applicable	Not Applicable
12345ZZ0030002-00	Not Met		Individual	Yes	Low	Not Met	Not Applicable	Not Applicable
12345ZZ0030002-01	Not Met		Individual	Yes	Low	Not Met	Not Applicable	Not Applicable
67899ZZ0350001-01	Met		Individual	No	Gold	Met	Met	Not Applicable
67899ZZ0350002-01	Met		Individual	No	Gold	Met	Met	Not Applicable
67899ZZ0350003-01	Met		Individual	No	Silver	Met	Met	Not Applicable
67899ZZ0350004-01	Met		Individual	No	Silver	Met	Met	Not Applicable
67899ZZ0290001-00	Met		Individual	No	Gold	Met	Not Applicable	Not Applicable
67899ZZ0290001-01	Met		Individual	No	Gold	Met	Met	Not Applicable
67899ZZ0290002-00	Met		Individual	No	Gold	Met	Not Applicable	Not Applicable
67899ZZ0290002-01	Met		Individual	No	Gold	Met	Met	Not Applicable
67899ZZ0290003-00	Met		Individual	No	Silver	Met	Not Applicable	Not Applicable
67899ZZ0290003-01	Met		Individual	No	Silver	Met	Met	Not Applicable
67899ZZ0290004-00	Met		Individual	No	Silver	Met	Not Applicable	Not Applicable
67899ZZ0290004-01	Met		Individual	No	Silver	Met	Met	Not Applicable
67899ZZ0320001-00	Met		Individual	No	Gold	Met	Not Applicable	Not Applicable
67899ZZ0320001-01	Met		Individual	No	Gold	Met	Met	Not Applicable
67899ZZ0320002-00	Met		Individual	No	Gold	Met	Not Applicable	Not Applicable
67899ZZ0320002-01	Met		Individual	No	Gold	Met	Met	Not Applicable
67899ZZ0320003-00	Met		Individual	No	Silver	Met	Not Applicable	Not Applicable
67899ZZ0320003-01	Met		Individual	No	Silver	Met	Met	Not Applicable

3. Using the data in the Cost Sharing Tool *Cost Sharing Review Summary* tab, **go to** the Master Review Tool *Benefit Cost Sharing* tab and **populate "Met"** or **"Not Met"** from the drop-down menus at the top of each column in the SELECT REVIEW RESULT row for each issuer.



4. **Open** the Master Review Tool *Review* Summary tab to see the auto-populated results in row 18.



Master Review Tool_2015v1.0.xlsm - Microsoft Excel

	A	B	K	L	M
1		**Master Review Tool**			
2					
3		HIOS Issuer ID:	67899	67899	67899
4		Type of Plan:	Standard Gold On Exchange Plan	Standard Gold On Exchange Plan	Standard Silver On Exchange Plan
5		Plan ID:	67899ZZ0350001-01	67899ZZ0350002-01	67899ZZ0350003-01
6		Plan Benefit Workbook Name, Benefits Package:	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1	PlanBenefits_ZZ_IND v2.xlsm, Benefits Package 1
7		Formulary ID:	ZZF005	ZZF005	ZZF006
8		Network ID:	ZZN003	ZZN003	ZZN003
9		Service area ID:	ZZS003	ZZS003	ZZS003
10	**Section/Standard**	**Function of Review**			
15	Category Class Drug Count	Ensure compliance with EHBs and check for discrimination by counting drugs in each USP category and class.	Met	Met	Met
16	Non-Discrimination Formulary Outlier	Identifies plans with an unusually large number of drugs that require step therapy or prior authorization in one of five	Not Met	Not Met	Met
17	Non-Discrimination Clinical Appropriateness	Ensures that enrollees have access to the drugs recommended in clinical guidelines for four diseases:	Met	Met	Not Met
18	Benefit Cost Sharing	Check in-network out-of-pocket maximum costs for individual and family EHB coverage against the annual dollar limit and ensure the cost sharing variations and catastrophic plans meet all requirements.	Met	Met	Met
	Meaningful Difference	Identify if an issuer submits one or more QHPs of the same plan type and metal level in a county and review further for	Met	Met	Met

Tools Overview | Instructions | All Plan Data | All Service Area Data | All ECP Data | Review Summary | Accreditation | Program Attestation | SHOP

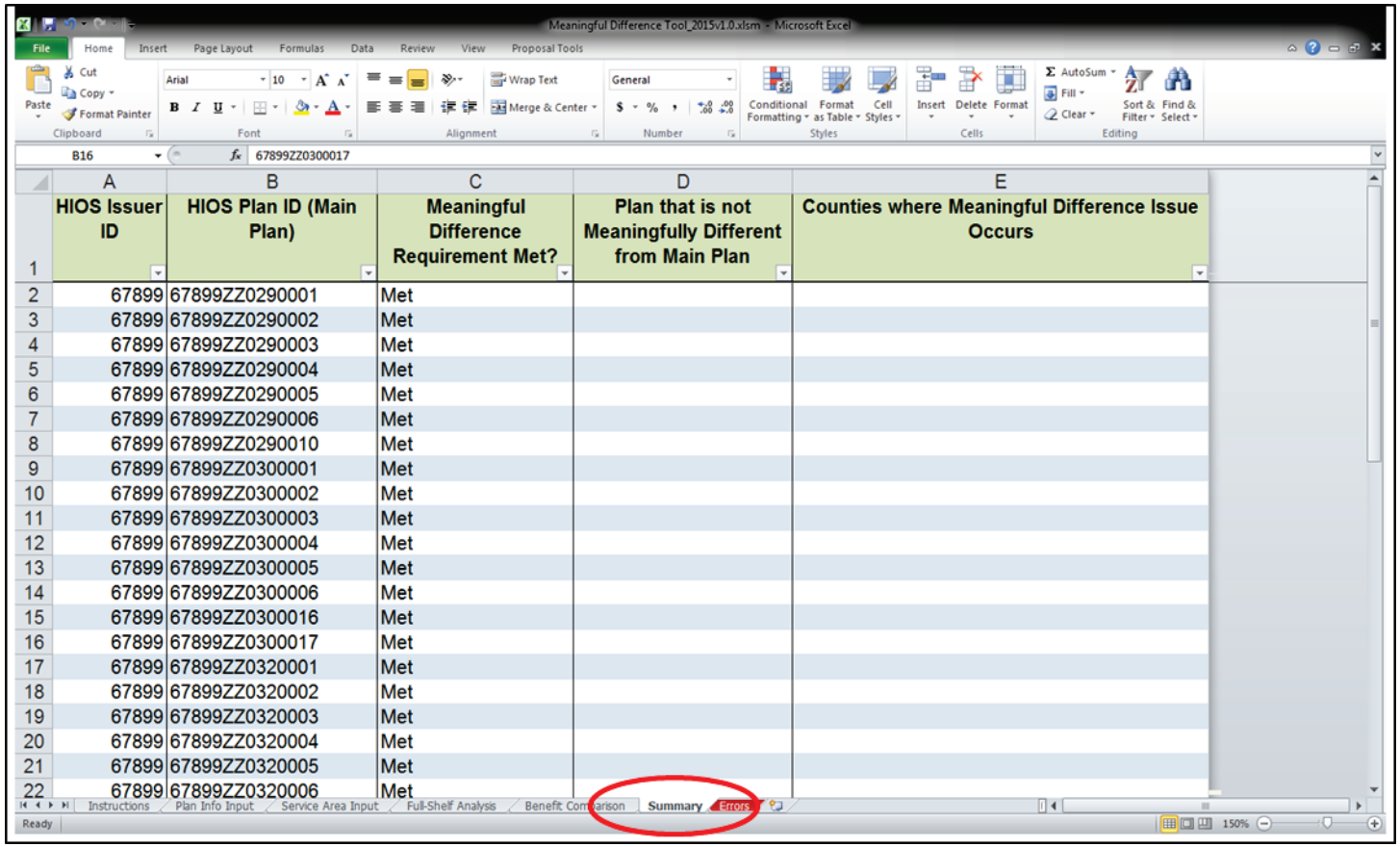
Ready — Average: 62343.6 Count: 552 Sum: 4987488 140%

5. **Save** the Master Review Tool after you have completed the benefit cost sharing review.

