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From: Center for Consumer Information and Insurance Oversight (CCIIO), Centers for Medicare & Medicaid Services (CMS)

Title: 2023 Final Letter to Issuers in the Federally-facilitated Exchanges[1]

The Centers for Medicare & Medicaid Services (CMS) is releasing this 2023 Final Letter to Issuers in the Federally-facilitated Exchanges (2023 Final Letter). This 2023 Final Letter provides updates on operational and technical guidance for the 2023 plan year for issuers seeking to offer qualified health plans (QHPs), including stand-alone dental plans (SADPs), in the Federally-facilitated Exchanges (FFEs) or the Federally-facilitated Small Business Health Options Programs (FF-SHOPs). It also describes how parts of this 2023 Final Letter apply to issuers in State-based Exchanges on the Federal Platform (SBE-FPs). Issuers should refer to these updates to help them successfully participate in any such Exchange in 2023. Unless otherwise specified, references to the FFEs include the FF-SHOPs.

The 2023 Final Letter focuses on guidance that has been updated for the 2023 plan year, and refers issuers to the 2017 through 2022 Letters to Issuers in the Federally-facilitated Exchanges in all instances where CMS guidance has not changed.[2] CMS notes that the policies articulated in this 2023 Final Letter apply to the QHP certification process for plan years beginning in 2023.[3]

[1] The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

[2] *See* Center for Consumer Information and Insurance Oversight, CMS, 2017 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 29, 2016), *available at:* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers_022916.pdf; Center for Consumer Information and Insurance Oversight, CMS, Addendum to 2018 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 17, 2017), *available at:* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces-and-February-17-Addendum.pdf; Center for Consumer Information and Insurance Oversight, CMS, 2019 Letter to Issuers in the Federally-facilitated Marketplaces (Apr. 9, 2018), *available at:* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Letter-to-Issuers.pdf; Center for Consumer Information and Insurance Oversight, CMS, 2020 Letter to Issuers in the Federally-facilitated Marketplaces (Apr. 18, 2019), *available at:* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2020-Letter-to-Issuers-in-the-Federally-facilitated-Exchanges.pdf; Center for Consumer Information and Insurance Oversight, CMS, Final 2021 Letter to Issuers in the Federally-facilitated Marketplaces (May 7, 2020), *available at:* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2021-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf; Center for Consumer Information and Insurance Oversight, CMS, Final 2022 Letter to Issuers in the Federally-facilitated Marketplaces (May 6, 2021), *available at:* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2022-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf.

[3] Plan years in the FF-SHOPs will not always align with calendar year 2023.

Throughout this 2023 Final Letter, CMS identifies the areas in which states performing plan management functions in the FFEs have flexibility to follow an approach different from that articulated in this guidance.

Previously published rules concerning market-wide and QHP certification standards, eligibility and enrollment procedures, and other Exchange-related topics are set out in Title 45 of the Code of Federal Regulations (CFR) Subtitle A, Subchapter B. Unless otherwise indicated, regulatory references in this 2023 Final Letter are to Title 45 of the CFR.[4] While certain parts of the 2023 Final Letter explain associated regulatory requirements, the 2023 Final Letter is not a complete list of regulatory requirements for issuers.

[4] *Available at:* https://ecfr.federalregister.gov/current/title-45.

CHAPTER 1: CERTIFICATION PROCESS FOR QUALIFIED HEALTH PLANS 1
Section 1. QHP Certification Process 1
Section 2. QHP Application Data Submission 2
Section 3. QHP Data Changes 4
Section 4. QHP Review Coordination with States 6
Section 5. Plan ID Crosswalk 7
Section 6. Value-based Insurance Design 7
Section 7. Alternative Payment Models (APMs) 7
Section 8. Issuer Participation for the Full Plan Year 8
Section 9. Standardized Options 8
CHAPTER 2: QUALIFIED HEALTH PLAN AND STAND-ALONE DENTAL PLAN CERTIFICATION STANDARDS 9
Section 1. Licensure and Good Standing 9
Section 2. Service Area 9
Section 3. Network Adequacy 10
Section 4. Essential Community Providers 17
Section 5. Accreditation 19
Section 6. Patient Safety Standards for QHP Issuers 19
Section 7. Quality Reporting 19
Section 8. Quality Improvement Strategy 19
Section 9. Review of Rates 20
Section 10. Discriminatory Benefit Design 20
Section 11. Prescription Drugs 20
Section 12. Third Party Payment of Premiums and Cost Sharing 20
Section 13. Cost-sharing Reduction Plan Variations 20
Section 14. Data Integrity Review 20
Section 15. Interoperability 21
CHAPTER 3: CONSUMER SUPPORT TOOLS AND PUBLIC INFORMATION 21
Section 1. Consumer Support Tools 21
Section 2. Transparency in Coverage Reporting 21
Section 3. Medical Cost Scenarios 22
CHAPTER 4: STAND-ALONE DENTAL PLANS: 2023 APPROACH 22
Section 1. SADP Annual Limitation on Cost Sharing 22
Section 2. SADP Actuarial Value Requirements 22

CHAPTER 5: QUALIFIED HEALTH PLAN PERFORMANCE AND OVERSIGHT 22
CHAPTER 6: CONSUMER SUPPORT AND RELATED ISSUES 23
Section 1. Coverage Appeals 23
Section 2. Consumer Case Tracking 23
Section 3. Meaningful Access 23
Section 4. Summary of Benefits and Coverage (SBC) 24
CHAPTER 7: TRIBAL RELATIONS AND SUPPORT 24

CHAPTER 1: CERTIFICATION PROCESS FOR QUALIFIED HEALTH PLANS

(This chapter relies on authority from Affordable Care Act (ACA) sections 1311(c) and (e) and 1321(a); and 45 CFR 147.106, Part 150, Part 155 Subpart K, 155.335(j), 156.200, 156.272, and 156.290.)

The ACA and applicable regulations provide that health plans, including SADPs, must meet a number of standards in order to be certified as QHPs. Several of these are market-wide standards that apply to plans offered in the individual and small group (including merged) markets, both inside and outside of the Exchanges. The remaining standards are specific to health plans seeking QHP certification from the Exchanges.

This chapter provides an overview of the QHP certification process. This process applies to all states in which an FFE operates, which include (1) states performing plan management functions and making QHP certification recommendations to CMS, (2) states where CMS is performing all plan management functions and certifying QHPs while the state is enforcing the insurance market reforms in the Public Health Service (PHS) Act, and (3) states where CMS is performing all plan management functions and where the state does not enforce insurance market reforms added to the Public Health Service Act by the ACA,[5] or by Titles I and II (the No Surprises Act and Transparency Act) of Division BB of the Consolidated Appropriations Act, 2021.[6] Additional information and instructions about the process for issuers to complete a QHP application can be found at https://www.qhpcertification.cms.gov.

Section 1. QHP Certification Process

CMS expects issuers and state regulatory authorities in states with Exchanges using the federal platform applying for QHP Certification to adhere to the plan year 2023 QHP Data Submission Timeline.[7]

Issuers will submit a complete QHP application for plans they intend to have certified in a state in which an FFE is operating. The "Early Bird" QHP Application submission window is an optional submission window for issuers to submit application data prior to the first formal submission deadline. CMS will review and return results on this data as available prior to the first submission deadline, and if any changes are made in response to CMS-identified needed corrections, CMS will not flag these as corrections in the full review round.

CMS will review QHP applications for all issuers applying for QHP certification in an FFE[8] and

[5] The list of states that do not enforce the ACA market wide-requirements is available at: https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/compliance.html.

[6] SBE-FPs retain the authority and primary responsibility for the certification of QHPs and should transfer plan data to CMS in accordance with the QHP application submission deadlines as specified in this Final Letter.

[7] *See* Plan Year 2023 QHP Data Submission Timeline (March 1, 2022) *available at:* https://www.cms.gov/files/document/py2023-qhp-data-submission-and-certification-timeline-bulletin.pdf. All dates are subject to change.

[8] In accordance with 45 CFR Part 155 Subpart K, CMS will review, and approve or deny, QHP applications from issuers that are applying to offer QHPs in the FFEs. CMS will not conduct QHP certification reviews of plans that are submitted for offering only outside of the FFEs, except for SADPs seeking off-Exchange certification. In the case of an FF-SHOP QHP certification, except when the QHP is decertified pursuant to 45 CFR 155.1080, the QHP certification remains in effect through the end of any plan year beginning in the calendar year for which the QHP was certified, even if the plan year ends after the calendar year for which the QHP was certified. FFEs will

notify issuers of any need for corrections after each round of review. After the final QHP application submission deadline, issuers may be required to submit corrected final QHP data during a limited data correction window to address CMS or state-identified errors.

