Key Priorities for FFM Compliance Reviews for the 2017 Benefit Year

Consistent with the Centers for Medicare & Medicaid Services' (CMS) authority under 45 C.F.R. 156.715, CMS will perform compliance reviews of Issuers offering Qualified Health Plans (QHPs) in the Federally-facilitated Marketplaces (FFM). For purposes of this document, QHPs include stand-alone dental plans (SADPs), unless otherwise indicated. We intend for these compliance reviews to focus on FFM requirements for QHP certification under 45 CFR part 156 and other key FFM operational standards for those states in which CMS is operating the Marketplace, including FFMs where states perform plan management. CMS will review data at both the Issuer and the QHP level. Policies, procedures, protocols, standard operating procedures, or other similar manuals and any other applicable documentation may be requested as part of the compliance review process to show compliance with Issuer standards. As additional final regulations and operational guidance are published, those standards may be included as part of the compliance reviews.

Table A below lists the regulatory standards governing QHP certification that we anticipate including as part of the FFM compliance reviews for the 2017 benefit year. This list is intended to help QHP Issuers understand the key priorities for CMS' 2017 FFM compliance reviews. We note that this list should not be construed as a comprehensive listing of all standards applicable to QHP Issuers in the FFMs, nor a limitation on CMS' authority or ability to review compliance with any standards not appearing on this list. The compliance reviews that are the subject of this document are separate from other audits and reviews that may be conducted to ensure compliance with the Affordable Care Act (e.g., Medical Loss Ratio [MLR] audits, policy and rate filing reviews, and reinsurance-eligible plan audits). We have provided illustrative examples in Table B of regulatory standards that fall into this second category of requirements that will be monitored for compliance through other review and oversight mechanisms. It is not intended to be an all-inclusive list.

Table A. Regulatory Standards That May Be Included in FFM Compliance Reviews for 2017

Regulatory Standard	Federal Regulation
QHP Issuer Participation Standards The QHP Issuer must meet Exchange participation standards by: ▪ Being certified by the Exchange for each health plan offered on the FFM ▪ Complying with FFM processes, procedures, and requirements under Subpart K of Part 155 and, in the small group market, 45 CFR 155.705 ▪ Maintaining licensure and good standing in each state in which QHP Issuer offers health insurance ▪ Implementing a quality improvement strategy, reporting quality and outcomes information, and implementing appropriate enrollee satisfaction surveys ▪ Offering at least one gold and one silver plan in the individual and small group markets, and one child-only plan in the individual market ▪ Not discriminating based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation ▪ Providing the same agent/broker compensation for similar coverage offered inside and outside the FFM ▪ Complying with FF-SHOP participation provisions	**45 CFR § 156.200** ▪ § 156.200(a) ▪ § 156.200(b)(2) ▪ § 156.200(b)(4) ▪ § 156.200(b)(5) ▪ § 156.200(c) ▪ § 156.200(e) ▪ § 156.200(f) ▪ § 156.200(g)
QHP Rate and Benefit Information The QHP Issuer must report rates by: ▪ Submitting justifications of rate increases to the Exchange prior to the implementation of the rate increase ▪ Prominently posting justifications of rate increases on the QHP Issuer's website	**45 CFR § 156.210** ▪ § 156.210(c) ▪ § 156.210(c)
Transparency in Coverage The QHP Issuer must comply with transparency in coverage standards by: ▪ Providing information on claims payment policies and practices ▪ Submitting data/information described in 45 CFR 156.220(a) in an accurate and timely manner to the Exchange, HHS, and the State insurance commissioner, and make the information available to the public ▪ Using plain language as defined in 45 CFR 155.20 when providing the required information	**45 CFR § 156.220** ▪ § 156.220(a)(1) ▪ § 156.220(b) ▪ § 156.220(c)
QHP Marketing and Benefit Design The QHP Issuer must not discourage enrollment of individuals with significant health needs by: ▪ Not employing marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs	**45 CFR § 156.225** ▪ § 156.225(b)

