Plan Year 2023 QHP Certification State Toolkit

Key Resources for FFEs, FFEs in States Performing Plan Management, and SBE-FPs

Last Updated: 4/21/2022

Contents

PURPOSE OF THE TOOLKIT

The Qualified Health Plan (QHP) Certification State Toolkit provides consolidated resources that states can refer to throughout the QHP certification process. This toolkit provides important information, including states' roles and responsibilities throughout the QHP certification process, key dates and reminders, submission trainings and manuals for the Health Insurance Oversight System (HIOS) and the System for Electronic Rate and Form Filing (SERFF),[1] and additional resources for states. The toolkit is a supplemental resource and is not intended to replace official guidance or instructions.

WHERE TO FIND HELP

- For technical questions related to HIOS, contact the Marketplace Service Desk at 1-855-CMS-1515 (1-855-267-1515) or CMS_FEPS@cms.hhs.gov.
- For technical questions related to SERFF, contact the SERFF Plan Management Help Desk at serffplanmgmt@naic.org.
- For questions regarding the Plan Management (PM) Community, states can review the PM Community User Guide.
- For state-related questions, contact the PM State Coordination mailbox at PlanManagementStateCoordination@cms.hhs.gov.
- For form-filing questions in states where Centers for Medicare & Medicaid Services (CMS) perform the reviews, contact FormFiling@cms.hhs.gov.
- For rate review questions, contact RateReview@cms.hhs.gov.
- For general CCIIO (Center for Consumer Information and Insurance Oversight) information, see the CCIIO Fact Sheets and FAQs.
- For key documents related to QHP certification, reference the QHP certification website.

[1] For SERFF support, please contact the National Association of Insurance Commissioners (NAIC).

QHP Certification Overview

Consumers and small business employers have access to the Health Insurance Exchanges through the Patient Protection and Affordable Care Act (PPACA). Eligible consumers in every state and the District of Columbia are able to buy QHPs and stand-alone dental plans (SADPs) available through their state's Exchange. States operate their own State-Based Exchanges (SBEs) or allow the federal government to facilitate the Exchange in their state (Federally Facilitated Exchange; FFE). Some states perform plan management functions in FFEs, and some SBEs use the federal platform (SBE-FP). **Table 1** describes the different plan management responsibilities of each Exchange model. Appendix A provides a map that illustrates each state's Exchange model.

Table 1. Responsibilities, by Exchange Model

Exchange Model	Description of State Responsibilities
Federally Facilitated Exchange (FFE)	CMS, as administrator of the FFE, certifies QHPs, whereas the state, with the exception of Missouri, Oklahoma, Texas, and Wyoming (see Appendix A), enforces market-wide standards[2] under the PPACA. For Missouri, Oklahoma, Texas, and Wyoming, CMS reviews rates and forms for compliance with PPACA provisions if states inform CMS that they do not have the authority to enforce, or are not otherwise enforcing, one or more provisions themselves.[3] Individuals can apply for and enroll in health insurance coverage, and small business employers can apply for determinations of eligibility to participate in the Small Business Health Options Program (SHOP) through HealthCare.gov.
FFE in states performing plan management functions	The state makes QHP certification recommendations to CMS. CMS is responsible for final certification decisions for QHPs based on the state's recommendation. Individuals can apply for and enroll in health insurance coverage, and small business employers can apply for determinations of eligibility to participate in the SHOP through HealthCare.gov.
State-Based Exchange using the federal platform (SBE-FP)	The state performs plan management functions and certifies QHPs. The state uses HealthCare.gov and the federal information technology infrastructure for plan display, selection, and enrollment. Individuals can apply for and enroll in health insurance coverage, and small business employers can apply for determinations of eligibility to participate in the SHOP through HealthCare.gov.
State-Based Exchange (SBE)	The state performs all Exchange functions for the individual market and/or the SHOP. Individuals can apply for and enroll in coverage, and business employers and their employees can apply for eligibility determinations and may be able to enroll in coverage through Exchange websites established and maintained by the states.