CMS will post a list of plans received and reviewed during the QHP application process in each issuer's profile in the CCIIO Plan Management Community (PM Community). Each issuer will access the plan list and confirm their plans within the PM Community. If an issuer wishes to withdraw a plan from consideration in the QHP Certification process, or to change an on-Exchange SADP under certification consideration to an off-Exchange SADP for certification consideration, the issuer must follow the plan withdrawal process provided by CMS. An issuer's final plan confirmation to CMS is generally the last opportunity for the issuer to withdraw a plan from certification consideration for the upcoming plan year.

After correcting plan data and finalizing the list of plans offered for certification, issuers intending to offer QHPs, including SADPs, in a state in which an FFE is operating, including states performing plan management functions, will sign and submit to CMS a QHP Certification Agreement and Privacy and Security Agreement (the "QHP Certification Agreement") and a Senior Officer Acknowledgement.[9] CMS will sign the QHP Certification Agreement and return it to issuers along with a final list of certified QHPs, completing the certification process for the upcoming plan year. After receiving the QHP Certification Agreement signed by CMS, issuers may begin marketing their plans as certified QHPs and providing information about the plans to FFE-registered agents and brokers.

Issuers may have their QHP application denied if they fail to meet the deadlines in the plan year 2023 QHP Data Submission Timeline, or if their applications are not accurate or complete after the deadline for issuer submission of changes to the QHP application.[10]

Section 2. QHP Application Data Submission

CMS requires issuers, including SADP issuers, to submit complete QHP applications by the initial submission deadline in the plan year 2023 QHP Data Submission Timeline and to make necessary updates to the QHP application prior to the last deadline for issuer submission. Additionally, issuers must comply with any CMS requirements related to rate filings. There are certain states where CMS is directly performing rate review as well as enforcing other applicable PHS Act requirements.

All issuers must obtain Health Insurance Oversight System (HIOS) product and plan IDs using HIOS.[11] All issuers must also register for the PM Community to receive correction and

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not display ancillary insurance products and health plans that are not QHPs (e.g., stand-alone vision plans, disability, or life insurance products). The FFEs will only offer QHPs, including SADPs.

[9] The documents will apply to all QHPs offered by a single issuer in an FFE at the HIOS Issuer ID level or designee company. Issuers should ensure that the legal entity information listed in HIOS under the Issuer General Information section is identical to the legal entity information that will be used when executing the documents.

[10] Regulations at 45 CFR 155.1000 provide Exchanges with broad discretion to certify QHPs that otherwise meet the QHP certification standards specified in Part 156, and afford Exchanges the discretion to deny certification of QHPs that meet minimum QHP certification standards, but are not ultimately in the "interest" of qualified individuals and qualified employers.

[11] *See* additional information on HIOS registration, which is contained in the HIOS Portal User Manual. The HIOS Portal User Manual is *available at:* https://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html#Content%20Requirements%20for%20Plan%20Finder. CMS expects issuers to use the same

certification notices, as well as other relevant communications regarding their QHP applications.[12]

Issuers applying for QHP certification in FFEs, excluding those in states performing plan management functions, must submit their QHP applications in HIOS.[13] Issuers in states performing plan management functions should submit QHP applications in the National Association of Insurance Commissioners' (NAIC) System for Electronic Rate and Form Filing (SERFF) in accordance with state and CMS review deadlines. Issuers submitting applications for QHP Certification in SERFF should work directly with the state to submit all QHP issuer application data in accordance with state guidance.[14]

Issuers are now able to comply with the requirement to submit the Unified Rate Review Template (URRT) to CMS by submitting the rate filing directly in SERFF. New functionality is available beginning with the 2023 plan year, such that a rate filing filed in SERFF is automatically uploaded to the Uniform Rate Review (URR) Module of HIOS and will be considered filed with CMS once submitted in SERFF.[15] Issuers in states with an Effective Rate Review Program that participate in SERFF[16] are required to file the 2023 plan year Rate Filing Justification in the new URRT tab of SERFF. This new functionality does not apply to states that do not have an Effective Rate Review Program[17] and states that do not participate in SERFF.[18] Issuers in those states will need to continue to submit the URRT directly in HIOS. These same guidelines apply to issuers in states that do not perform plan management functions and otherwise submit QHP application data in HIOS.

All issuers applying for QHP certification must access the Plan Preview environment to review plan benefit data and identify and correct data submission errors before the QHP application data

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HIOS plan identification numbers for plans, including SADPs, submitted for certification for the 2023 plan year that are the same as plans, including SADPs, certified as QHPs for the 2022 plan year, as defined in 45 CFR 144.103 and pursuant to 45 CFR 147.106. While 45 CFR 147.106 is not applicable to issuers of SADPs, CMS expects that SADP issuers' HIOS plan identification numbers will be the same for the 2023 plan year if the plan has not changed since the SADP was certified for the 2022 plan year, even if the plan has been modified, to the extent the modification(s) are made uniformly and solely pursuant to the removal of the requirement for SADPs to offer the pediatric dental EHB at a specified actuarial value. The same definition of "plan" also will apply to re-enrollment of current enrollees into the same plan, pursuant to 45 CFR 155.335(j). If an issuer chooses to not seek certification of a plan for a subsequent, consecutive certification cycle in the Exchange, or fails to have a plan certified for the 2023 plan year that had been certified for the 2022 plan year, the issuer is subject to the standards outlined in 45 CFR 156.290.

[12] For issuers not currently participating in the PM Community, in spring 2022 CMS intends to make instructions available on how to enroll to receive information for the 2023 plan year QHP application period.

[13] While some states in which an FFE is operating use the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF) to collect plan data, which may include copies of the QHP templates, that data will not be submitted to CMS in states that do not perform plan management functions, and must be submitted in HIOS.

[14] CMS will work with states performing plan management functions in an FFE to ensure that such guidance is consistent with federal regulatory standards and operational timelines.

[15] For additional details and operational guidance on submission of the URRT to CMS through the SERFF, see 2023 Unified Rate Review Instructions, *available at*: https://www.cms.gov/files/document/urr-py23-instructions.pdf.

[16] For information on states with an Effective Rate Review Program, see https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet. For information on state participation in SERFF, see https://www.serff.com/serff_participation_map.htm.

[17] CMS will be responsible for reviewing the 2023 plan year rate filing in two states (Oklahoma and Wyoming) that do not have an Effective Rate Review Program.

[18] See supra note 16.

submission deadline. Issuers can use Plan Preview to check their plan data display for most enrollment scenarios, including service areas, cost sharing for benefits, and URLs (including payment redirect). Issuers will use the Plan Preview environment to verify that their plan display reflects their state-approved filings. Issuers in states performing plan management functions in the FFEs will be able to view their plan data after the state transfers QHP data from SERFF to HIOS. To use Plan Preview, issuers must first submit rates data to CMS. CMS encourages issuers to review the data in Plan Preview throughout the QHP certification process to ensure that the plan benefit data are correct.

Discrepancies between an issuer's QHP application and approved state filings may result in a plan not being certified, or if CMS has already certified a plan as a QHP, decertification or other appropriate compliance or enforcement action. All issuers must complete quality assurance activities to ensure the completeness and accuracy of QHP application data, including reviewing plan data in the Plan Preview environment.

Section 3. QHP Data Changes

CMS will allow issuers to make changes to their QHP application based on the guidelines below. These changes are in addition to any corrections that CMS identifies during its review of QHP applications.

Table 1.1 outlines the parameters under which issuers may change their submitted QHP data. Issuers may make changes to their QHP applications without state or CMS authorization until the deadline for initial application submission. After the close of the initial QHP application submission window, issuers may not add new plans to a QHP application or change an off-Exchange plan to be both on and off-Exchange. Issuers also may not change plan type(s) or market type and may not change QHPs, excluding SADPs, from a child-only plan to a non-child-only plan. For all other changes, issuers will be able to upload revised QHP data templates and make other necessary changes to QHP applications in response to state or CMS feedback until the deadline for issuer changes. For all other changes, issuers are also not required to submit data change requests or document state authorization to CMS. CMS will monitor all data changes and contact issuers if there are concerns about changes made.