Meaningful Difference Review

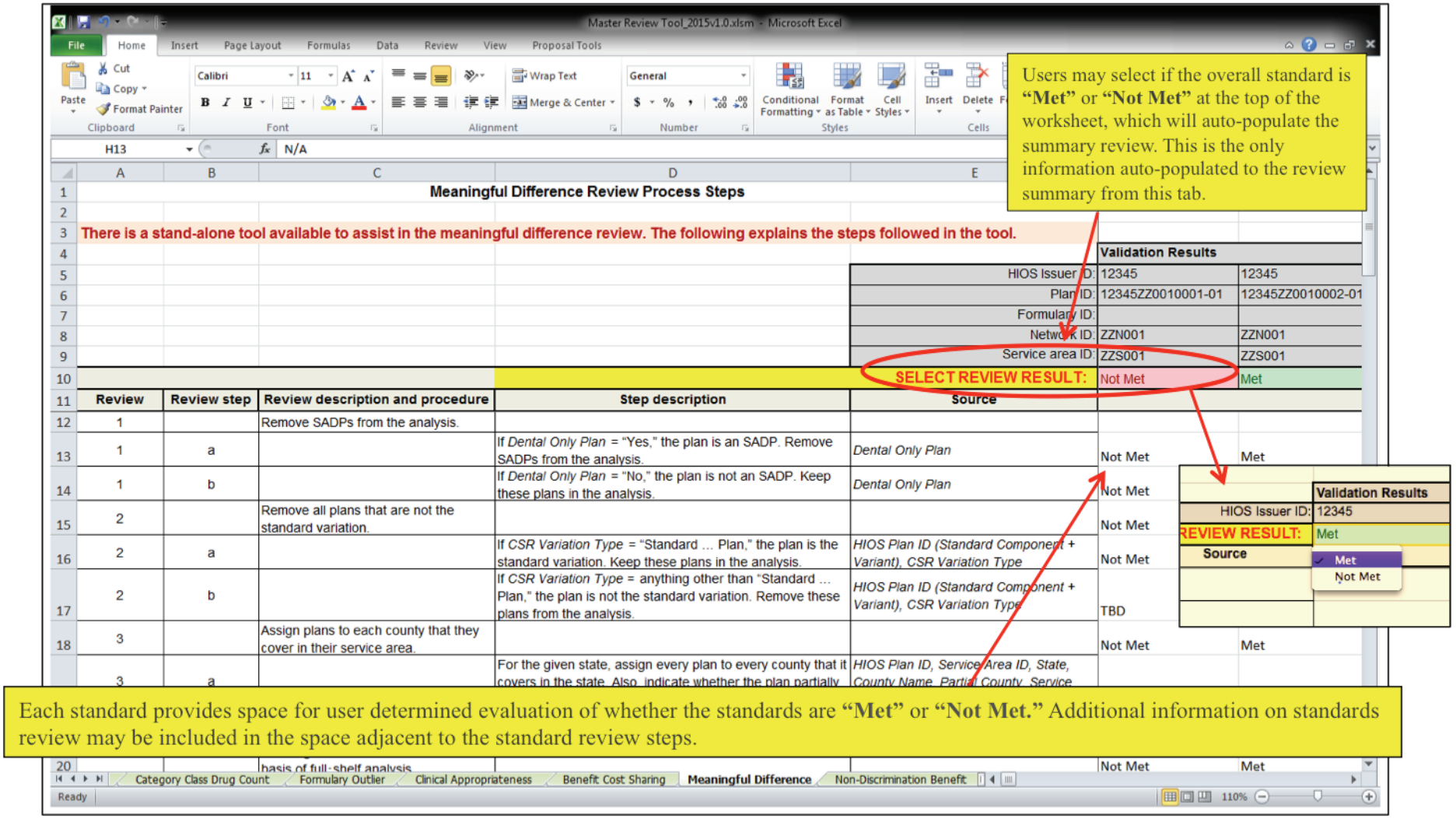
The meaningful difference review process in the Master Review Tool reviews an issuer's QHPs of the same plan type and metal level in a county for substantial differences.

1. **Open** the QHP Application Review Tools folder and **run** the Meaningful Difference Tool for all the plans you wish to evaluate. *See the Meaningful Difference Tool User Guide for instructions.*
2. **Open** the Meaningful Difference Tool *Summary* tab to see the issuer's plans you wish to review.

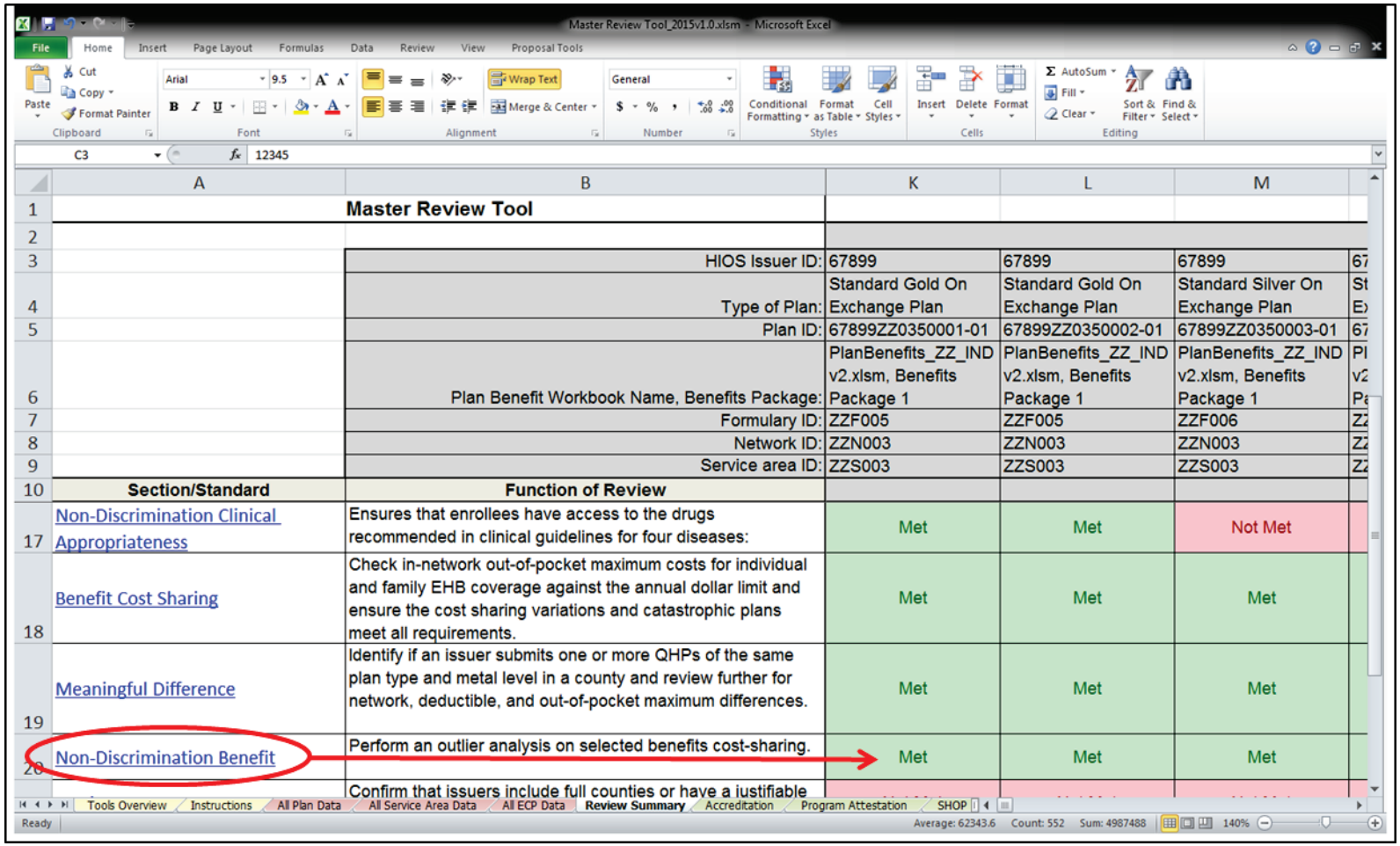


1	A HIOS Issuer ID	B HIOS Plan ID (Main Plan)	C Meaningful Difference Requirement Met?	D Plan that is not Meaningfully Different from Main Plan	E Counties where Meaningful Difference Issue Occurs
2	67899	67899ZZ0290001	Met		
3	67899	67899ZZ0290002	Met		
4	67899	67899ZZ0290003	Met		
5	67899	67899ZZ0290004	Met		
6	67899	67899ZZ0290005	Met		
7	67899	67899ZZ0290006	Met		
8	67899	67899ZZ0290010	Met		
9	67899	67899ZZ0300001	Met		
10	67899	67899ZZ0300002	Met		
11	67899	67899ZZ0300003	Met		
12	67899	67899ZZ0300004	Met		
13	67899	67899ZZ0300005	Met		
14	67899	67899ZZ0300006	Met		
15	67899	67899ZZ0300016	Met		
16	67899	67899ZZ0300017	Met		
17	67899	67899ZZ0320001	Met		
18	67899	67899ZZ0320002	Met		
19	67899	67899ZZ0320003	Met		
20	67899	67899ZZ0320004	Met		
21	67899	67899ZZ0320005	Met		
22	67899	67899ZZ0320006	Met		

3. Using the data in the Meaningful Difference Tool *Summary* tab, **go to** the Master Review Tool *Meaningful Difference* tab. **Populate "Met"** or **"Not Met"** from the drop-down menus at the top of each column in the SELECT REVIEW RESULT row for each issuer.