[2] Market-wide standards include essential health benefits (EHBs) and actuarial value reviews.
[3] CMS enforces market-wide standards under the PPACA for Missouri, Oklahoma, Texas, and Wyoming. CMS expects all other states to enforce these standards.

States performing plan management functions in FFEs and SBE-FPs conduct certification reviews for issuers applying for QHP certification in their state. SBEs are responsible for performing all Exchange functions and therefore are not included in Table 2, which gives an overview of state plan management activities, by Exchange model.

Table 2. State Plan Management Overview

Federally Facilitated Exchange (FFE)	FFE in States Performing Plan Management Functions	State-Based Exchange Using the Federal Platform (SBE-FP)
1. Read General Information • Regulations and Guidance • Application/Template Updates • Attend the QHP Certification Webinar Series	**1. Read General Information** • Regulations and Guidance • Application/Template Updates • Attend the QHP Certification Webinar Series	**1. Read General Information** • Regulations and Guidance • Application/Template Updates • Attend the QHP Certification Webinar Series
2. Review CMS Collection of Rate Information • Review Letter to Issuers for changes for upcoming plan year • Review HIOS Manual • Review Uniform Rate Review Template (URRT) Instructions	**2. Prepare for Reviews** • Review Letter to Issuers for changes for upcoming plan year • Confirm state review responsibilities[4] • Review tool summaries and functionality • Watch QHP Application review tool instructional videos • Review Plan Year 2023 required supporting documents • Advise issuers to submit rate information to CMS, review URRT Instructions	**2. Prepare for Reviews** • Review Letter to Issuers for changes for upcoming plan year • Confirm state review responsibilities • Review tool summaries and functionality • Watch QHP Application review tool instructional videos • Review Plan Year 2023 required supporting documents • Advise issuers to submit rate information to CMS, review URRT Instructions
3. Confirm Initial List of Plans in the PM Community • Review and confirm plan list; inform CMS of any discrepancies	**3. Collect QHP Applications via SERFF** • Review SERFF Manual • Watch SERFF trainings	**3. Collect QHP Applications via SERFF and/or State System** • Review SERFF Manual • Watch SERFF trainings

[4] Per the Final Notice of Payment and Benefit Parameters for 2023, states performing plan management will need to inform CMS if they intend to conduct their own network adequacy reviews and work with CMS to determine whether their network adequacy reviewing and enforcing standards are at least as stringent as the federal standards.

Federally Facilitated Exchange (FFE)	FFE in States Performing Plan Management Functions	State-Based Exchange Using the Federal Platform (SBE-FP)
4. Review Corrections • Review notices displayed on the PM Community and reach out to CMS, as needed	**4. Review Plans** • Run review tools • Use the HIOS State Reviewer function • Reach out to CMS Help Desk with questions, as necessary, at CMS_FEPS@cms.hhs.gov	**4. Review Plans** • Run review tools • Use the HIOS State Reviewer function • Reach out to CMS Help Desk with questions, as necessary, at CMS_FEPS@cms.hhs.gov
5. Confirm Final List of Plans in the PM Community • Review and confirm plan list	**5. Transfer Plans** • Coordinate transfer with CMS and SERFF, if needed	**5. Transfer Plans** • Coordinate transfer with CMS and SERFF, if needed
	6. Confirm Initial List of Plans in the PM Community • Review and confirm plan list	**6. Confirm Initial List of Plans in the PM Community** • Review and confirm plan list
	7. Review Corrections • Review notices displayed on the PM Community and reach out to CMS, if needed	**7. Review Corrections** • Review notices displayed on the PM Community and reach out to CMS, if needed
	8. Confirm Final List of Plans in the PM Community • Review and confirm plan list	**8. Confirm Final List of Plans in the PM Community** • Review and confirm plan list

QHP Application Data Collection

Issuers use three systems to submit QHP Application data: HIOS, the PM Community, or SERFF.[5] The system that issuers use depends on their state's Exchange model. All states complete plan confirmation with the PM Community. States can review their issuers' data within the corresponding system using the appropriate log-in credentials. The QHP certification website provides more detail about the systems that states are using for their QHP Application and plan data review. Appendix B provides the plan year 2023 QHP certification timeline.