Regulatory Standard	Federal Regulation
Delegated and Downstream Entities The QHP Issuer must comply with standards applicable to delegated and downstream entities, such as: ▪ Ensuring that its delegated/downstream entities comply with the standards of 45 CFR Part 156, Subpart C, including the prohibition under 45 CFR 156.225(b) against employing marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs ▪ Ensuring that a delegation agreement includes the specified elements in accordance with 45 CFR 156.340(b)	**45 CFR § 156.340** ▪ § 156.340(a)(1) ▪ § 156.340(b)
Agent/Broker Standards The QHP Issuer must ensure compliance by its appointed agents/brokers, as downstream/delegated entities, in the following areas: ▪ Satisfying applicable FFM registration and training requirements ▪ Maintaining licensure and good standing in each state in which the agent/broker operates ▪ Executing the FFM Privacy / Security Agreement(s) and (if applicable) the General Marketplace Agreement ▪ Using the required disclaimers if an agent/broker non-FFM website is used to assist with QHP selection	**45 CFR § 156.340** ▪ § 156.340(a)(3) ▪ § 156.340(a)(3) ▪ § 156.340(a)(3) ▪ § 155.220(e)
Network Adequacy Standards A QHP Issuer that uses a provider network must maintain a sufficient provider network by: ▪ Ensuring that services, including mental health and substance abuse services, are accessible without unreasonable delay ▪ Publishing a provider directory online and providing a hard copy upon request ▪ Identifying providers that are not accepting new patients in the provider directory ▪ Making the provider directory publicly available on the QHP Issuer's website in a machine-readable file and also provide it upon request by HHS in a format and manner specified by HHS ▪ Making a good faith effort to provide written notice to impacted enrollees of discontinuation of a provider 30 days prior to the effective date of the change ▪ Allowing an enrollee in an active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates, if a provider is terminated without cause	**45 CFR § 156.230** ▪ § 156.230(a)(2) ▪ § 156.230(b) ▪ § 156.230(b) ▪ § 156.230(c) ▪ § 156.230(d)(1) ▪ § 156.230(d)(2)

Regulatory Standard	Federal Regulation
Essential Community Providers A QHP Issuer that uses a provider network must ensure access to Essential Community Providers (ECPs) by: ▪ Including a sufficient number and geographic distribution of ECPs to ensure access for low-income, medically underserved individuals in the QHP's service area ▪ Paying appropriate reimbursement to federally qualified health centers for covered services provided to QHP enrollees	**45 CFR § 156.235** ▪ § 156.235(a),(b) ▪ § 156.235(e)
Meaningful Access to QHP Information The QHP Issuer must ensure the readability of Health Plan Application and Notices by: ▪ Making these documents accessible for individuals in accordance with the Americans with Disabilities Act and for individuals with limited English proficiency	**45 CFR § 156.250** ▪ § 156.250
Rating Variations The QHP Issuer must provide parity with respect to the cost of coverage offered inside and outside the Exchange by: ▪ Charging the same premium rate without regard to whether the plan is offered through an Exchange, directly from the Issuer, or through an agent	**45 CFR § 156.255** ▪ § 156.255(b)
Enrollment Periods for Qualified Individuals The QHP Issuer must follow a defined enrollment process for the individual market by: ▪ Enrolling qualified individuals during the annual open enrollment periods ▪ Allowing for special enrollment periods in cases of specific triggering life events ▪ Complying with the rules governing effective dates of coverage, as established by the Exchange ▪ Providing accurate information on effective dates of coverage to qualified individuals	**45 CFR § 156.260** ▪ § 156.260(a) ▪ § 156.260(a) ▪ § 156.260(a) ▪ § 156.260(b)

Regulatory Standard	Federal Regulation
Enrollment Process for Qualified Individuals The QHP Issuer must adhere to the required enrollment processes for the individual market by:	**45 CFR § 156.265**
▪ Allowing for enrollment through the Exchange rather than only direct enrollment through the QHP Issuer	▪ § 156.265(b)
▪ Safeguarding enrollment information with respect to personally identifiable information	▪ § 156.265(c)
▪ Complying with premium payment rules established by the Exchange	▪ § 156.265(d)
▪ Providing new enrollees with an enrollment information package that meets readability and accessibility standards for individuals with disabilities or limited English proficiency	▪ § 156.265(e)
▪ Reconciling enrollment files with the Exchange no less than once a month	▪ § 156.265(f)
▪ Acknowledging receipt of enrollment information provided to the QHP Issuer by the Exchange	▪ § 156.265(g)
▪ Accepting premium and cost-sharing payments from certain third-party entities on behalf of plan enrollees (the QHP Issuer's downstream entities must also comply to the extent they routinely collect premiums or cost-sharing payments)	▪ § 156.1250
Termination of Coverage for Qualified Individuals The QHP Issuer must adhere to termination-of-coverage processes in the individual market by:	**45 CFR § 156.270**
▪ Terminating coverage only under certain permitted circumstances	▪ § 156.270(a)
▪ Providing termination-of-coverage notices promptly to affected enrollees	▪ § 156.270(b)
▪ Establishing a policy for handling terminations of coverage due to nonpayment of premium	▪ § 156.270(c)
▪ Following the special termination guidelines for recipients of the advance payment of the premium tax credits	▪ § 156.270(c),(d),(e),(g)
▪ Providing payment delinquency notices to affected enrollees	▪ § 156.270(f)
▪ Maintaining termination-of-coverage records in accordance with Exchange standards	▪ § 156.270(h)
▪ Complying with the rules for effective dates of termination of coverage	▪ § 156.270(i)