4. After you have **manually populated "Met"** or **"Not Met"** for each issuer's plan in the Master Review Tool *Meaningful Difference* tab, **open** the Master Review Tool *Review Summary* tab to see the auto-populated results in row 19.

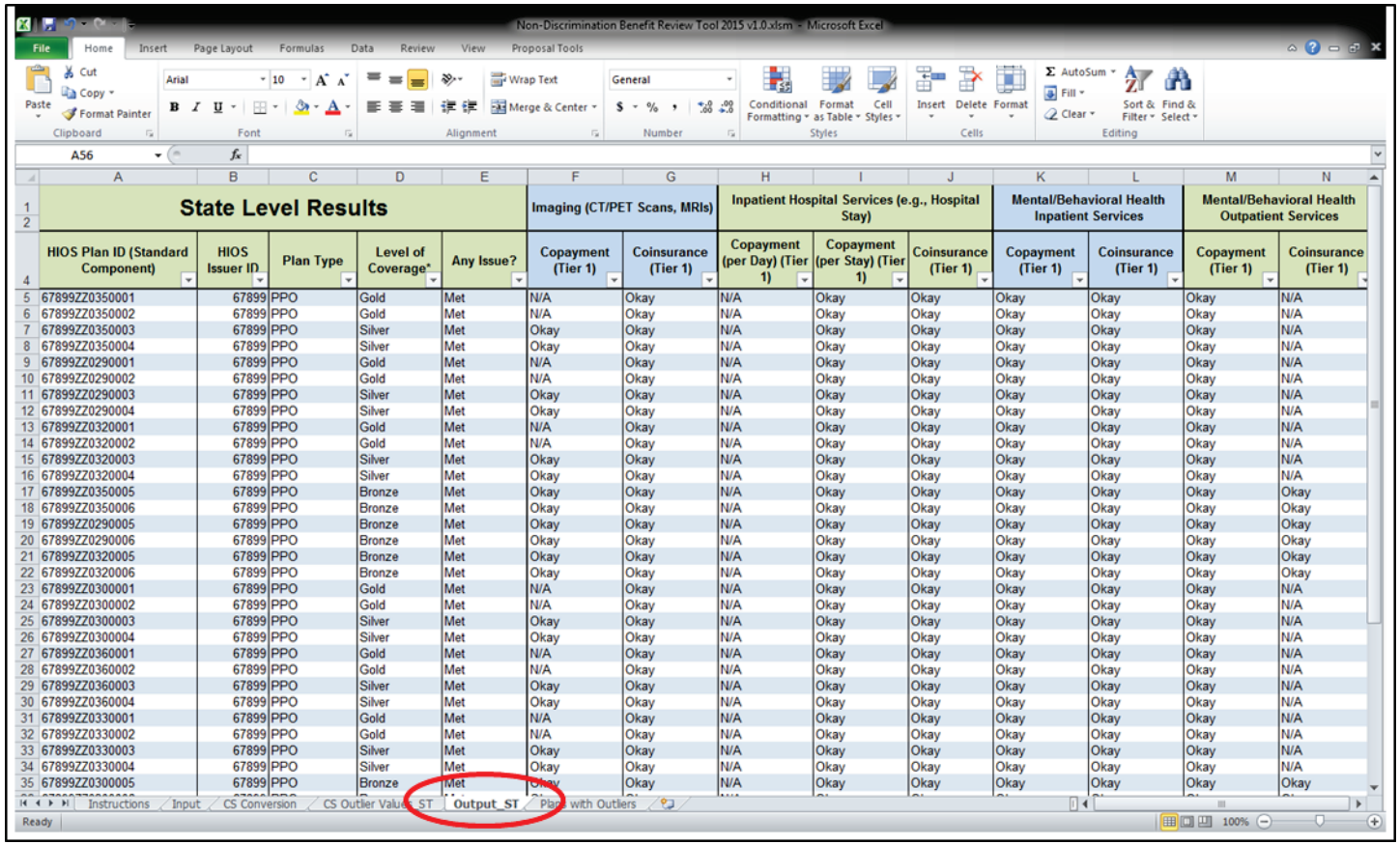


5. **Save** the Master Review Tool after you have completed the meaningful difference review.

Non-Discrimination Benefit Review

The non-discrimination benefit review conducts plan-level analyses targeting areas where discrimination would most likely occur, consistent with applicable regulations, to ensure that issuers do not employ benefit designs that discourage enrollment of individuals with significant health needs.

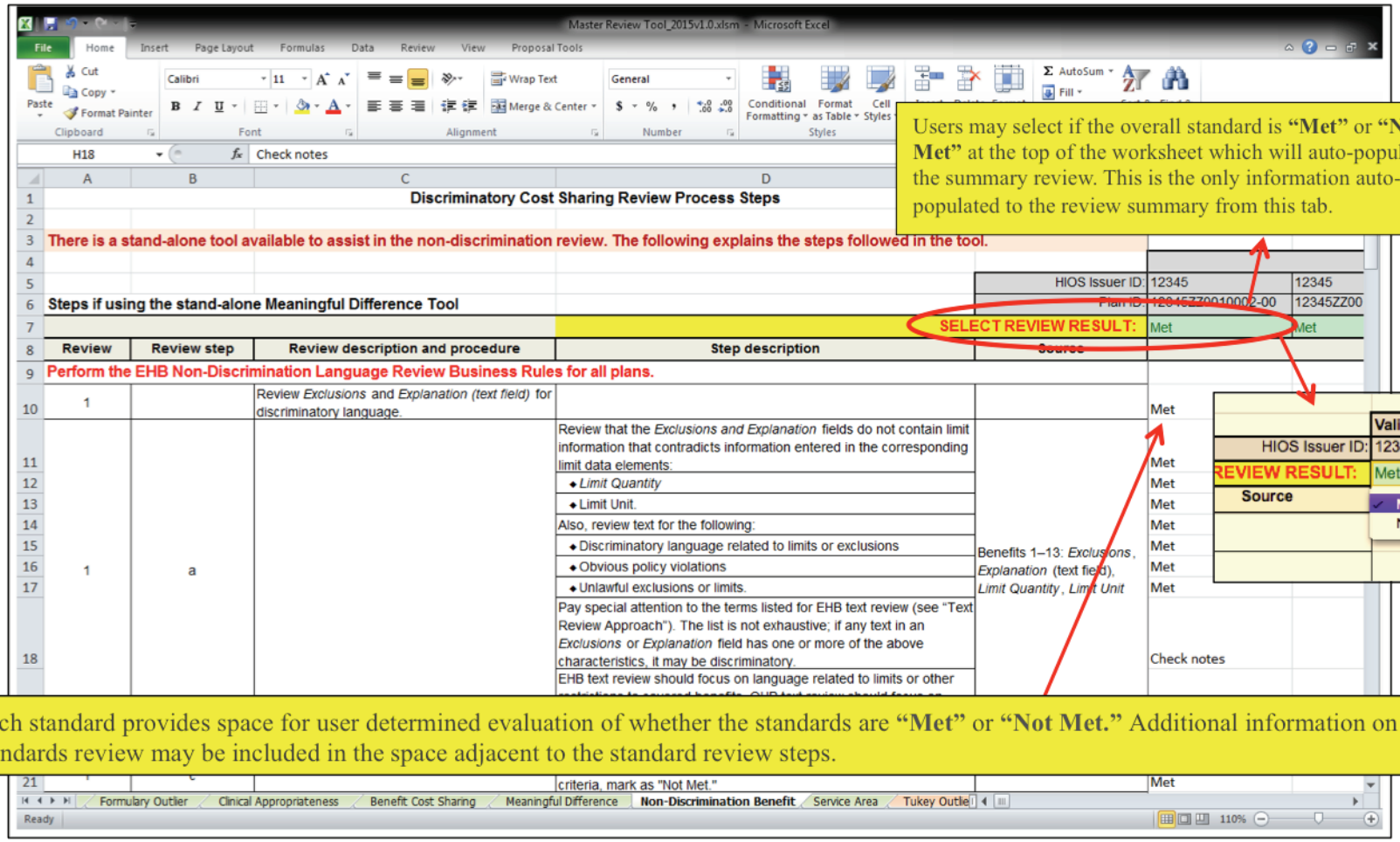
1. **Open** the QHP Application Review Tools folder and **run** the Non-Discrimination Benefit Tool for all the plans you wish to evaluate. *See the Non-Discrimination Benefit Review Tool User Guide for instructions*.
2. **Open** the Non-Discrimination Benefit Review Tool *output* tab to see the issuer's plans you wish to review.