HIOS

The Health Insurance Oversight System (HIOS) collects QHP Application data from issuers and SERFF, and CMS stores this material through HIOS. State users can register for the state reviewer role in HIOS to review these data. For more information about how to obtain access to HIOS, refer to the HIOS User Manual or the HIOS Quick Reference Guide.

Questions related to HIOS should be directed to the Marketplace Service Desk at 1-855-267-1515 or CMS_FEPS@cms.hhs.gov.

SERFF

The System for Electronic Rate and Form Filing (SERFF) is used to collect QHP Application data in states performing plan management functions in FFEs and SBE-FP states (as applicable). These data are transferred from SERFF to HIOS for CMS review.

States performing plan management functions in FFEs and SBE-FP states must transfer their QHP Applications from SERFF to HIOS. The SERFF data transfer deadline aligns with the HIOS QHP Application submission deadlines. State transfers should include all on-exchange QHP and all on- and off-exchange SADPs submitted to the state for certification. States can transfer plans through SERFF multiple times, and they are strongly encouraged to transfer plans early to avoid transmission delays. However, SBE-FPs should not transfer off-exchange SADPs. For more information, refer to the SERFF State Manual and User Manual Appendix or SERFF Plan Management Training.

Questions related to SERFF functionality should be directed to the SERFF Plan Management Help Desk at 816-783-8500 or serffplanmgmt@naic.org.

[5] Issuers are required to submit Plan ID Crosswalk Templates in the PM Community.

REVIEW TOOLS

CMS provides tools for issuers and states to review their QHP Application data. States can download the review tools from the QHP certification website. **Table 3** summarizes the publicly available review tools. In addition, CMS has developed a series of instructional videos for the QHP Application review tools, which are intended to help issuers and states use the review tools to check their QHP Application data. Appendix C outlines state responsibilities for QHP reviews, by Exchange model.

Table 3. Tools for State QHP Certification Reviews

Review Tool	Description	Applicable Template(s)
Data Integrity Tool	• Identifies critical data errors within and across templates. • Provides immediate feedback about data, reducing issuers' resubmissions. • Alerts issuers and state reviewers to irregularities in the template submissions. • Imports QHP and SADP data from most application templates. • Conducts validation checks beyond the standard HIOS and SERFF checks. • Looks across templates for consistency in key fields. • Produces error reports that describe the error and its location in the template.	Plans & Benefits; Business Rules; Network ID; Prescription Drug; Service Area; Rates Table; Unified Rate Review
Master Review Tool	• Aggregates data from the Plans & Benefits, Service Area, ECP/Network Adequacy, and Prescription Drug Templates. • Serves as a data input file to the other stand-alone tools. • Many tools require the import of a populated Master Review Tool in order to run, so CMS recommends this tool be used after the Data Integrity Tool has been run.	Plans & Benefits; Service Area; ECP/Network Adequacy; Prescription Drug
Review Process Guide	• Provides model step-by-step processes that state regulators can follow to review QHP Applications for compliance with specific PPACA standards. This tool includes descriptions of the back-end functionality in the other automated review tools. • Allows users to see the steps taking place in each of the stand-alone tools and is also helpful in completing reviews that cannot be automated.	N/A