Regulatory Standard	Federal Regulation
Additional Standards Specific to FF-SHOP The QHP Issuer offering a QHP through an FF-SHOP must adhere to additional FF-SHOP standards, such as:	**45 CFR § 156.285**
▪ Accepting payments from the FF-SHOP on behalf of the qualified employer or an enrollee	▪ § 156.285(a)(1)
▪ Following established rate-setting timelines	▪ § 156.285(a)(2)
▪ Charging the same rate for the entire plan year	▪ § 156.285(a)(3)
▪ Following open and special enrollment periods, including adherence to the rules governing effective dates of coverage	▪ § 156.285(b)
▪ Complying with the enrollment timeline and process for the SHOP	▪ § 156.285(c)(1)
▪ Receiving electronic enrollment information from the SHOP and safeguarding personally identifiable information received	▪ § 156.285(c)(2)
▪ Providing enrollment information packages to new enrollees	▪ § 156.285(c)(4)
▪ Reconciling enrollment files with the FF-SHOP at least monthly	▪ § 156.285(c)(5)
▪ Acknowledging receipt of enrollment information per SHOP standards	▪ § 156.285(c)(6)
▪ Adhering to the applicable qualified employer's plan year for purposes of enrolling qualified employees	▪ § 156.285(c)(7)
▪ Providing notices regarding termination of coverage to enrollees and qualified employers	▪ § 156.285(d)(1)(ii)
▪ Following the applicable rules for effective dates for termination of coverage	▪ § 156.285(d)(1)(iii)
▪ Terminating coverage for all employees of a withdrawing qualified employer	▪ § 156.285(d)(1)(i)
Nonrenewal and Decertification of QHPs The QHP Issuer must follow nonrenewal and decertification processes by:	**45 CFR § 156.290**
▪ Adhering to notification standards when the QHP Issuer is not seeking recertification	▪ § 156.290(a)(1)
▪ Fulfilling benefit coverage obligations to enrollees	▪ § 156.290(a)(2)
▪ Fulfilling reporting obligations to the Exchange	▪ § 156.290(a)(3)
▪ Providing written non-renewal notices to affected enrollees in a timely manner	▪ § 156.290(a)(4), (b)
▪ Following the specific termination standards governing decertification by the Exchange	▪ § 156.290(c)

Regulatory Standard	Federal Regulation
Prescription Drug Formulary The QHP Issuer must comply with essential health benefits (EHB) requirements for prescription drugs by:	**45 CFR § 156.122**
▪ Covering at least the greater of one drug in every United States Pharmacopeia category and class or the same number of prescription drugs in each category and class of EHB benchmark plan	▪ § 156.122(a)(1) and (2)
▪ Using a pharmacy and therapeutics committee that meets required membership standards, meets at least quarterly, establishes and manages the formulary drug list, as well as documents procedures and decisions related to formulary development and revision	▪ § 156.122(a)(3)
▪ Having procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan	▪ § 156.122(c)
▪ Making the formulary publicly available on the QHP Issuer's website in a machine-readable file and format specified by HHS	▪ § 156.122(d)(1) and (2)
Maintenance of Records The QHP Issuer must follow maintenance of records processes by:	**45 CFR § 156.705**
▪ Maintaining all FFM-related documents and records and evidence of accounting procedures and practices necessary for HHS to periodically audit financial records and conduct compliance reviews	▪ § 156.705(a)
▪ Retaining FFM-related records for a period of 10 years	▪ § 156.705(c)
Handling of Health Insurance Casework System (HICS) The QHP Issuer must follow standards processes for cases by:	**45 CFR § 156.1010**
▪ Investigating and resolving cases forwarded to the QHP Issuer by HHS	▪ § 156.1010(b)
▪ Resolving cases received by a QHP Issuer from HHS within 15 calendar days of receipt of the case, and urgent cases must be resolved no later than 72 hours after receipt of the case	▪ § 156.1010(d)
▪ Notifying enrollees regarding the disposition of cases received from HHS within the required timeframes and format	▪ § 156.1010(f)