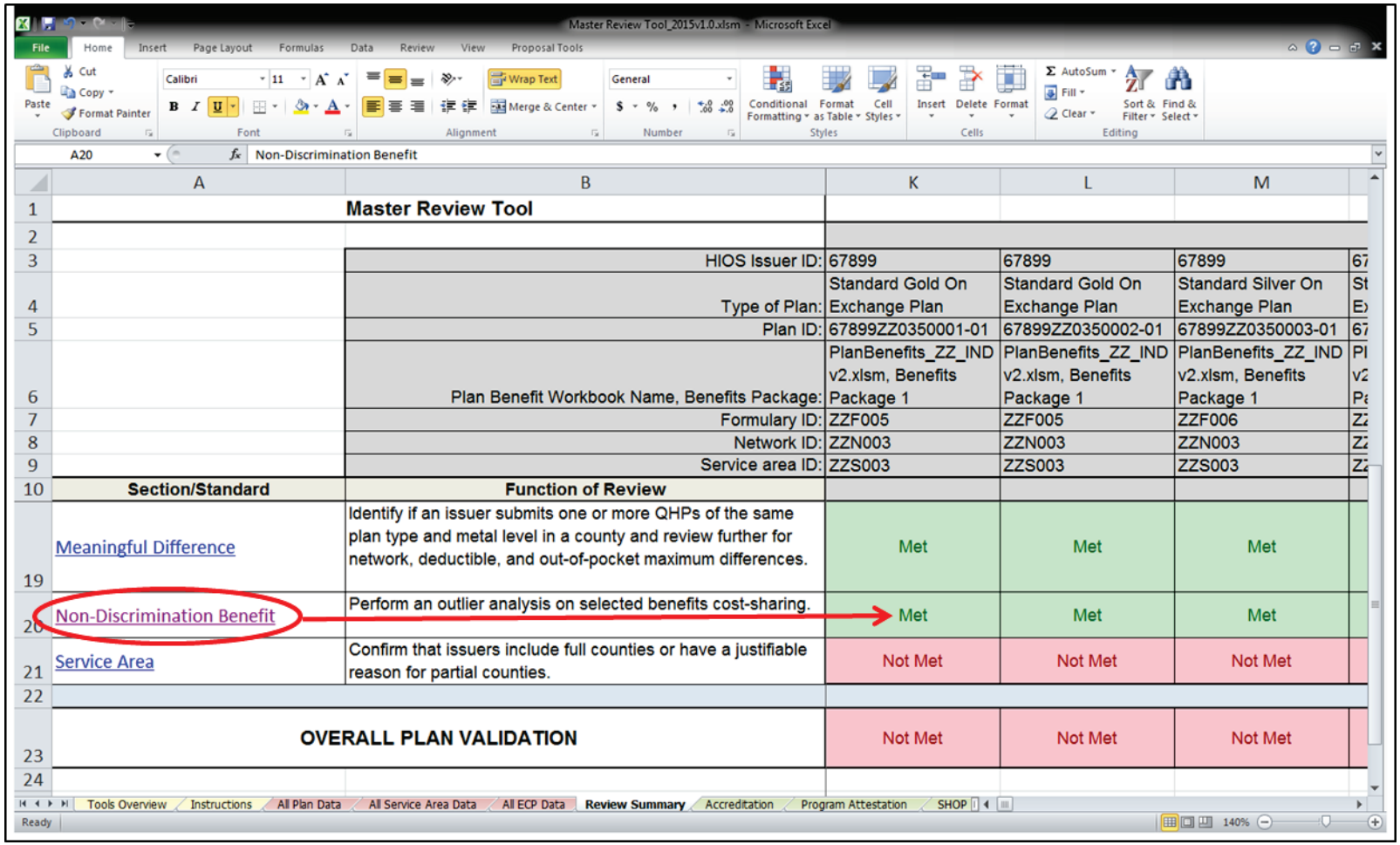
Non-Discrimination Benefit Review Tool 2015 v1.0.xlsm - Microsoft Excel

State Level Results					Imaging (CT/PET Scans, MRIs)		Inpatient Hospital Services (e.g., Hospital Stay)			Mental/Behavioral Health Inpatient Services		Mental/Behavioral Health Outpatient Services	
HIOS Plan ID (Standard Component)	HIOS Issuer ID	Plan Type	Level of Coverage*	Any Issue?	Copayment (Tier 1)	Coinsurance (Tier 1)	Copayment (per Day) (Tier 1)	Copayment (per Stay) (Tier 1)	Coinsurance (Tier 1)	Copayment (Tier 1)	Coinsurance (Tier 1)	Copayment (Tier 1)	Coinsurance (Tier 1)
67899ZZ0350001	67899	PPO	Gold	Met	N/A	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0350002	67899	PPO	Gold	Met	N/A	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0350003	67899	PPO	Silver	Met	Okay	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0350004	67899	PPO	Silver	Met	Okay	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0290001	67899	PPO	Gold	Met	N/A	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0290002	67899	PPO	Gold	Met	N/A	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0290003	67899	PPO	Silver	Met	Okay	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0290004	67899	PPO	Silver	Met	Okay	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0320001	67899	PPO	Gold	Met	N/A	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0320002	67899	PPO	Gold	Met	N/A	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0320003	67899	PPO	Silver	Met	Okay	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0320004	67899	PPO	Silver	Met	Okay	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0350005	67899	PPO	Bronze	Met	Okay	Okay	N/A	Okay	Okay	Okay	Okay	Okay	Okay
67899ZZ0350006	67899	PPO	Bronze	Met	Okay	Okay	N/A	Okay	Okay	Okay	Okay	Okay	Okay
67899ZZ0290005	67899	PPO	Bronze	Met	Okay	Okay	N/A	Okay	Okay	Okay	Okay	Okay	Okay
67899ZZ0290006	67899	PPO	Bronze	Met	Okay	Okay	N/A	Okay	Okay	Okay	Okay	Okay	Okay
67899ZZ0320005	67899	PPO	Bronze	Met	Okay	Okay	N/A	Okay	Okay	Okay	Okay	Okay	Okay
67899ZZ0320006	67899	PPO	Bronze	Met	Okay	Okay	N/A	Okay	Okay	Okay	Okay	Okay	Okay
67899ZZ0300001	67899	PPO	Gold	Met	N/A	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0300002	67899	PPO	Gold	Met	N/A	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0300003	67899	PPO	Silver	Met	Okay	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0300004	67899	PPO	Silver	Met	Okay	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0360001	67899	PPO	Gold	Met	N/A	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0360002	67899	PPO	Gold	Met	N/A	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0360003	67899	PPO	Silver	Met	Okay	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0360004	67899	PPO	Silver	Met	Okay	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0330001	67899	PPO	Gold	Met	N/A	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0330002	67899	PPO	Gold	Met	N/A	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0330003	67899	PPO	Silver	Met	Okay	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0330004	67899	PPO	Silver	Met	Okay	Okay	N/A	Okay	Okay	Okay	Okay	Okay	N/A
67899ZZ0300005	67899	PPO	Bronze	Met	Okay	Okay	N/A	Okay	Okay	Okay	Okay	Okay	Okay

3. Using the data in the Meaningful Difference Tool *summary* tab, **go to** the *Non-Discrimination Benefits* tab in the Master Review Tool. **Populate "Met"** or **"Not Met"** from the drop-down menus at the top of each column in the SELECT REVIEW RESULT row for each issuer.



4. After you have populated **"Met"** or **"Not Met"** for each issuer's plan in the Master Review Tool *Non-Discrimination* tab, **open** the Master Review Tool *Review Summary* tab to see the auto-populated results in row 21.