Table 1.1 Data Changes

	Permitted with No State or CMS Authorization Required	**Permitted with Authorization***	**Not Permitted**
Before the Initial Submission Deadline	All data changes permitted.	N/A	N/A
Between the Initial and Final Data Submission Deadlines	All changes are permitted, including changes in response to CMS-identified corrections, except where noted.	N/A	Issuers may not: Add new plans to a QHP application; Change an off- Exchange plan to be both on and off-Exchange; Change plan type(s) or market type; or Change QHPs, excluding SADPs, from a child-only plan to a non-child-only plan.

	Permitted with No State or CMS Authorization Required	Permitted with Authorization*	Not Permitted
After the Final Submission Deadline	N/A	Issuers may request critical data changes to align with state filings. URLs may be changed with state authorization; CMS authorization is not required.	Issuers may not change certified QHP data without the explicit direction and authorization of CMS and the state.

*Required authorization to change QHP data, and the process for requesting authorization, will differ by state Exchange model. More information is available at https://www.qhpcertification.cms.gov.

To withdraw a plan from QHP certification consideration, an issuer must follow the plan withdrawal process as outlined by CMS at https://www.qhpcertification.cms.gov. After submission of an initial QHP application, an issuer should not remove plan data from the application templates, even if the issuer withdraws a plan. In addition, issuers seeking to change an on-Exchange SADP under certification consideration to an off-Exchange SADP for certification consideration must submit a plan withdrawal request.

After the deadline for issuer changes to QHP applications, issuers will only make corrections directed by CMS or by their state. States may direct changes by contacting CMS with a list of requested corrections. Issuers whose applications are not accurate after the final deadline for issuer submission of changes to the QHP application, and are then required to resubmit corrected data during the limited data correction window, may be subject to compliance action by CMS.[19] Issuer changes made in the limited data correction window not approved by CMS and/or the state may result in compliance action by CMS, which could include decertification and suppression of the issuer's plans on HealthCare.gov.

After completion of the QHP certification process, CMS may offer additional data correction windows. CMS will only consider approving changes that do not alter the QHP's certification status or require re-review of data previously approved by the state or CMS. CMS will offer windows for SHOP quarterly rate updates for issuers in an FF-SHOP. Administrative data changes such as URL updates should be made in HIOS Plan Finder or the QHP Supplemental Submission Module and do not require a data change request to CMS. URL changes require state authorization prior to being updated.

A request for a data change after the final submission deadline, excluding administrative changes or SHOP quarterly rate updates, may be made due to inaccuracies in or the incompleteness of a QHP application, and may result in compliance action. Discrepancies between the issuer's QHP application and approved state filings may result in a plan not being certified or a compliance action if CMS has already certified a plan as a QHP. Issuers that request to make changes that affect consumers may have their plans suppressed from display on HealthCare.gov until the data are corrected and refreshed for consumer display.

[19] *See* 45 CFR 156.805(a)(5).

Section 4. QHP Review Coordination with States

Each state will define the relevant submission window for state-level reviews as well as dates and processes for corrections and resubmissions. CMS will rely on states' reviews of issuer-submitted policy forms and rate filings for market-wide standards as part of its QHP certification process, provided that states review for compliance with federal laws and regulations and complete the reviews in a manner consistent with FFE operational timelines.[20] States that have an Effective Rate Review Program should consult guidance from CMS regarding timelines for rate filings for the appropriate plan year coverage.[21]

When states perform QHP certification reviews,[22] they may exercise reasonable flexibility in their application of CMS's QHP certification standards, provided that the state's application of each standard is consistent with CMS regulations and guidance. Issuers seeking QHP certification in states that are performing plan management functions in the FFEs should continue to refer to state direction in addition to this guidance.

CMS expects that states will establish the timeline, communication process, and resubmission window for any reviews conducted under state authority. As noted previously, issuers should comply with any state-specific guidelines for review and resubmission related to state review standards. CMS notes that issuers may be required to submit data to state regulators in addition to what is required for QHP certification through the FFEs, if required by a state, and must comply with any requests for resubmissions from the state or from CMS in order to be certified. CMS will seek to coordinate with states so that any state-specific review guidelines and procedures are consistent with applicable federal law and operational deadlines. Issuers must meet all applicable obligations under state law to be certified for sale on the FFEs.

In states performing plan management functions in the FFEs, the state will also review QHP applications for compliance with the standards described in this guidance and will provide a certification recommendation for each plan to CMS. CMS will review the state's QHP certification recommendations, make QHP certification decisions, and load certified QHP plans on HealthCare.gov. CMS will work closely with states performing plan management functions to coordinate this process. States performing plan management functions must provide CMS with state recommendations for QHP certification in keeping with the timeline specified by CMS in

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[20] States are the primary regulators of health insurers and are responsible for enforcing the market reform provisions in title XXVII of the PHS Act both inside and outside the Exchanges. Under sections 2723 and 2761 of the PHS Act and existing regulations, codified at 45 CFR Part 150, CMS is responsible for enforcing the provisions of Parts A and B of title XXVII of the PHS Act in a state if the state notifies CMS that it has "not enacted legislation to enforce or that it is not otherwise enforcing" one or more of the provisions, or if CMS determines that the state is not substantially enforcing the requirements. As necessary, CMS will provide additional information on enforcement. In direct enforcement states, CMS enforces the market-wide provisions. The list of direct enforcement states is *available at:* https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/compliance.html. Issuers in these states should work with CMS in instances in which this guidance references the "state," but should be aware that they will still generally continue to have some obligations under state law.

[21] *See* Center for Consumer Information and Insurance Oversight, CMS, Bulletin: Timing of Submission of Rate Filing Justifications for the 2022 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2023 (March 24, 2022), *available at:* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Rate-Review-Bulletin-for-CY2022.pdf.

[22] States performing plan management functions in the FFEs will conduct certification reviews. In addition, all states in the FFE, regardless of whether they perform plan management functions, will conduct certification reviews for certain review areas, as detailed in Chapter 2.

order for CMS to consider the recommendations and certify QHPs, or deny certification to QHPs, including SADPs.

For states performing plan management functions in the FFEs, the SERFF data transfer deadlines will align with the HIOS submission deadlines. These state transfers should include all plans submitted to the state for certification, including SADPs for off-Exchange sale.[23] CMS understands that all state reviews might not be complete by the submission deadlines, but as stated above, requires state confirmation of approval of QHPs for sale prior to CMS certification.

All states are encouraged to provide CMS with feedback regarding certification of QHPs, as well as the status of issuers and plans in relation to state guidelines separate from ACA certification requirements, as early in the certification process as practicable. For CMS to ensure this information is taken into account for certification, states must provide all of their recommendations and relevant information to CMS in a timely manner and no later than the state plan confirmation deadline in the QHP Data Submission Timeline. CMS will provide states with detailed guidance regarding the process for submitting plan approval recommendations to CMS prior to the start of and throughout the QHP certification cycle. CMS will work with all state regulators to confirm by the state plan confirmation deadline that all potential QHPs meet applicable state and federal standards, and are approved for sale in the state.

Section 5. Plan ID Crosswalk

Issuers are required to submit plan ID crosswalk data for each medical QHP and SADP that was certified for the 2022 plan year. Please refer to the 2018 Letter to Issuers in the Federally-facilitated Exchanges (2018 Letter to Issuers) for more information regarding submission requirements pertinent to the Plan ID Crosswalk. The 2023 certification approach for alternate enrollments also remains unchanged from 2018 and later years for QHPs that are not SADPs. SADPs, as plans that offer excepted benefits, are not subject to the guaranteed renewability standards specified at 45 CFR 147.106. However, CMS aims to apply the processes established for the 2022 Plan ID Crosswalk Template to SADPs in order to support automatic re-enrollment for plans offered during the 2023 plan year.

Section 6. Value-based Insurance Design

The approach for 2023 remains unchanged from 2021 and 2022. Please refer to the 2021 Letter to Issuers in the Federally-facilitated Exchanges (2021 Letter to Issuers) for more information.

Section 7. Alternative Payment Models (APMs)

The approach for 2023 remains unchanged from 2022 as CMS continues to encourage issuers and states to advance efforts to support value-based care and value-based payments across the health care system, with a particular emphasis on the individual market population. Please refer to the 2022 Letter to Issuers in the Federally-facilitated Exchanges (2022 Letter to Issuers) for more information and for some possible pathways for adoption of such approaches.