Review Tool	Description	Applicable Template(s)
Cost-Sharing Tool	• Runs four different checks (if applicable to the plan) for cost-sharing standards: Maximum Out-of-Pocket Review, Cost-Sharing Reduction Plan Variation Review, Catastrophic Plan Review, and Expanded Bronze Plan Review • *Note*: For expanded bronze plan designs where the issuer covers at least one major service before applying the deductible, it is the state's responsibility to determine whether the submitted design's coverage of the major service uses a reasonable cost-sharing rate. Reasonable cost sharing is defined as a coinsurance less than or equal to 50% coinsurance or equal to a benefit-specific copay limit set by the state.	Plans & Benefits Master Review Tool is required to use this tool
Medical QHP Essential Community Providers Tool	• Calculates the total number and types/categories of medical (non-dental) ECPs an issuer has in each plan's network within the plan's service area and compares this number to the number and type/category of available medical (non-dental) ECPs in that service area. • Checks the following to demonstrate satisfaction of the ECP inclusion standard specified at 45 C.F.R. 156.235: – Whether the percentage of the plan's network ECPs is equal to or greater than the ECP threshold (as defined by federal or state regulators) – Whether the plan's network includes the requisite types/categories of ECPs in each county in the plan's service area – Whether the plan's network includes available Indian health care ECPs in the plan's service area	Plans & Benefits; Service Area; ECP/NA Master Review Tool is required to use this tool

Review Tool	Description	Applicable Template(s)
Stand-Alone Dental Plan Essential Community Providers Tool	• Calculates the total number of dental ECPs and Indian dental care ECPs an issuer has in each plan's network within the plan's service area and compares this number to the number of available dental ECPs and Indian dental care ECPs in that service area. • Checks the following to demonstrate satisfaction of the ECP inclusion standard specified at 45 C.F.R. 156.235: – Whether the percentage of the plan's network dental ECPs is equal to or greater than the ECP threshold (as defined by federal or state regulators) – Whether the plan's network includes available Indian dental ECPs in the plan's service area	Plans & Benefits; Service Area; ECP/NA Master Review Tool is required to use this tool
Non-Discrimination Cost-Sharing Tool	• Performs an outlier analysis for QHP Discriminatory Benefit Design. • Reviews a group of predetermined benefits and determines if any plan has a significantly higher copay or coinsurance for those benefits, which may mean that the coverage is discriminatory. Conducted for all plans in the state.	Plans & Benefits Master Review Tool is required to use this tool
Formulary Review Suite	Includes the tools to run two reviews: • ***Non-Discrimination Clinical Appropriateness Review*:** Analyzes the availability of covered drugs associated with 11 conditions, as recommended in clinical guidelines, to ensure that issuers are offering a sufficient type and number of drugs. • ***Non-Discrimination Formulary Outlier Review:*** Identifies and flags as outliers plans that have unusually large numbers of drugs subject to prior authorization and/or step therapy requirements in 27 classes of the United States Pharmacopeia Medicare Model Guidelines.	Prescription Drug Use of the Master Review Tool with Plans & Benefits data is recommended with this tool

Review Tool	Description	Applicable Template(s)
Plan ID Crosswalk Tool	Checks that the Plan ID Crosswalk Template has been completed accurately by ensuring the following: • All counties in all FFE plans (including FFEs in states performing plan management functions) that were offered in the previous plan year are included in the crosswalk • The plans are mapped to valid plans • The crosswalk reasons selected are consistent with plan offerings • The crosswalk is compliant with the regulation in 45 C.F.R. 155.335(j)	Plans & Benefits; Service Area; Plan ID Crosswalk
Category & Class Drug Count Tool	• Compares the count of unique chemically distinct drugs in each United States Pharmacopeia Medicare Model Guidelines version 8 category and class for each drug list against a state's benchmark.	Prescription Drug Use of the Master Review Tool with Plans & Benefits data is recommended with this tool
Plan Preview HIOS Module	• Displays plans to issuers, similar to the way Plan Compare displays plans to consumers on HealthCare.gov. States with HIOS state reviewer access can use Plan Preview to preview the plan benefit displays for all issuers in their state. • Issuers are also strongly encouraged to use Plan Preview to verify the accuracy of their plans' displays to consumers before finalizing the plan data. • Marketplace Plan Management Group (MPMG) will provide customized support to issuers to address their Plan Preview questions and give issuers a complete explanation of the Plan Preview system, as needed. Issuers should work with their account manager[6] to schedule this support.	Plans & Benefits; Service Area; Business Rules; Rates Table

[6] All issuers on the exchange are assigned an account manager. The account manager is generally assigned after a plan is certified and is the primary point of contact for all non-technical matters pertaining to QHP certification.