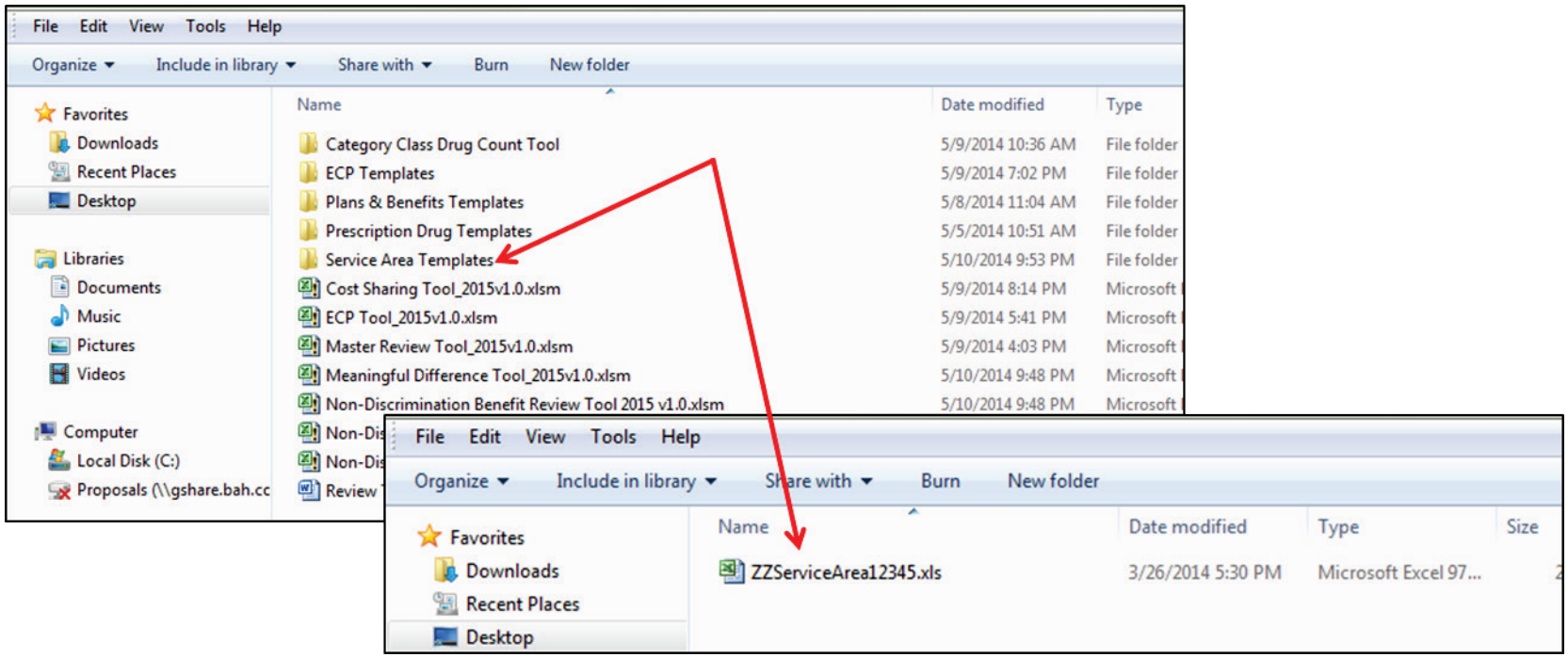


5. **Save** the Master Review Tool after you have completed the non-discrimination benefit review.

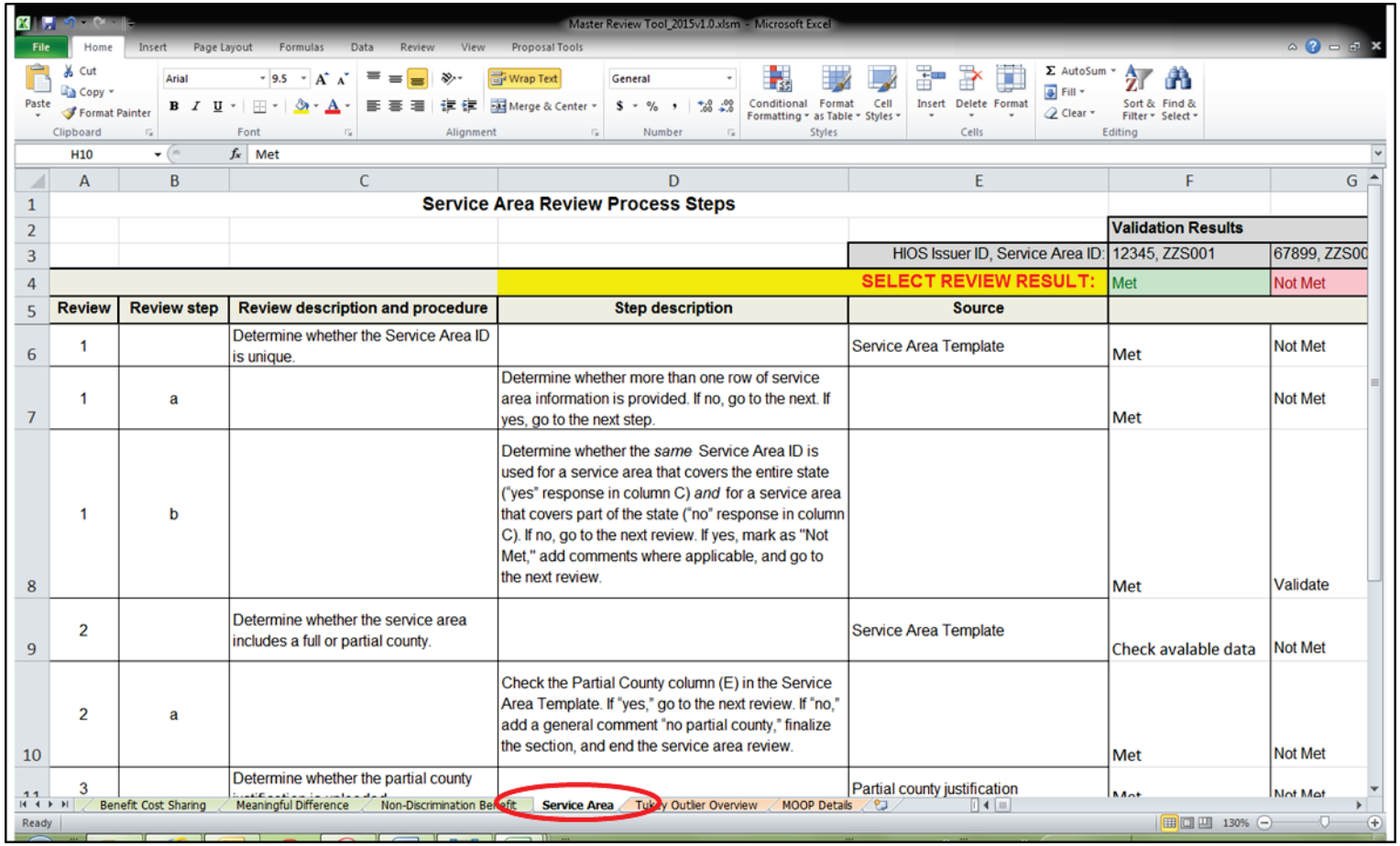
Service Area Review Screen shot of Master Review Tool

The service area review verifies that each service area meets geographic standards set forth in the Exchange Final Rule (http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf) and is nondiscriminatory (e.g., service areas of at least an entire county).

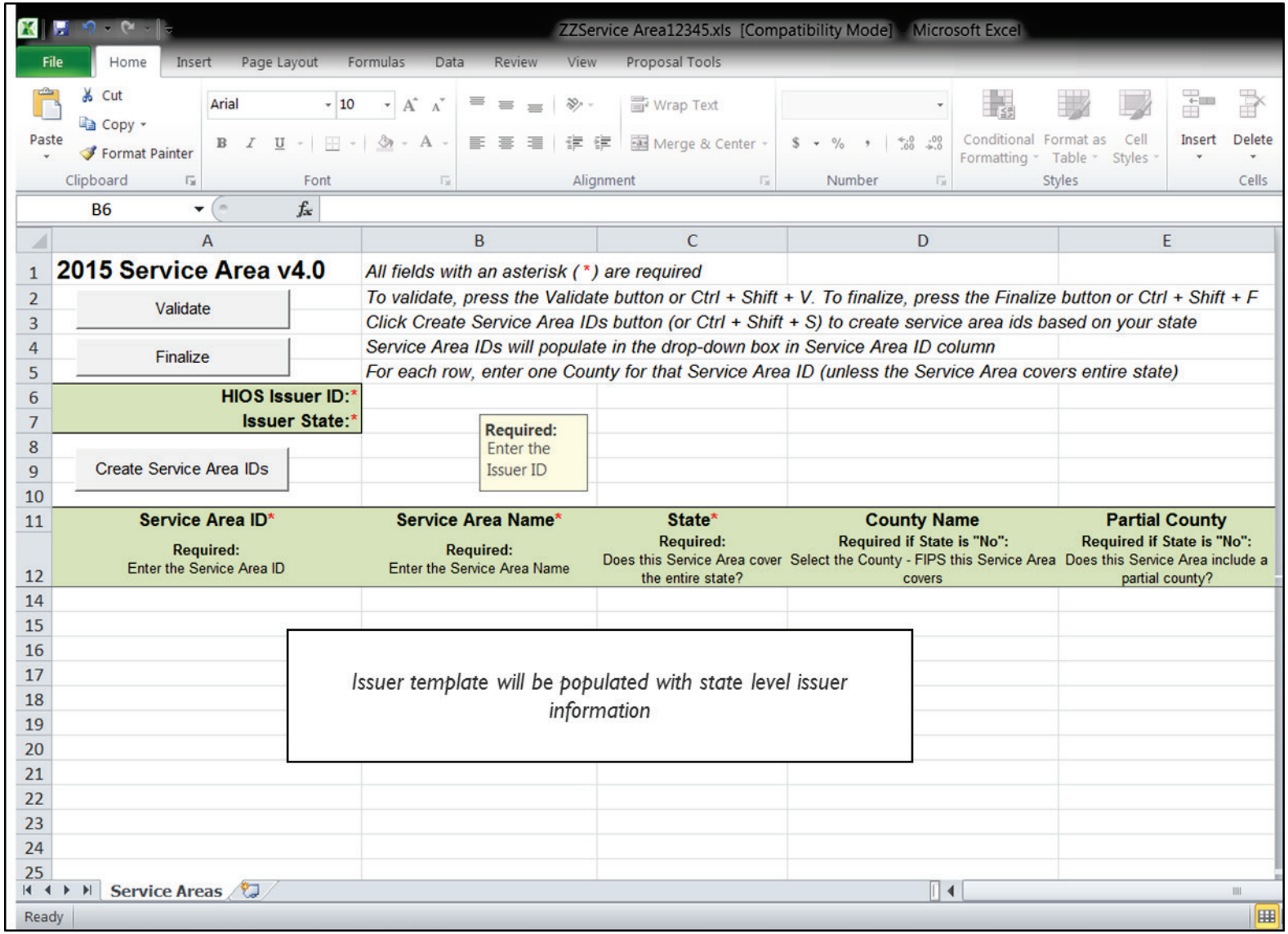
1. Use the service area templates to complete the service area review.