The CMS Center for Medicare & Medicaid Innovation (Innovation Center)'s vision for the next decade is a health system that achieves equitable outcomes through high quality, affordable, person-centered care. The five strategic objectives that will guide the Innovation Center's

[23] SBE-FPs should not transfer off-Exchange SADPs.

implementation of this vision are: drive accountable care, advance health equity, support care innovations, improve access by addressing affordability, and partner to achieve system transformation.[24] In addition to value-based insurance design, one such approach is alignment with APMs through the Innovation Center. As part of the objective to partner to achieve system transformation, the Innovation Center is collaborating with other payers and/or states to amplify the impacts of models across Medicare and Medicaid, as well as commercial payers where possible. Providers have found that multi-payer alignment can make it easier to transition to and sustain participation in value-based care. More information can be found on the Innovation Center website.[25]

Section 8. Issuer Participation for the Full Plan Year

The approach for 2023 remains unchanged from 2018 and later years. Please refer to the 2018 Letter to Issuers for more information.

Section 9. Standardized Options

In the 2023 Payment Notice Final Rule (2023 Payment Notice), CMS finalized the provision at § 156.201 to require issuers of QHPs in FFEs and SBE-FPs, for the 2023 plan year and beyond, to offer through the Exchange standardized QHP options designed by CMS at every product network type, as the term is used in the definition of "product" at § 144.103, at every metal level, and throughout every service area that they offer non-standardized QHP options. Under these requirements, if an FFE or SBE-FP issuer offers, for example, a non-standardized gold health maintenance organization (HMO) QHP in a particular service area, that issuer must also offer a standardized gold HMO QHP throughout that same service area. These requirements are not applicable to QHPs offered through State-based Exchanges using their own platform, to SADPs, or to SHOP QHPs.

CMS finalized two sets of the following standardized options: one bronze plan, one bronze plan that meets the requirement to have an actuarial value up to 5 points above the 60 percent standard, as specified in § 156.140(c) (known as an expanded bronze plan), one standard silver plan, one version of each of the three income-based silver CSR plan variations, one gold plan, and one platinum plan. The first set of these standardized options applies to all FFE and SBE-FP issuers, except issuers in Delaware and Louisiana. The second set of these standardized options, applicable only to issuers in Delaware and Louisiana, has copays of $150 or less for the specialty drug tiers of standardized options at all metal levels. This copay limitation for specialty drug tiers is the key feature that distinguishes the second set of standardized options from the first. Specialty drug cost sharing laws in Delaware and Louisiana necessitate this design feature.

Issuers of QHPs in FFEs and SBE-FPs that are already required to offer standardized options under state action taking place on or before January 1, 2020, such as issuers in the State of Oregon, are exempt from these requirements. The standardized QHP options that FFE and SBE-FP issuers are required to offer are specified in the discussion of § 156.201 in the preamble to the 2023 Payment Notice.

CMS also finalized a policy to exercise its existing authority under § 155.205(b)(1) to resume the differential display of standardized QHP options on HealthCare.gov beginning with the plan year

[24] *Available at:* https://innovation.cms.gov/strategic-direction.
[25] *See* Innovation Models *available at*: https://innovation.cms.gov/innovation-models#views=models.

2023 open enrollment period. Similarly, also beginning with the plan year 2023 open enrollment period, CMS finalized a policy to resume enforcement of the existing standardized QHP options display requirements under §§ 155.220(c)(3)(i)(H) and 156.265(b)(3)(iv) for approved web-brokers and QHP issuers using a direct enrollment pathway to facilitate enrollment through an FFE or SBE-FP – including those using the Classic DE and EDE Pathways – meaning that these entities will be required to differentially display standardized QHP options in a manner consistent with how standardized QHP options are displayed on HealthCare.gov, unless CMS approves a deviation. CMS finalized a policy stating that any requests from web-brokers or QHP issuers that seek approval for an alternate differentiation format will be reviewed based on whether the same or similar level of differentiation and clarity would be provided under the requested deviation as is provided on HealthCare.gov.

CHAPTER 2: QUALIFIED HEALTH PLAN AND STAND-ALONE DENTAL PLAN CERTIFICATION STANDARDS

(This chapter relies on authority from ACA sections 1302, 1311(c) and (e), 1321(a), and 1402; PHS Act section 2794; and 45 CFR 146.130, 147.136, 147.138, Part 154, 155.1045, 155.1065, 156.115, 156.122, 156.125, 156.150, 156.200, 156.210, 156.221, 156.225, 156.230, 156.235, 156.410, 156.420, 156.425, 156.1110-1130, Subpart L, and 156.1250.)

This chapter provides an overview of key QHP certification standards for both QHPs and SADPs in FFEs, including those in states performing plan management functions, and how CMS or the state will evaluate and conduct reviews of 2023 QHPs and SADPs for compliance.

Section 1. Licensure and Good Standing

The approach for licensure and good standing remains unchanged from 2018 and later years. Please refer to the Guidance to States on Review of Qualified Health Plan Certification Standards in Federally-facilitated Marketplaces for plan years 2018 and Later ("State Guidance on QHP Reviews") for more information.[26] As noted in the State Guidance on QHP Reviews, CMS does not review issuers' compliance with licensure and good standing standards. In FFEs, including in states performing plan management functions, states will continue to ensure issuer compliance with 45 CFR 156.200(b)(4).

Section 2. Service Area

The approach for reviews of service area generally remains unchanged from 2018 and later years. Please refer to the 2018 Letter to Issuers for more information. New for the 2023 plan year, issuers may make changes to their plan's service area after the initial submission deadline without first submitting a data change request for CMS authorization. After the final submission deadline listed in the Plan Year (PY) 2023 Qualified Health Plan (QHP) Data Submission and Certification Timeline,[27] a data change request is required for any change to QHP data, including service area.

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[26] *See* Center for Consumer Information and Insurance Oversight, CMS, Guidance to States on Review of Qualified Health Plan Certification Standards in Federally-facilitated Marketplaces for Plan Years 2018 and Later (Apr. 13, 2017), *available at:* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/QHP-Certifcation-Reviews-Guidance-41317.pdf.

[27] *See* Plan Year 2023 QHP Data Submission Timeline (March 1, 2022) *available at:* https://www.cms.gov/files/document/py2023-qhp-data-submission-and-certification-timeline-bulletin.pdf. All dates are subject to change.

Section 3. Network Adequacy

In the 2023 Payment Notice, CMS finalized that it would conduct network adequacy reviews. This section describes how CMS will conduct reviews of the network adequacy standards for medical QHP and SADP certification for the 2023 plan year. Pursuant to 45 CFR 156.230(a)(2), an issuer of a QHP that has a provider network must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay.

As described in the 2023 Payment Notice, starting in the 2023 plan year, CMS will evaluate QHPs for compliance with network adequacy standards based on time and distance standards. Starting in the 2024 plan year, CMS will also evaluate QHPs for compliance with appointment wait time standards. In the 2023 Payment Notice, CMS did not finalize the proposal that for plans that use tiered networks to count toward the issuer's satisfaction of network adequacy standards, providers must be contracted within the network tier that results in the lowest cost-sharing obligation. Finally, as described in the 2023 Payment Notice, CMS will collect from QHPs information on whether providers participating in their network offer telehealth services. CMS will continue to coordinate closely with state authorities to address network adequacy compliance issues, eliminate duplicative requirements or reviews, and reduce stakeholder burden.

i. FFE Network Adequacy Reviews

As described in the 2023 Payment Notice, CMS will evaluate network adequacy for plans to be offered as QHPs through the FFEs, except in certain states performing plan management functions. States performing plan management functions are states served by an FFE where the state has agreed to assume primary responsibility for reviewing issuer-submitted QHP certification material and making certification recommendations to CMS. CMS will not evaluate network adequacy in states performing plan management functions that elect to perform their own reviews of plans seeking QHP certification in their state, provided that the state applies and enforces quantitative network adequacy standards that are at least as stringent as the federal network adequacy standards established for QHPs under 45 CFR 156.230, and that reviews are conducted prior to plan confirmation to support timely QHP certification.