Additional State Roles in QHP Certification

Plan ID Crosswalk and Alternate Enrollment

The Plan ID Crosswalk Template maps the QHP standard component ID and service area combinations from the current plan year (e.g., Plan ID and county combinations) to a QHP Plan ID for the upcoming plan year. These data will facilitate 834 enrollment transactions, which CMS uses to transfer consumer enrollment information to the issuer for those enrollees in the individual market Exchanges who have not actively selected a QHP during open enrollment. These instructions apply to QHP and SADP issuers that offered individual market QHPs on the Exchange. SADPs, as plans that offer excepted benefits, are not subject to the guaranteed renewability standards specified at 45 CFR 147.106.

Issuers are expected to submit evidence from the state, such as a completed form, email confirmation, or State Authorization Form,[7] that the issuer is authorized to submit its Plan ID Crosswalk.

What do states need to do for Plan ID Crosswalk and alternate enrollment?

Issuers submitting Plan ID Crosswalk Templates in FFEs, states performing plan management functions, and SBE-FPs should submit evidence from the state, such as a State Authorization Form or an email confirmation, that the issuer is authorized to submit its Plan ID Crosswalk Template via the PM Community. States can return authorization forms directly to issuers.

Additionally, 45 CFR 155.335(j)(3) authorizes Exchanges to determine alternate enrollments for enrollees in QHPs in which the issuer will have no Exchange enrollment option available for the upcoming plan year, unless otherwise directed by the state. In the FFEs, including FFEs in states performing plan management functions and in SBE-FPs, alternate enrollment will apply to all QHP enrollees for whom the original issuer no longer has a QHP available through the Exchange for the upcoming plan year. Alternate enrollment does not apply to SADPs or SHOP plans.

If the enrollee's current QHP is not available to the enrollee through the Exchange, and no QHP from the original issuer is available to the enrollee for auto reenrollment in the Exchange, and no direction is provided by the state, CMS, if feasible, will determine an alternate enrollment for the affected enrollee. CMS will determine an alternate enrollment in another QHP available through the Exchange with a service area that covers the enrollee's location, taking into account the issuer's ability to absorb new enrollments and the lowest cost premium plan. This is done to help maintain coverage through the Exchange for affected enrollees who fail to return to the Exchange to make their own plan selection before open enrollment closes. Unless otherwise directed by the state, the Exchange directs such selections.

[7] Use of this form is optional. A state may choose to develop its own form or method to document state authorization for submission via the PM Community.

What do states need to do if they wish to direct alternate enrollment?

States that wish to direct alternate enrollments must notify CMS of this decision. CMS will send communications outlining the process states should follow to submit their decisions. States and CMS work closely to ensure that state and issuer concerns are addressed throughout the alternate enrollment process.

Plan Confirmation

States must confirm submitted plans at the end of the certification process in the PM Community. After the close of the initial and final data submission windows, all FFEs, states performing plan management functions in FFEs, and SBE-FPs that have issuers with an active QHP Application will receive instructions for participating in plan confirmation activities.[8]

What do states need to do for plan confirmation?

FFEs, states performing plan management functions in FFEs, and SBE-FPs must review their plan lists and indicate whether the state approves the required regulatory submissions associated with the certification of on-exchange plans in their state.