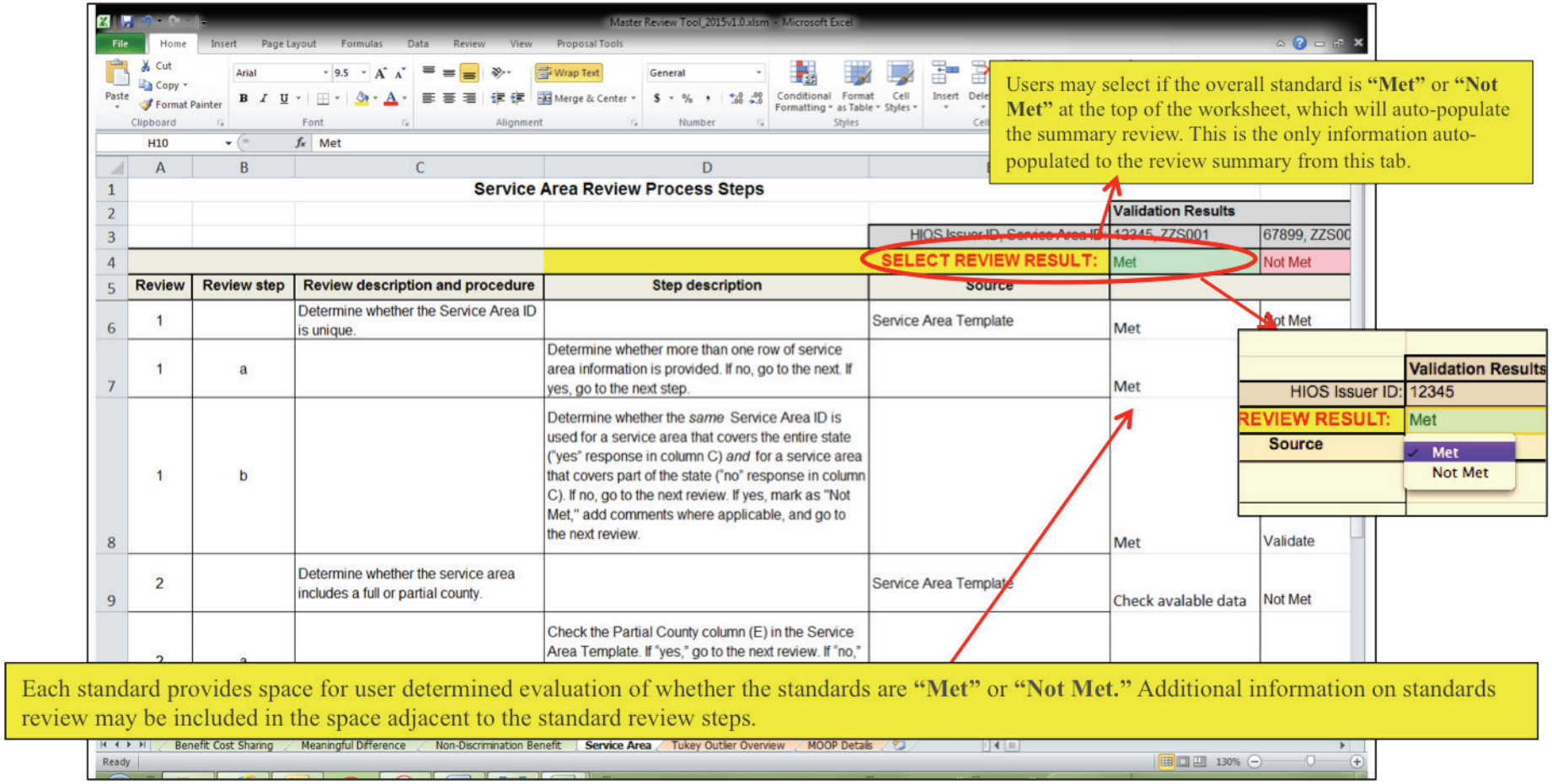
2. **Open** the Master Review Tool.



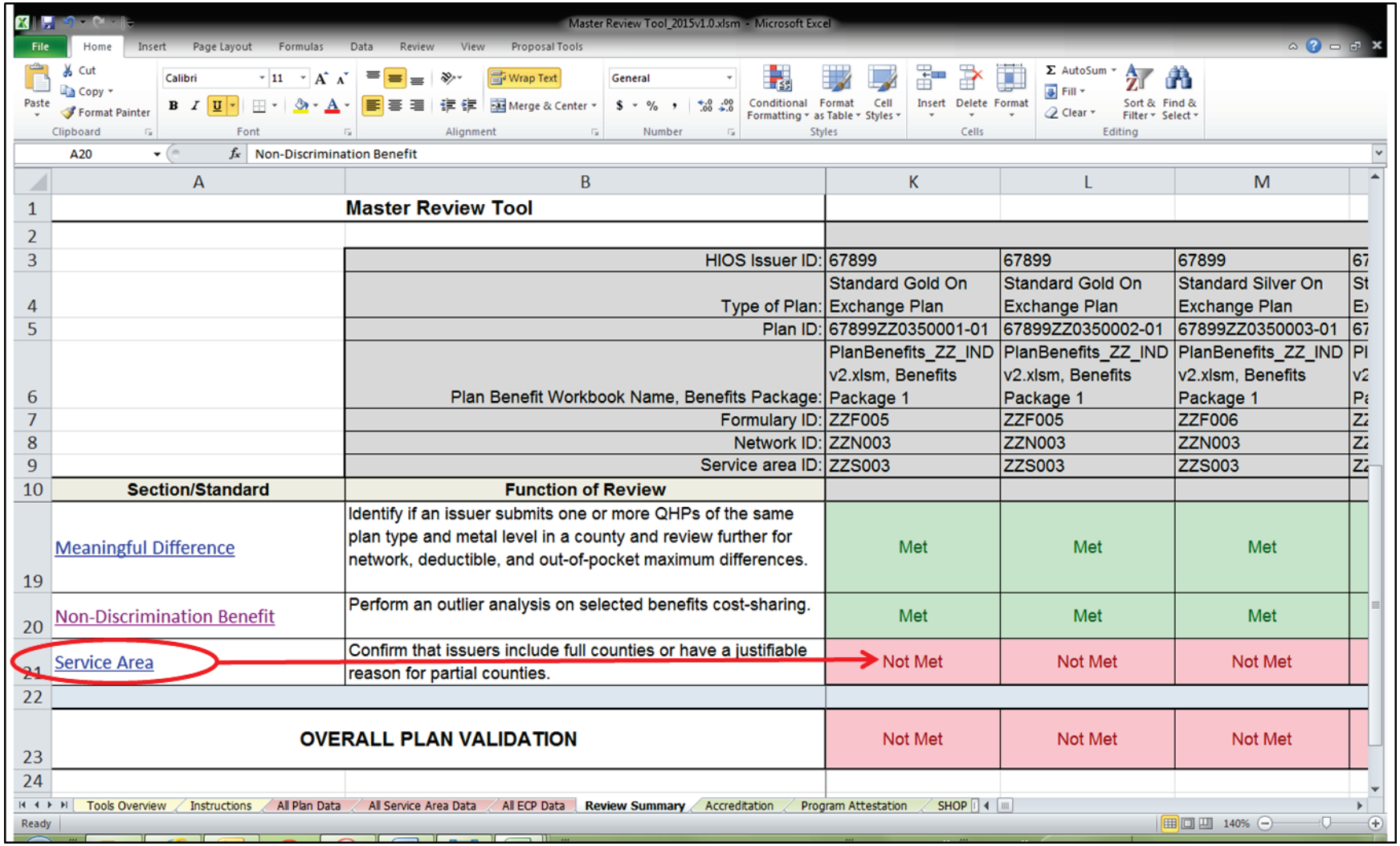
3. **Open** the *service area templates* for issuers listed in the Master Review Tool.



4. **Populate "Met"** or **"Not Met"** for each issuer's plan in row 4 SELECT REVIEW RESULT in the Master Review Tool *Service Area* tab.