Starting in the 2023 plan year, CMS is interpreting "as stringent as" to mean that the reviews include assessing compliance with time and distance standards using a specialty list that includes the same specialties as the CMS provider specialty lists and parameters that are at least as narrow as CMS's parameters. Starting in the 2024 plan year, "as stringent as" will also mean that the reviews include assessing compliance with appointment wait time standards using a specialty list that includes the same specialties as the CMS provider specialty lists and parameters that are at least as narrow as CMS's parameters. States can implement network adequacy standards and reviews that are more stringent than CMS's. For both time and distance standards and appointment wait time standards, the specialty list can be broader than CMS's specialty list, but must include all the provider specialties included in CMS's list. The parameters can be narrower than CMS's parameters, meaning shorter time and/or distance. Time and distance reviews must be based on quantitative data collected from the issuer (not attestation) and supported by a justification requirement if an issuer does not meet one or more of the standards. Starting in the 2024 plan year, appointment wait time reviews must be based on methods as stringent as CMS's

methods and supported by a justification requirement if an issuer attests to not meeting one or more of the standards.

We will closely partner with these states to ensure they understand CMS's standards, that the states have adequate state authority to conduct such reviews, and that their reviews will appropriately assess network adequacy for QHPs in their state prior to plan confirmation to support timely QHP certification.

Issuers in all FFE states, including states performing plan management functions, will be required to submit their network adequacy data to CMS via the Essential Community Provider/Network Adequacy (ECP/NA) template.

ii. Network Adequacy for QHP Issuers in FFEs

a. Time and Distance Standards

Similar to our approach in prior years, CMS will adopt time and distance standards to assess whether QHPs in FFEs fulfill the network adequacy regulatory requirement. Tables 3.1 and 3.2 list the final time and distance standards for medical QHPs and the provider types to which they apply. For medical QHPs, CMS will assess compliance only for the dental provider type for those medical QHPs that have embedded dental services as a benefit. For SADPs, table 3.3 lists the final time and distance standard for the dental provider type.

To count towards meeting the time and distance standards, individual and facility providers listed on Tables 3.1, 3.2, and 3.3 must be appropriately licensed, accredited, or certified to practice in their state, as applicable, and must have in-person services available.

Taxonomy codes that crosswalk into each individual provider and facility specialty type are listed in the Taxonomy Codes tab of the ECP/NA template so that issuers know which providers to include in the respective individual and facility specialty categories. For the sake of brevity, when discussing provider types for network adequacy, we will use the term "behavioral health" to encompass mental health and substance use disorders. Under the circumstances described below, advanced practice registered nurses (APRNs) and physician assistants (PAs) can be included as primary care providers, and APRNs who specialize in behavioral health services can be included in the outpatient clinical behavioral health provider category. The purpose of including these specialties is to inform CMS of the rare times that contracting with non-MD/DO primary care and behavioral health services providers in underserved counties is necessary to serve as the major source of these types of care for enrollees. Organizations may include submissions under this specialty code only if the contracted APRN or PA is currently licensed in the state, meets the state's requirements governing the qualifications of that provider type, and is fully credentialed by the organization as a provider of primary care or behavioral health services. In addition, to count towards meeting the time and distance standard, the providers listed under this specialty code must function in accordance with state law as the primary source for the enrollee's primary care or behavioral health services, not supplement a physician's care, and be practicing in or rendering services to enrollees residing in a Health Professional Shortage Area.[28]

CMS will assess time and distance standards at the county level. In alignment with Medicare Advantage's approach, CMS will classify counties into five county type designations: Large

[28] *Available at:* https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas.

Metro, Metro, Micro, Rural, and Counties with Extreme Access Considerations (CEAC). CMS will use a county type designation method that is based upon the population size and density parameters of individual counties. These parameters are foundationally based on approaches used by the Census Bureau in its classification of "urbanized areas" and "urban clusters," and by the Office of Management and Budget in its classification of "metropolitan" and "micropolitan." For the population and density parameters, see pages 6-7 of the Medicare Advantage Network Adequacy Criteria Guidance.[29]

Table 3.1 Time and Distance Standards for Individual Provider Specialty Types for Medical QHPs for Exchange Plan Year 2023 QHP Certification.

Individual Provider Specialty Types	Maximum Time and Distance Standards Time is measured in minutes and distance is measured in miles.									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiology	20	10	30	20	50	35	75	60	95	85
Cardiothoracic Surgery	30	15	60	40	100	75	110	90	145	130
Chiropractor	30	15	45	30	80	60	90	75	125	110
Dental	30	15	45	30	80	60	90	75	125	110
Dermatology	20	10	45	30	60	45	75	60	110	100
Emergency Medicine	20	10	45	30	80	60	75	60	110	100
Endocrinology	30	15	60	40	100	75	110	90	145	130
ENT/Otolaryngology	30	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
General Surgery	20	10	30	20	50	35	75	60	95	85
Gynecology, OB/GYN	10	5	15	10	30	20	40	30	70	60
Infectious Diseases	30	15	60	40	100	75	110	90	145	130
Nephrology	30	15	45	30	80	60	90	75	125	110
Neurology	20	10	45	30	60	45	75	60	110	100
Neurosurgery	30	15	60	40	100	75	110	90	145	130
Occupational Therapy	20	10	45	30	80	60	75	60	110	100
Oncology - Medical, Surgical	20	10	45	30	60	45	75	60	110	100
Oncology - Radiation	30	15	60	40	100	75	110	90	145	130
Ophthalmology	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85

[29] *Available at:* https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf.

Individual Provider Specialty Types	Maximum Time and Distance Standards Time is measured in minutes and distance is measured in miles.									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Outpatient Clinical Behavioral Health (Licensed, accredited, or certified professionals)	10	5	15	10	30	20	40	30	70	60
Physical Medicine and Rehabilitation	30	15	45	30	80	60	90	75	125	110
Physical Therapy	20	10	45	30	80	60	75	60	110	100
Plastic Surgery	30	15	60	40	100	75	110	90	145	130
Podiatry	20	10	45	30	60	45	75	60	110	100
Primary Care – Adult	10	5	15	10	30	20	40	30	70	60
Primary Care – Pediatric	10	5	15	10	30	20	40	30	70	60
Psychiatry	20	10	45	30	60	45	75	60	110	100
Pulmonology	20	10	45	30	60	45	75	60	110	100
Rheumatology	30	15	60	40	100	75	110	90	145	130
Speech Therapy	20	10	45	30	80	60	75	60	110	100
Urology	20	10	45	30	60	45	75	60	110	100
Vascular Surgery	30	15	60	40	100	75	110	90	145	130

Table 3.2 Time and Distance Standards for Facility Specialty Types for Medical QHPs for Exchange Plan Year 2023 QHP Certification.

Facility Specialty Type	Maximum Time and Distance Standards Time is measured in minutes and distance is measured in miles.									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Acute Inpatient Hospitals (must have Emergency services available 24/7)	20	10	45	30	80	60	75	60	110	100
Cardiac Catheterization Services	30	15	60	40	160	120	145	120	155	140
Cardiac Surgery Program	30	15	60	40	160	120	145	120	155	140
Critical Care Services - Intensive Care Units (ICU)	20	10	45	30	160	120	145	120	155	140

Facility Specialty Type	Maximum Time and Distance Standards Time is measured in minutes and distance is measured in miles.									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Diagnostic Radiology (Free-standing; hospital outpatient; ambulatory health facilities with Diagnostic Radiology)	20	10	45	30	80	60	75	60	110	100
Inpatient or Residential Behavioral Health Facility Services	30	15	70	45	100	75	90	75	155	140
Mammography	20	10	45	30	80	60	75	60	110	100
Outpatient Infusion/Chemotherapy	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Facilities	20	10	45	30	80	60	75	60	95	85
Surgical Services (Outpatient or ASC)	20	10	45	30	80	60	75	60	110	100
Urgent Care	20	10	45	30	80	60	75	60	110	100

Table 3.3 Time and Distance Standards for SADPs for Exchange Plan Year 2023 QHP Certification.

Individual Provider Specialty Type	Maximum Time and Distance Standards Time is measured in minutes and distance is measured in miles.									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Dental	30	15	45	30	80	60	90	75	125	110

To assess whether QHPs comply with these standards, CMS will review provider data for in-network providers that QHP issuers submit via the ECP/NA template. For each specialty and time and distance standard listed in the table, CMS will review the issuer-submitted data to ensure that the plan provides access to at least one provider in each of the above-listed provider type categories for at least 90 percent of enrollees. For example, for endocrinology in a large metro county, at least 90 percent of enrollees would be required to have reasonable access to at least one provider within 15 miles and 30 minutes.