Application Tips

- Watch the review tool instructional videos to learn how to use the review tools, and allow ample time to use the tools.
- States using SERFF should transfer plans to HIOS far enough in advance of the deadline to allow time to resolve any issues that may arise.
- Review the QHP certification website FAQs for answers to questions before contacting the CMS Help Desk.
- Attend QHP certification webinars to ask questions about the QHP certification process and learn about operational guidance (see Registration for Technical Assistance Portal [REGTAP] for more information and registration).

Plan Withdrawal

Plan withdrawal refers to withdrawing a plan from consideration for certification as a QHP to be offered through the Exchange, which is distinct from (but sometimes a consequence of) discontinuing a product or withdrawing completely from the market in a state—the individual market or small-group market, both inside and outside the Exchange. An issuer's submission of final plan confirmation determinations to CMS is generally the last opportunity for the issuer to withdraw a plan from certification consideration for the upcoming plan year. States will have a final opportunity to indicate a disposition during the final plan confirmation process. *Note*: Issuers are required to submit an updated Plan ID Crosswalk Template if their

[8] SBE-FP states must respond to Final Plan Confirmation, indicating their intent to CMS to certify the listed plans.

submitted template includes a withdrawn plan. The Plan ID Crosswalk Template is the only template that should be updated to reflect a withdrawn plan.

- Plan Withdrawal Notification Form:
  - Issuers and states can submit the Plan Withdrawal Notification Form through the PM Community by following the instructions on the QHP certification website.

Data Changes

The process for making changes to QHP data, including the state's role in approving data change requests from issuers, varies depending on the timing of the request within the QHP certification cycle. Table 4 provides an overview of the acceptable data changes according to the timing of the change request (i.e., before the initial application submission window, between the initial and final data submission deadlines, and after the final QHP Application deadline).

Table 4. Overview of Allowable Data Changes During the QHP Certification Cycle

Time Frame	Allowable Data Changes	Data Change Request Required?
Before the initial submission deadline	Issuers may make any changes to their data without CMS authorization, but issuers should seek state guidance and consent. These changes include adding or removing plans or changing plan type.	No
Between the initial and final data submission deadlines	Issuers are allowed to make a wide array of changes, including changes to their service areas as well as withdrawing plans. CMS does not require a data change request for changes to a plan's service area. Plan withdrawal forms are required to remove plans.	No
After the final submission deadline	Issuers may request critical data changes to align with state filings, but authorization and explicit direction from CMS and the state is required to make changes to certified QHP data. URLs may be changed with applicable state authorization; CMS authorization is not required.	Yes (excluding URL changes)

Issuers may make changes to their QHP Applications without state or CMS authorization up until the deadline for initial QHP 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 can upload revised QHP data templates and make other necessary changes to their QHP Applications in response to state or CMS feedback up until the deadline for issuer changes.

Additionally, administrative data changes, including URLs, should be made in the HIOS Plan Finder or the QHP Supplemental Submission Module (SSM) and do not require a data change request to CMS. By submitting URL changes in the SSM, issuers are attesting that the changes have been approved by the applicable state. Note that states can view any of their issuers' URL data by logging into the HIOS State Evaluation Module and accessing the issuer's SSM.

After the deadline for issuer changes to QHP Applications, issuers may only make corrections directed by CMS or by their state. Issuers whose applications are not accurate after the deadline for issuers to change their QHP Applications are required to resubmit corrected data during the limited data correction window and may be subject to compliance action by CMS. Table 5 indicates, by Exchange model, which data change request documents need to be submitted to CMS.[9]

Table 5. Data Change Request Approval Process, by Exchange Model (Post-QHP Certification)

Exchange Model*	Issuer Data Change Request Form	State Approval Documentation	CMS Form-Filing Approval Documentation
FFE	✓	✓	None
FFEs in Missouri, Oklahoma, Texas, and Wyoming (QHP)	✓	None	✓
FFEs in Missouri, Oklahoma, Texas, and Wyoming (SADP)	✓	Approval or deferral required†	None
FFEs in states performing plan management functions	✓	None‡	None

*SBE-FPs retain the authority and primary responsibility for plan management functions, including review and approval of data change requests.
†CMS requires either state approval documentation or documentation that the state declines to review the data change request.
‡Issuers are not required to provide CMS with state approval documentation but do need state approval to make changes. The transfer of plan data from SERFF to HIOS indicates state authorization.