Regulatory Standard	Federal Regulation
Patient Safety Standards for QHP Issuers The QHP Issuer must establish patient safety standards by: ▪ Verifying that hospitals the QHP Issuer contracts with having greater than 50 beds utilize a patient safety evaluation system as defined in 42 CFR 3.2028 and have implemented a comprehensive person-centered discharge program to improve care coordination and health care quality for each patient; or have implemented an evidence-based initiative to improve health care quality through the collection, management, and analysis of patient safety events that reduces all cause-preventable harm, prevents hospital readmission, or improves care coordination. Collecting information from each of its contracted hospitals with greater than 50 beds to demonstrate that those hospitals meet the applicable patient safety standards ▪ Making available to the Exchange the documentation referenced in 45 CFR 156.1110(b) upon request by the Exchange, in a time and manner specified by the Exchange	**45 CFR § 156.1110** ▪ § 156.1110(a)(2) ▪ § 156.1110(b)(2) ▪ § 156.1110(c)
Quality Rating System The QHP Issuer must follow quality rating system processes by: ▪ Submitting data on an annual basis that has been validated in a form and manner and on a timeline set forth by HHS	**45 CFR § 156.1120** ▪ § 156.1120
Enrollee Satisfaction Survey System The QHP Issuer must follow enrollee satisfaction survey system processes by: ▪ Contracting with an HHS-approved enrollee satisfaction survey vendor ▪ Submitting data on an annual basis that has been validated in a form and manner and on a timeline specified by HHS	**45 CFR § 156.1125** ▪ § 156.1125(a) ▪ § 156.1125(b), (d)
Quality Improvement Strategy The QHP Issuer must follow quality improvement strategy processes by: ▪ Implementing and reporting on a quality improvement strategy in accordance with HHS participation criteria ▪ Submitting data on an annual basis that has been validated in a manner and on a timeframe specified by the applicable Exchange to support the evaluation of quality improvement strategies	**45 CFR § 156.1130** ▪ § 156.1130(a) ▪ § 156.1130(b), (c)
Other Notices for Special Enrollment Periods The QHP Issuer must comply with notice requirements related to material or benefit display errors and the enrollees' eligibility for an SEP, included in 45 CFR 155.420(d)(4) by: ▪ Notifying affected enrollees within 30 calendar days after being notified by the FFM that the error has been fixed, if directed to do so.	**45 CFR § 156.1256** ▪ § 156.1256

Table B. Examples of Regulatory Standards Monitored Through Other Oversight Mechanisms

Example of Regulatory Standard	Federal Regulation
The QHP Issuer must comply with benefit design standards, including provision of Essential Health Benefits and following cost-sharing limits, with respect to each of its QHPs.	45 CFR § 156.200(b)(3)
The QHP Issuer must pay applicable user fees to HHS.	45 CFR § 156.200(b)(6)
The QHP Issuer must comply with the standards related to the risk adjustment program.	45 CFR § 156.200(b)(7)
The QHP Issuer must adhere to any requirements imposed by a state in connection with its Exchange.	45 CFR § 156.200(d)
The QHP Issuer must set rates for the entire benefit or plan year.	45 CFR § 156.210(a)
The QHP Issuer must submit rate and benefit information to the Exchange.	45 CFR § 156.210(b)
The QHP Issuer must meet the standards related to the administration of cost-sharing reductions and advance payments of the premium tax credit.	45 CFR § 156.215(a)
The QHP Issuer must comply with any applicable state laws and regulations regarding marketing of health insurance coverage.	45 CFR § 156.225(a)
The QHP Issuer must demonstrate consistent application of premium variations by geographic rating areas.	45 CFR § 156.255(a)
The QHP Issuer must meet and maintain compliance with the accreditation standards of an HHS-recognized accrediting entity in the applicable categories based on the QHP Issuer's area of operation.	45 CFR § 156.275
The QHP Issuer must comply with applicable state laws prohibiting abortion coverage in QHPs and must follow financial standards for the segregation of funds for abortion services.	45 CFR § 156.280