In the 2023 Payment Notice, CMS determined that when a QHP does not meet one or more of the time and distance standards, the issuer can 1) add more contracted providers to the network to come into alignment with the standards and re-submit their updated ECP/NA template to CMS, and/or 2) submit a completed Network Adequacy Justification Form. Issuers with network

adequacy deficiencies will receive a partially pre-populated Network Adequacy Justification Form via the Plan Management (PM) Community and will need to submit the completed form to the PM Community in the required Excel format. The justification process will require issuers that do not yet meet the time and distance standards to detail: the reasons that one or more time and distance standards were not met; the mitigating measures the issuer is taking to ensure enrollee access to respective provider specialty types; information regarding enrollee complaints regarding network adequacy; and the issuer's efforts to recruit additional providers. CMS will use any updated provider data submitted on its ECP/NA template and the completed Network Adequacy Justification Form submitted as part of the certification process to assess whether the issuer meets the regulatory requirement, prior to making the certification decision. CMS will continue to monitor network adequacy throughout the year and will coordinate with state departments of insurance should it be necessary to remedy an issuer's network adequacy deficiencies.

b. Appointment Wait Times

In the 2023 Payment Notice, CMS finalized that it would assess network adequacy using appointment wait time standards to assess whether QHPs offered through the FFEs fulfill network adequacy standards applicable to plans that use a provider network. Implementation of appointment wait time standards will begin in the 2024 plan year. See Table 3.4 for the list of provider specialties and parameters. Appointment wait time standards will apply to medical QHPs. For SADPs, only the dental provider specialty within the Specialty Care (Non-Urgent) category of appointment wait time standards will apply. The dental provider specialty includes all dental providers (including general dentists and dental specialists) listed in the Taxonomy Codes tab. To count towards meeting appointment wait time standards, providers listed in Table 3.4 must be appropriately licensed, accredited, or certified to practice in their state, as applicable, and must have in-person services available. Taxonomy codes that crosswalk into each provider and facility specialty type will be listed in the ECP/NA template. In general, provider specialty types that crosswalk into the Outpatient Clinical Behavioral Health category will be counted towards the Behavioral Health category for appointment wait time standards. Primary care providers will crosswalk into the Primary Care (Routine) category. All other provider specialty types that are reviewed for time and distance standards and do not crosswalk into the Behavioral Health or Primary Care (Routine) categories will crosswalk into the Specialty Care (Non-Urgent) category. The appointment wait time standards measure the number of business days between when an individual requests an appointment and when the first in-person appointment is available. In alignment with the National Committee for Quality Assurance (NCQA), CMS will base the appointment wait time standards on business days. These standards apply to appointments for both new and existing patients. Issuers will be required to meet the below standards 90 percent of the time at a minimum.

Table 3.4 Appointment Wait Time Standards for Exchange Plan Year 2024 QHP Certification.

Provider/Facility Specialty Type	**Appointments Must Be Available Within**
Behavioral Health	10 business days
Primary Care (Routine)	15 business days
Specialty Care (Non-Urgent)	30 business days

As CMS is adopting appointment wait time standards beginning with the 2024 plan year, CMS will explain how issuers will demonstrate compliance with appointment wait time standards in the 2024 Payment Notice and 2024 Letter to Issuers.

When CMS begins reviewing compliance with appointment wait time standards, in accordance with the 2023 Payment Notice, when an issuer does not meet appointment wait time standards, the issuer will have the same options as when not meeting time and distance standards: 1) add more contracted providers to the network to come into alignment with the standards, or 2) submit a completed Network Adequacy Justification Form. The justification process will require issuers that do not yet meet the appointment wait time standards to detail the same information described in the time and distance standards section above. CMS will use any updated provider data submitted on its ECP/NA template and completed Network Adequacy Justification Form submitted as part of the certification process in assessing whether the issuer meets the regulatory requirement, prior to making the certification decision. CMS will continue to monitor network adequacy throughout the year and will coordinate with state departments of insurance should it be necessary to remedy potential deficiencies.

c. Tiered Networks

As stated in the 2023 Payment Notice, CMS is not finalizing the tiered network policy for network adequacy. The tiered network policy proposal was that for plans that use tiered networks, to count toward the issuer's satisfaction of the network adequacy standards, providers must be contracted within the network tier that results in the lowest cost-sharing obligation for the respective plan's enrollees.

iii. Telehealth Services

As stated in the 2023 Payment Notice, starting in the 2023 plan year, CMS will collect data from QHPs on which of their in-network providers offer telehealth services. For each provider on the Individual Providers (NA) tab of the ECP/NA template, issuers must indicate yes or no to whether that provider offers telehealth services. For this purpose, CMS defines telehealth as "professional consultations, office visits, and office psychiatry services through brief communication technology-based service/virtual check-in, remote evaluation of pre-recorded patient information, and inter-professional internet consultation." As stated in the 2023 Payment Notice, issuers that do not already have data on whether their providers offer telehealth will need to collect this information prior to QHP certification. QHP issuers that do not currently collect this information may do so using the same means and methods by which they already collect information from their network providers related to time and distance standards and provider directory information. Issuers that do not have the information available by the time of the QHP certification process can indicate within the ECP/NA template dropdown options that they have requested the information from the provider and are awaiting the response. For the 2023 plan year, this data will inform network adequacy standards for future plan years and will not be made available to the public.

iv. Network Transparency

This section discusses how CMS will label each QHP network's breadth as compared to other QHP networks on HealthCare.gov. This section applies to all QHP issuers in states participating in the network breadth pilot, including where the state is performing plan management functions

and SBE-FPs, but excludes SADPs. This information will be available to consumers to provide them with information on a network's relative breadth. The purpose of the labeling is to provide increased transparency to enrollees about the breadth of the provider network for the coverage they are selecting.

For the 2023 plan year, each network's breadth will be compared to the network breadth of other QHPs available in the same county. CMS will identify network breadth based on analysis of QHP provider and facility data submitted as part of the 2023 plan year certification process via the ECP/NA template. This analysis will compare an issuer's contracted providers to the number of specific providers and facilities included across all QHP networks available in a county. The rating will focus on hospitals, adult primary care, and pediatric primary care with a separate classification for each of the three categories.

CMS will determine these classifications by calculating the percentage of providers in a plan's network compared to the total number of providers in QHP networks available in a county based on a time and distance calculation. To calculate network breadth, CMS will divide the number of each QHP's servicing providers at the issuer, network, county, and specialty combination level by the total number of all available QHP servicing providers for that county, including essential community providers (ECPs). The resulting number will be the Provider Participation Rate (PPR).

CMS classifies networks that contain:

- Fewer than 30 percent of available providers as Basic;
- 30−69 percent of available providers as Standard; and
- 70 percent or more of available providers as Broad.

Section 4. Essential Community Providers

The ECP standard for the 2023 plan year and the approach for reviews of the ECP standard, as stated in the 2023 Payment Notice, remains the same as for the 2022 and 2021 plan years, with the exception of the changes noted below. Please refer to the 2018 Letter to Issuers for full details.

At 45 CFR 156.235, CMS established QHP issuer requirements for inclusion of ECPs in provider networks, which requires that issuers include at least a certain threshold percentage, as determined by the Department of Health and Human Services (HHS), of available ECPs (based on a non-exhaustive HHS ECP List provided to issuers and updated annually) within the plan's service area in the issuer's provider network(s). The calculation methodology outlined in the 2018 Letter to Issuers and 2018 Payment Notice applies to issuers offering plans with a provider network.

In the 2023 Payment Notice, CMS announced that, for the 2023 plan year and beyond, CMS will increase the required threshold from 20 percent to 35 percent of available ECPs in the plan's service area, including approved ECP write-ins that would also count toward the issuer's satisfaction of the 35 percent threshold.

For the 2021 plan year, the percentage of medical and dental FFE issuers that could have satisfied a 35 percent ECP threshold was 80 percent and 74 percent, respectively; while the mean and median ECP score across all FFE issuers was 55 percent and 54 percent, respectively. Given

that, when the ECP threshold was 30 percent during the 2015-2017 plan years, all issuers satisfied the 30 percent standard when permitted to supplement their QHP applications with ECP write-ins and justifications, CMS anticipates that any issuers falling shy of the 35 percent threshold for the 2023 plan year will be able to satisfy the standard by relying on these same supplemental aids.