5. **Open** the Master Review Tool *Review Summary* tab to see the auto-populated results.



6. **Save** the Master Review Tool after you have completed the service area review.

REFERENCE TABS

Non-Discrimination Review Outlier Methodology

The outlier test used for the Non-Discrimination Cost-Sharing Outlier and Non-Discrimination Formulary Outlier reviews is a modified version of Tukey's Outlier Test 1. Tukey's Outlier Test (also known as Tukey's Outlier Filter or Tukey's Method) uses quartiles to determine the outliers in a given data set. It is a commonly utilized outlier test due to its ease of use and applicability to a variety of analyses. Tukey's Outlier Test can be used regardless of data distribution, while most other outlier tests require advance knowledge or assumptions about the data distribution.

To find outliers, the test first finds the interquartile range (IQR) of the data set: the middle 50 percent of the data set, or the 75th percentile (Q3) minus the 25th percentile (Q1). The IQR is then multiplied by a multiplier (M), subtracted from Q1, and added to Q3. The two most commonly used multiplier values are 1.5 and 2.0 (1.5 is the default value used in the tools). The two resulting values then set the bounds for what is considered an outlier. (Anything outside of the bounds is an outlier, and anything inside the bounds is not an outlier.) Expressed mathematically, the two bounds are calculated as follows:

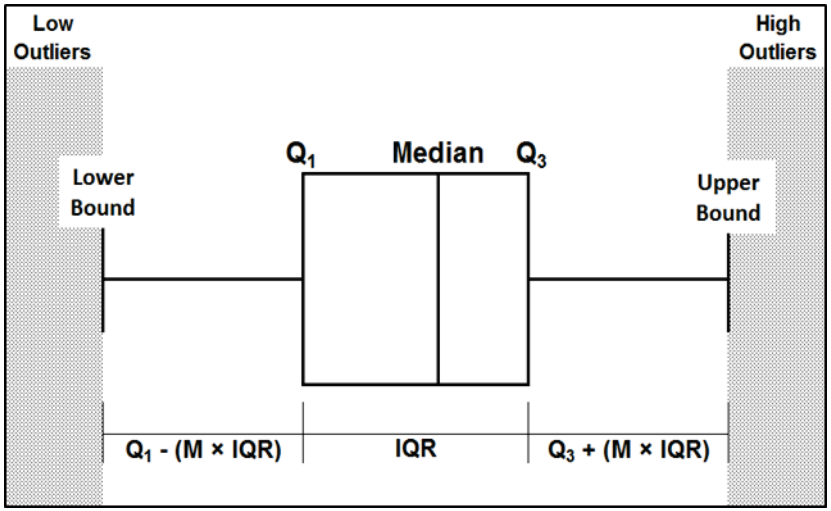
IQR = Q3 – Q1.
Lower Bound (LB) = Q1 – (M × IQR).
Upper Bound (UB) = Q3 + (M × IQR).

One flaw of using the IQR is the potential for a zero IQR if too many data points have the same value. A zero IQR makes it impossible to identify outliers using the method described above. Although the chances of this occurring are low, it does present a potential issue. The test used for the reviews modifies Tukey's Outlier Test so that if an IQR is initially equal to zero, Q1 will be multiplied by 0.75, and Q3 will be multiplied by 1.25. This will create a spread between Q1 and Q3 and make a non-zero IQR. The rest of the test will then be performed as described above.

Another flaw of Tukey's Outlier Test is that there needs to be at least five data points in a data grouping to calculate outlier bounds. If there are four data points or less in a data grouping, none of the data points in that grouping can be evaluated.

Any value below the LB is considered a "low outlier," while any value above the UB is considered a "high outlier." For the Non-Discrimination Cost-Sharing Outlier review, Tukey's Outlier Test is used to identify high outliers in the cost-sharing fields. For the Non-Discrimination Formulary Outlier review, Tukey's Outlier Test is used to identify low outliers in the number of unrestricted drugs for various USP classes. The test is often displayed as a "box-and-whiskers plot," as shown below.

[1] David Hoaglin, Frederick Mosteller, and John Tukey, eds., Understanding Robust and Exploratory Data Analysis (New York: John Wiley & Sons, 1983), p. 39, 54, 62, 223.



Maximum Out-of-Pocket (MOOP) Details

This table shows you which data elements to compare against the MOOP thresholds when doing the MOOP review. Go through each column to find the row with the combination of fields that apply to a particular plan, and then compare the data elements in column F to the threshold.

The "Integrated/separate (medical and drug)" column indicates whether the medical and drug MOOP are integrated or separate.

The "Individual/family" column indicates whether you are looking to compare the individual MOOP or the family MOOP.

The "Tier/no tier (in network)" column indicates whether the plan has multiple in-network tiers ("Tier") or only one in network tier ("No Tier").

The "Combined in and out of network" column indicates whether the plan is using the combined in and out of network MOOP, as indicated by "Not Applicable" being entered for the in network MOOP fields ("Yes") or has separate in network and out of network MOOPs ("No").

Integrated/separate (medical and drug)	Individual/family	Tier/no tier (in network)	Combined in and out of network	Data element to compare against thresholds
Integrated	Individual	Tier	No	*Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) In Network Individual*
				Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) In Network (Tier 2) Individual
Integrated	Individual	No tier	No	*Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) In Network Individual*
Integrated	Family	Tier	No	*Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) In Network Family*
				Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) In Network (Tier 2) Family
Integrated	Family	No tier	No	*Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) In Network Family*
Separate	Individual	Tier	No	*Maximum Out of Pocket for Medical EHB Benefits for In Network Individual* + *Maximum Out of Pocket for Drug EHB Benefits for In Network Individual*

Integrated/separate (medical and drug)	Individual/family	Tier/no tier (in network)	Combined in and out of network	Data element to compare against thresholds
				Maximum Out of Pocket for Medical EHB Benefits for In Network (Tier 2) Individual + Maximum Out of Pocket for Drug EHB Benefits for In Network (Tier 2) Individual
Separate	Individual	No tier	No	*Maximum Out of Pocket for Medical EHB Benefits for In Network Individual + Maximum Out of Pocket for Drug EHB Benefit In Network Individual*
Separate	Family	Tier	No	*Maximum Out of Pocket for Medical EHB Benefits for In Network Family + Maximum Out of Pocket for Drug EHB Benefits for In Network (Tier 2) Family*
				Maximum Out of Pocket for Medical EHB Benefits for In Network (Tier 2) Family + Maximum Out of Pocket for Drug EHB Benefits for In Network (Tier 2) Family
Separate	Family	No tier	No	*Maximum Out of Pocket for Medical EHB Benefits for In Network Family + Maximum Out of Pocket for Drug EHB Benefits for In Network (Tier 2) Family*
Integrated	Individual	Tier	Yes	*Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) Combined In/Out of Network Individual*
Integrated	Individual	No tier	Yes	*Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) Combined In/Out of Network Individual*
Integrated	Family	Tier	Yes	*Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) Combined In/Out of Network Family*
Integrated	Family	No tier	Yes	*Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) Combined In/Out of Network Family*
Separate	Individual	Tier	Yes	*Maximum Out of Pocket for EHB Benefits for Combined In/Out of Network Individual + Maximum Out of Pocket for Drug EHB Benefits for Combined In/Out of Network Individual*
Separate	Individual	No tier	Yes	*Maximum Out of Pocket for EHB Benefits for Combined In/Out of Network Individual + Maximum Out of Pocket for Drug EHB Benefits for Combined In/Out of Network Individual*

Integrated/separate (medical and drug)	Individual/family	Tier/no tier (in network)	Combined in and out of network	Data element to compare against thresholds
Separate	Family	Tier	Yes	*Maximum Out of Pocket for EHB Benefits for Combined In/Out of Network Family + Maximum Out of Pocket for Drug EHB Benefits for Combined In/Out of Network Family*
Separate	Family	No tier	Yes	*Maximum Out of Pocket for EHB Benefits for Combined In/Out of Network Family + Maximum Out of Pocket for Drug EHB Benefits for Combined In/Out of Network Family*

Non-Discrimination in Benefit Design

The intent of this guidance is to clarify non-discrimination standards and provide examples of benefit design that are potentially discriminatory under the ACA. Ultimately, the regulator who reviews EHB and /or QHP non-discrimination will determine if a plan design is a discriminatory practice.

The ACA enacted standards that protect consumers from discrimination based on age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or health condition, and prohibit issuers from designing benefits or marketing QHPs in a manner that would discourage individuals with significant health care needs from enrolling in QHPs. In addition, the Public Health Service Act (PHS) Section 2711, generally prohibits group health plans and health insurance issuers offering group insurance coverage from imposing lifetime or annual limits on the dollar value of essential health benefits (listed below) offered under the plan or coverage. Furthermore, with respect to plans that must provide coverage of the essential health benefit package, issuers may not impose benefit-specific waiting periods, except in covering pediatric orthodontia, in which case any waiting periods must be reasonable pursuant to §156.125 and providing EHB. It is also important to note that benefit designs must meet the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements.