As stated in the 2023 Payment Notice, when CMS determines that a QHP does not meet ECP standards, the issuer will have two options: 1) add more contracted providers to the network to come into alignment with the standard, or 2) submit a completed ECP Justification Form. The justification process will require issuers that do not yet meet the ECP standards to detail: the reasons that one or more ECP standards were not met; the mitigating measures the issuer is taking to ensure enrollee access to ECPs; information regarding enrollee complaints regarding access to ECPs; and the issuer's efforts to recruit additional ECPs. CMS will use any updated provider data and the completed ECP Justification Form submitted as part of the certification process to assess whether the issuer meets the regulatory requirement, prior to making the certification decision.

For issuers needing to submit an ECP Justification Form, CMS will accept only the official ECP Justification Form and will no longer accept individually customized supplemental response forms as a substitute for the official form. The issuer will run the ECP Tool to identify any ECP deficiencies and generate the applicable ECP Justification Form that must be completed by the issuer and submitted through the PM Community. If CMS identifies ECP deficiencies for an issuer and the issuer has not submitted an ECP Justification Form with its QHP application, CMS will generate the ECP Justification Form for the issuer to retrieve from the PM Community.

As stated in the 2023 Payment Notice, for plans that use tiered networks, ECPs must be contracted within the network tier that results in the lowest cost-sharing obligation for the respective plan's enrollees in order for those ECPs to count toward the issuer's satisfaction of each element of the ECP standard. For example, a QHP issuer must not include in their ECP/NA template providers contracted within their PPO network when applying for QHP certification of their HMO network, if use of the PPO network providers would result in higher cost-sharing obligations for HMO plan enrollees. For plans with two network tiers (for example, participating providers and preferred providers), such as many PPOs, where cost sharing is lower for preferred providers, only providers in the preferred network will be counted towards satisfying the ECP standards. The elements of the ECP standard are: contracting with a minimum of 35 percent of available ECPs in the plan's service area; offering contracts in good faith to all available Indian health care providers; and offering contracts in good faith to at least one ECP in each ECP category in each county in the service area.

Additionally, for the 2023 plan year and beyond, CMS has added Substance Use Disorder Treatment Centers under the category of Other ECP Providers, as these facilities are critical to CMS's efforts to ensure that low-income, medically underserved individuals have sufficient access to these providers. Furthermore, the ECP category of "Other ECP Providers" is defined in the 2023 Payment Notice to include the following types of providers: Substance Use Disorder Treatment Centers, Community Mental Health Centers, Rural Health Clinics, Black Lung Clinics, Hemophilia Treatment Centers, Sexually Transmitted Disease Clinics, and Tuberculosis Clinics.

Section 5. Accreditation

The approach for reviews of the accreditation standard remains largely unchanged from 2020. In continued consideration of the announcements by HHS-recognized accrediting entities making modifications to accreditation standards due to the COVID-19 public health emergency,[30] CMS may provide flexibilities with regard to health plan accreditation reviews, as appropriate. HHS encourages issuers to provide their accrediting entity (AE) the HIOS ID number associated with their organization as they begin to work with the AE(s) on accreditation.

Section 6. Patient Safety Standards for QHP Issuers

The approach for QHP patient safety annual certification standards remains unchanged from 2017 and later years. Please refer to the 2017 Letter to Issuers in the Federally-facilitated Exchanges (2017 Letter to Issuers) for details regarding guidance for QHP issuers who contract with a hospital with more than 50 beds. CMS will continue to assess these standards and any related burden for issuers and hospitals.

Section 7. Quality Reporting

The approach for review of QHP issuer compliance with quality reporting standards related to the Quality Rating System (QRS) and QHP Enrollee Experience Survey (QHP Enrollee Survey) remains unchanged[31] from 2018. Please refer to the 2018 Letter to Issuers for more information, and to the Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2022[32] for more detailed information on issuer data collection and reporting requirements for the 2022 calendar year.

At this time, QRS and QHP Enrollee Survey reporting requirements do not apply to indemnity plans, SADPs, or to child-only plans offered on Exchanges. The QRS and QHP Enrollee Survey requirements also do not apply to Basic Health Program (BHP) plans.

Section 8. Quality Improvement Strategy

The approach for QHP certification reviews for quality improvement strategy (QIS) reporting remains unchanged from 2018.[33] Please refer to the 2018 Letter to Issuers for more information. CMS intends to provide information on the applicable QIS requirements in the forthcoming QIS Technical Guidance and User Guide for the 2023 plan year.

At this time, the QIS requirements do not apply to SADPs or to child-only plans offered on Exchanges.

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[30] *See* announcements *available at:* https://www.ncqa.org/covid/, https://www.urac.org/press-room/urac-responds-coronavirus, and https://www.aaahc.org/what-you-need-to-know/.

[31] The suspension of activities related to the collection of clinical quality measures for the QRS and survey measures for the QHP Enrollee Survey noted in the 2021 Letter to Issuers was specific to the 2021 plan year (2020 ratings year).

[32] *See* Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2022 (October 2021), *available at:* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html.

[33] The suspension of reporting QIS data noted in the 2021 Letter to Issuers was specific to the 2021 plan year (2020 calendar year).

Section 9. Review of Rates

The approach for 2023 remains unchanged from the 2020 Letter to Issuers in the Federally-facilitated Exchanges (2020 Letter to Issuers). Please refer to the 2020 Letter to Issuers and the Unified Rate Review Instructions for more information.[34]

Section 10. Discriminatory Benefit Design

The approach to discriminatory benefit design generally remains unchanged from 2017 and later years. Please refer to the 2017 Letter to Issuers for more information regarding discriminatory benefit design, QHP discriminatory benefit design, and the treatment protocol calculator. However, the 2023 Payment Notice refined the essential health benefits (EHB) nondiscrimination policy for health plan designs. CMS will assess compliance of QHPs in the FFEs by ensuring consistent application of EHB nondiscrimination policy, which will better safeguard consumers who depend on nondiscrimination protections. While states are generally the primary enforcers of EHB policy, CMS will continue to monitor issuer compliance with EHB nondiscrimination policy and provide technical assistance and available data, research, or other information to states. CMS will assess benefit designs to ensure they are nondiscriminatory and consistent with 45 CFR 156.125, regardless of how a discriminatory benefit design originated.

Section 11. Prescription Drugs

The approach for reviewing issuers' prescription drug benefit offerings remains unchanged from 2019 and later years. For the 2023 plan year, asthma will be added as a condition to the clinical appropriateness review. Please refer to the 2019 Letter to Issuers in the Federally-facilitated Exchanges (2019 Letter to Issuers) for more information.

Section 12. Third Party Payment of Premiums and Cost Sharing

Requirements related to QHP and SADP issuers' acceptance of third-party payments of premiums and cost sharing on behalf of QHP enrollees remain unchanged from 2018. Please refer to the 2018 Letter to Issuers for more information.

Section 13. Cost-sharing Reduction Plan Variations

The approach for issuers to provide cost-sharing reductions (CSRs) to consumers through CSR plan variations remains unchanged from 2018 and later years. Please refer to the 2018 Letter to Issuers for more information. Eligible consumers can enroll in these plan variations for the 2023 plan year and will continue to receive CSRs provided by issuers. Since October 2017, CMS has not made CSR payments to issuers and cannot make CSR payments unless Congress appropriates funds for these payments.

Section 14. Data Integrity Review

The approach for conducting data integrity reviews remains unchanged from 2018 and later years. Please refer to the 2018 Letter to Issuers for more information.

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[34] *See, e.g.,* the 2023 Unified Rate Review Instructions, *available at*: https://www.cms.gov/files/document/urr-py23-instructions.pdf.

Section 15. Interoperability

The Interoperability and Patient Access Final Rule[35] was finalized on May 1, 2020. For the 2023 plan year, the policy remains unchanged from the 2022 plan year. To assess compliance with all interoperability requirements, the FFEs will require QHP issuers to attest that they are meeting the requirements at 45 CFR 156.221 or submit a justification as part of the QHP application. Please refer to the 2022 Letter to Issuers for more information on previous interoperability requirements. As noted in the final rule, the interoperability requirements specifically exclude QHP issuers on the FFEs offering only SADPs or issuers only offering QHPs in the FF-SHOPs.

As noted in the Notification of Enforcement Discretion released on December 10, 2021,[36] CMS has opted to employ enforcement discretion for 45 CFR 156.221(f), known as the payer-to-payer data exchange provision, which instructs issuers to maintain a process for the electronic exchange of data classes and elements with other payers for current and prior enrollees. Enforcement of the payer-to-payer data exchange requirement is delayed and will not be incorporated in QHP certification for the 2023 plan year. QHP issuers are encouraged to review the Federal Register notice referenced above announcing enforcement discretion for more information.