The Essential Health Benefits:

> (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

The Affordable Care Act and implementing regulations prohibit discrimination through the design of benefits, but also state that issuers should not be prevented from employing benefit designs that encourage efficient utilization and reasonable medical management techniques. A number of benefit design features are utilized in the context of medical management, including but not limited to:

- Exclusions.
- Cost-sharing.
- Medical necessity definitions.

- Drug formularies.
- Visit limits.
- Benefit substitution.
- Utilization management.

Each of these features has the potential to be either discriminatory or an important element in a QHP's quality and affordability, depending on how the feature is designed and administered. The Centers for Medicare & Medicaid Services (CMS) has identified examples of potentially discriminatory benefit design within each of these domains, as well as best practices for minimizing the discriminatory potential of these features (see Table 1). These examples are not definitively discriminatory. As potential discrimination is assessed, issuers should consider the design of singular benefits in the context of the plan as a whole, taking into account all plan features, including MOOP limits.

Furthermore, issuers should note that EHB-benchmark plans are based on 2012 plan designs and do not necessarily reflect non-discrimination standards effective for plan years beginning on or after January 1, 2014. When designing plans that are substantially equal to the EHB-benchmark plans, issuers should ensure that benefit design also complies with the aforementioned non-discrimination requirements.

Examples of Potentially Discriminatory Benefit Design

Note. This is not an exhaustive list of examples of potentially discriminatory benefit designs.

Domains	Example Benefit	Potentially Discriminatory Benefit Design Example	Reason Example Benefit Design is Potentially Discriminatory	Possible Method for Minimizing the Potential for Discrimination for the Example Provided
Exclusions	Transplant	Bone marrow transplants are excluded from transplant coverage, regardless of medical necessity	Excluding bone marrow transplants regardless of medical necessity may discriminate against individuals with specific conditions, including certain cancers and immune deficiency disorders, for which this procedure is a medically necessary treatment	Transplant coverage is dictated by medical evidence and consideration of patient history
Cost-Sharing	Emergency Room Services	Emergency room services with significantly increasing cost-sharing burden as the number of visits increases	Increasing the cost-sharing burden with increasing emergency room visits may discriminate against individuals with certain medical conditions that reasonably necessitate more frequent emergency room usage (e.g., but not limited to, asthma, sickle cell anemia, heart failure)	Emergency room services cost-sharing design that is not contingent on the frequency of service utilization

Domains	Example Benefit	Potentially Discriminatory Benefit Design Example	Reason Example Benefit Design is Potentially Discriminatory	Possible Method for Minimizing the Potential for Discrimination for the Example Provided
Medical Necessity Definitions	Speech Therapy	Medical necessity for rehabilitative speech therapy services that is defined with the use of restrictive phrases such as "recovery of lost function" or "restoration to previous levels of functioning" when habilitative speech therapy is not covered	Defining medical necessity for rehabilitative speech therapy with restrictive phrases may discriminate against individuals with health conditions that would benefit from this therapy to improve functionality that may have never been present (e.g. individuals with cerebral palsy) and/or to prevent further deterioration of function (e.g. multiple sclerosis)	Medical necessity for rehabilitative speech therapy services includes coverage for all conditions in which medical evidence supports the use of speech therapy services, regardless of whether this service is used to recover lost function, improve functionality that was never present, or to prevent further deterioration of function
Drug Formularies	Non-Preferred Brand/Specialty Drugs	Requiring consumers to receive specialty medications particularly for certain medical conditions from mail-order pharmacies and not allowing the use of retail pharmacies	Eliminating access to certain specialty medications through retail pharmacies may discriminate against individuals with significant health care needs or with certain conditions, such as rheumatoid arthritis, who are eligible to receive discounts on those drugs through retail pharmacies	Permitting consumers to use retail pharmacies when discounts are available and the cost-sharing is lower than the mail-order pharmacy option
	Non-Preferred Brand/Specialty Drugs	Placing expensive life-saving or life-prolonging drugs, for which there is no generic and/or less expensive comparable alternative treatment, in tiers with high consumer cost-sharing	Placing high consumer cost-sharing on life-saving or life-prolonging drugs may discriminate against individuals with conditions such as HIV/AIDS for which these drugs are a necessary treatment	Structuring prescription drug cost-sharing design in manner that does not place disproportionate burden on individuals with specific conditions
Visit Limits	Outpatient Rehabilitation Services	The number of covered outpatient rehabilitation visits is limited without regard to best medical practices for a given condition	Limiting the number of covered outpatient rehabilitation visits without regard to medical necessity may discriminate against individuals conditions that require more rehabilitation services than are covered to fully regain function after certain conditions, such as stroke	The number of covered outpatient rehabilitation visits is determined by medical necessity and best medical practices

Domains	Example Benefit	Potentially Discriminatory Benefit Design Example	Reason Example Benefit Design is Potentially Discriminatory	Possible Method for Minimizing the Potential for Discrimination for the Example Provided
Benefit Substitution	Chiropractic Services	Chiropractor visit limit substantially reduced in comparison to the state benchmark plan benefit in order to substantially increase outpatient physical therapy visit limit	Limiting the number of covered chiropractor visits may discriminate against individuals with certain conditions, such as back pain, for which medical evidence supports the use of chiropractic services as beneficial treatment	Benefit substitution that is actuarially equivalent to the benefit that is being replaced is within the same EHB benefit category, is not a prescription drug benefit, and does not result in effectively eliminating a benefit included in the EHB benchmark plan for a benefit applicable to a population with more favorable risk
Utilization Management	Non-Preferred Brand/ Specialty Drugs	Requiring prior authorization and/or step therapy for most or all drugs in drug classes such as anti-HIV protease inhibitors, and/or immune suppressants regardless of medical evidence	Requiring prior authorization and/or step therapy for most or all medications in a specific drug class may discriminate against individuals with conditions for which those drug classes are applicable, such as HIV or rheumatoid arthritis, and cause undue burden to receive necessary therapies	Using current medical evidence to establish clinically appropriate prior authorization, step therapy, or unrestricted coverage for drugs in a given drug class
	Imaging (CT/PET Scans, MRIs)	Covering mammography alone and not covering breast MRIs in combination with mammography, for individuals who would benefit from breast cancer evaluation that incorporates an MRI	Denying coverage of diagnostic imaging without regard to medical evidence and necessity may discriminate against individuals who have either been previously diagnosed with or are more susceptible to developing breast cancer	Determining cancer diagnostic testing and treatment coverage based on current medical evidence and medical necessity

APPENDIX

Acronyms and Terms

Acronym	Definition
AAAHC	Accreditation Association for Ambulatory Health Care
AV	actuarial value
AVC	actuarial value calculator
APTC	advance premium tax credits
ACA	Affordable Care Act
API	application programming interface
BCBS	Blue Cross Blue Shield
BPCK	branded pack
CCIIO	Center for Consumer Information and Insurance Oversight
CMS	Centers for Medicare & Medicaid Services
COA	certificate of authority
CALT	Collaborative Application Lifecycle Tool
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CSR	cost-sharing reduction
DOB	date of birth
DIT	data integrity tool
DMARDs	disease-modifying antirheumatic drugs
DOI	Department of Insurance
DPP	diabetes prevention program
DSH	disproportionate share hospital
EIDM	Electronic imaging and document management

Acronym	Definition
EIN	employer identification number
ECP	essential community provider
EHB	essential health benefit
EPO	exclusive provider organization
FEIN	Federal employer identification number
FPL	Federal poverty level
FQHC	Federally qualified health center
FFM	Federally-facilitated Marketplace
GSA	General Services Administration
GPCK	generic pack
HHS	U.S. Department of Health and Human Services
HIOS	Health Insurance Oversight System
HIPAA	Health Insurance Portability and Accountability Act
HMO	health maintenance organization
HPSA	health professional shortage area
HRA	health reimbursement arrangement
HSA	health savings account
ISS	interactive survey system
MCO	managed care organization
MOOP	maximum out-of-pocket
M	multiplier

Acronym	Definition
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
NPI	national provider identifier
OIG	Office of the Inspector General
OOPM	out-of-pocket maximum
POS	point of service
PPO	preferred provider organization
PA	prior authorization
QHP	qualified health plan
RXCUI	RxNorm Concept Unique Identifier
SBC	summary of benefits and coverage
SBD	semantic branded drug
SCD	semantic clinical drug
SHOP	Small Business Health Options Program
SEP	special enrollment period
SBM	State-based Marketplace
SPM	State Partnership Marketplace
SSN	social security number
SGLT2	sodium glucose co-transporter 2 inhibitors
ST	step therapy
TIN	taxpayer identification number
TNF	tumor necrosis factors
TTY	term types
UMLS	Unified Medical Language System
UCAA	Uniform Certificate of Authority Application
USP	United States Pharmacopeia
.xlms	Excel macro-enabled workbook