CHAPTER 3: CONSUMER SUPPORT TOOLS AND PUBLIC INFORMATION

(This chapter relies on authority from ACA sections 1311(c) and (e) and 1321(a); and 45 CFR 147.200, 155.706(a), 156.122, 156.220, 156.230, and 156.286.)

Section 1. Consumer Support Tools

CMS developed several decision support tools and publishes certain plan data to empower patients to understand their insurance options and select a plan through an FFE or SBE-FP, including through an FF-SHOP. Please refer to the 2018 Letter to Issuers for more information on these consumer support tools, including provider and formulary search functions and the out-of-pocket cost comparison tool.

Section 2. Transparency in Coverage Reporting

This section provides an overview of the transparency reporting requirements for all QHP issuers, including SADP issuers, in the FFEs, including in states that are performing plan management functions.

Pursuant to 45 CFR 156.220, issuers are required to annually report transparency in coverage data to CMS. CMS submitted its information collection request, CMS-10572, "Transparency in

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[35] *See* Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers Final Rule, 85 Fed. Reg. 25,510 (May 1, 2020), *available at:* https://www.govinfo.gov/content/pkg/FR-2020-05-01/pdf/2020-05050.pdf.

[36] *See* Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers Notification of Enforcement Discretion, 85 Fed. Reg. 70,412 (Dec 10, 2021), *available at:* https://www.govinfo.gov/content/pkg/FR-2021-12-10/pdf/2021-26764.pdf.

Coverage Reporting by Qualified Health Plan Issuers," under the Paperwork Reduction Act (PRA) to OMB for an additional 3-year collection period, and it is pending OMB approval. If approved, the data collection elements that QHP issuers reported from 2020 to 2022 would remain part of the collection for the 2023 plan year. Transparency in Coverage URL submissions should be made in the QHP Supplemental Submission Module at the time of QHP application submission.

Section 3. Medical Cost Scenarios

Consumer testing of the summary of benefits and coverage (SBC) shows that hypothetical medical scenarios illustrating the consumer portion of medical costs, such as those found on the SBC, help consumers understand and compare health plan coverage options. CMS will continue to analyze ways to provide additional medical cost scenarios to QHP customers.

CHAPTER 4: STAND-ALONE DENTAL PLANS: 2023 APPROACH

(This chapter relies on authority from ACA sections 1311(c), (d), and (e) and 1321(a); and 45 CFR 156.150.)

The approach for submitting applications for certification of SADPs remains unchanged from 2021. Please refer to the 2018 and 2021 Letters to Issuers for more information.

Section 1. SADP Annual Limitation on Cost Sharing

For the 2023 plan year, the SADP annual limitation on cost sharing for one covered child is $350 increased by the 12.696 percentage point increase in the Consumer Price Index (CPI) for dental services of 516.519 for 2021 over the CPI for dental services for 2016 of 458.330, increasing the annual limitation on cost sharing for SADPs by $44.44 to a total of $394.44. The regulation at 45 CFR 156.150(d) requires incremental increases to be rounded down to the next lowest multiple of $25, meaning the annual limitation on cost sharing for SADPs for the 2023 plan year will be $375 for one child and $750 for two or more children. For more information on how this limitation is determined, please refer to § 156.150 and to the 2018 Letter to Issuers.

Section 2. SADP Actuarial Value Requirements

The approach to actuarial value requirements and certification for SADP coverage of the pediatric EHB remains unchanged from 2021. Please refer to the 2021 Letter to Issuers for more information. For the 2023 plan year, SADP issuers may offer the pediatric dental EHB at any actuarial value. SADP issuers will be required to certify the actuarial value of each SADP's coverage of pediatric dental EHB.

CHAPTER 5: QUALIFIED HEALTH PLAN PERFORMANCE AND OVERSIGHT

(This chapter relies on authority from ACA sections 1311(c) and (d), and 1321(a); and 45 C.F.R. § 147.104(e), 45 C.F.R. §§ 155.201, 155.220, 155.221, and 155.1010, and 45 C.F.R. §§ 156.200, 156.225, 156.260, 156.272, 156.340, 156.705, 156.715, and 156.1230.)

Guidance on QHP issuer account management, issuer compliance monitoring, issuer compliance reviews, and issuer participation for the full plan year generally remains unchanged from 2018 and later years. Please refer to the Letter to Issuers from 2018 and letters from later years for more information.

CHAPTER 6: CONSUMER SUPPORT AND RELATED ISSUES

(This chapter relies on authority from ACA sections 1311(c) and (e) and 1321(a); PHS Act sections 2715 and 2719; and 45 CFR 147.136, 147.200, Part 155 Subpart C, and 156.1010.)

Section 1. Coverage Appeals

The approach to coverage appeals generally remains unchanged from 2018 and later years. Please refer to the 2018 Letter to Issuers for more information.

However, please note that section 2719 of the PHS Act, as amended by Title I (the No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021, and implemented through interim final rules published on October 7, 2021[37] amends the scope of claims eligible for external review to include adverse benefit determinations related to compliance with the surprise billing and cost-sharing protections under sections 2799A-1 or 2799A-2 of the PHS Act, as added by the No Surprises Act. The interim final rules also extend the external review requirement to grandfathered health plans for adverse benefit determinations involving items and services covered by the requirements under sections 2799A-1 or 2799A-2 of the PHS Act.

Section 2. Consumer Case Tracking

The approach to consumer case tracking remains unchanged from 2018 and later years. Please refer to the 2018 Letter to Issuers for more information.

Section 3. Meaningful Access

This section summarizes the laws, regulations, and guidance that require QHP issuers (including SADP issuers) to take reasonable steps to ensure meaningful access by limited English proficient (LEP) speakers and individuals with disabilities.

In the 2018 Payment Notice, CMS finalized changes to the tagline requirements applicable to Exchanges and QHP issuers pursuant to section 1311 of the ACA (1311 tagline requirements), as implemented at 45 CFR 155.205(c)(2)(iii)(A), with the intent to reduce overlapping regulatory burden on Exchanges and QHP issuers in relation to tagline requirements.[38] This rule stated that Exchanges and QHP issuers will be deemed to be in compliance with 45 CFR 155.205(c)(2)(iii)(A) if they are in compliance with 45 CFR 92.8.

In June 2020, HHS published a final rule[39] eliminating 45 CFR 92.8 and the section 1311 tagline requirements. Nonetheless, section 1557 of the ACA, Title VI of the Civil Rights Act of 1964 (Title VI), and section 504 of the Rehabilitation Act still require covered entities to take reasonable steps to ensure meaningful access to their programs by LEP individuals and individuals with disabilities. Therefore, in some cases, the provision of notices and taglines may

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[37] *See* Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55980 (Oct. 7, 2021), *available at*: https://www.govinfo.gov/content/pkg/FR-2021-10-07/pdf/2021-21441.pdf.

[38] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program, 81 Fed. Reg. 94058 (December 22, 2016), *available at*: https://www.govinfo.gov/content/pkg/FR-2016-12-22/pdf/2016-30433.pdf.

[39] Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37160 (June 19, 2020), *available at*: https://www.govinfo.gov/content/pkg/FR-2020-06-19/pdf/2020-11758.pdf.

be necessary to ensure meaningful access by LEP individuals and individuals with disabilities.

Additionally, in light of priorities to improve health equity and remove potential barriers that underserved communities and individuals may face to enrollment in and access to benefits in federal programs, we strongly encourage QHP issuers and Exchanges to continue to meet tagline standards as set forth in the 2018 Letter to Issuers. HHS intends to issue future rulemaking proposing to reaffirm and clarify these standards as requirements.

Section 4. Summary of Benefits and Coverage (SBC)

The guidance on the SBC remains unchanged. Please refer to the 2022 Letter to Issuers for more information.

CHAPTER 7: TRIBAL RELATIONS AND SUPPORT

(This chapter relies on authority from ACA sections 1311(c) and (e) and 1321(a).)

CMS guidance concerning Indian health care providers remains unchanged from 2018 and later years. For more information, please refer to the 2018 Letter to Issuers.[40]

[40] The model QHP Addendum for Indian health providers is *available at*: https://www.qhpcertification.cms.gov/s/Model_QHP_Addendum_Indian_Health_Care_Providers.pdf?v=1.