QHP Application Corrections and Notices

Throughout the QHP Application submission process, CMS releases review results to issuers in the PM Community. These review results include corrections that issuers must make to their applications. As reviews are completed, CMS will publish new required corrections on the PM Community. Issuers and states are encouraged to log into the PM Community to review these corrections. Appendix D provides more information about the PM Community functionality. In addition to corrections, CMS will send notices to states through the certification process, Table 6 outlines the different communications and identifies the notices that require a response.

CMS expects that states will establish the timeline, communication process, and resubmission window for any reviews conducted under state authority. Issuers should comply with any state-specific guidelines for review and resubmission related to state review standards. CMS notes that issuers may be required by the state to submit data to state regulators in addition to the data required for QHP certification through the FFEs. Issuers 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 for plans to be certified for sale on the FFEs.

[9] SBE-FP states coordinate and approve data change requests according to state guidelines.

Table 6. Overview of QHP Notices

CMS will send notices to states throughout the certification process; some notices will request a response.

Notice	State Response Requested? (Yes/No)	Issuer Response Requested? (Yes/No)
Initial Plan Confirmation	Optional—States will review the plan confirmation list under the Plans in State tab in the PM Community. States will send any questions or concerns to the Marketplace Plan Management Group State Coordination email. State responses are optional unless there are errors in the plan list.	No
Alternate Enrollment Notices	Yes—States must tell CMS if they wish to direct the specific plans into which consumers will be auto-reenrolled.	No
Final Plan Confirmation	Yes—States will use the PM Community to finalize the list of plans in their state that are eligible for availability and will indicate whether they do or do not approve the regulatory submissions of each plan for certification on the Exchange.	Yes—Issuers use the drop-down menus in the PM Community to complete plan confirmation for each plan.
Certification Notice	No	No

What do states need to do?

States performing plan management functions in the FFE will be included in communications to issuers from CMS approving or denying data change requests and notifying the issuer and state when the state should transfer all data changes. SBE-FP states must notify CMS when they have approved a data change. If the data change occurs after the submission deadline, CMS will schedule a date for the state to transfer the change to CMS.

How can states notify CMS of changes that issuers need to make after the QHP Application deadline but before certification?

States may contact CMS at PlanManagementStateCoordination@cms.hhs.gov with a list of required corrections. States should only refer changes that would prevent an issuer's QHP certification if not made.

Does CMS communicate with states after a data change?

CMS may reach out to issuers and states after a data change to notify both parties that the issuer has made an unapproved change (in addition to the approved change) or that the issuer did not make the change as approved via the PM Community. CMS requests that issuers reply to CMS to confirm whether the change was intentional. CMS provides the issuer and the state with the next steps to take after receiving the issuer's response. CMS also emails all issuers and states when the data have been refreshed on HealthCare.gov.

STATE FLEXIBILITY FOR EHBS

States may retain their current EHB-benchmark plan or select one of the three options listed below:

Option 1

Select the EHB-benchmark plan that another state used for the 2017 plan year.

Option 2

Replace one or more categories of EHBs under the EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another state used for the 2017 plan year.

Option 3

Select a set of benefits, subject to certain requirements, that would become the state's EHB-benchmark plan. To select a new EHB-benchmark plan, the state must submit the following via the PM Community:

- State Confirmation
- EHB-Benchmark Plan Actuarial Certificate
- State EHB-Benchmark Plan's Benefits and Limits
- EHB-Benchmark Plan Formulary Drug List
- EHB-Benchmark Plan Document

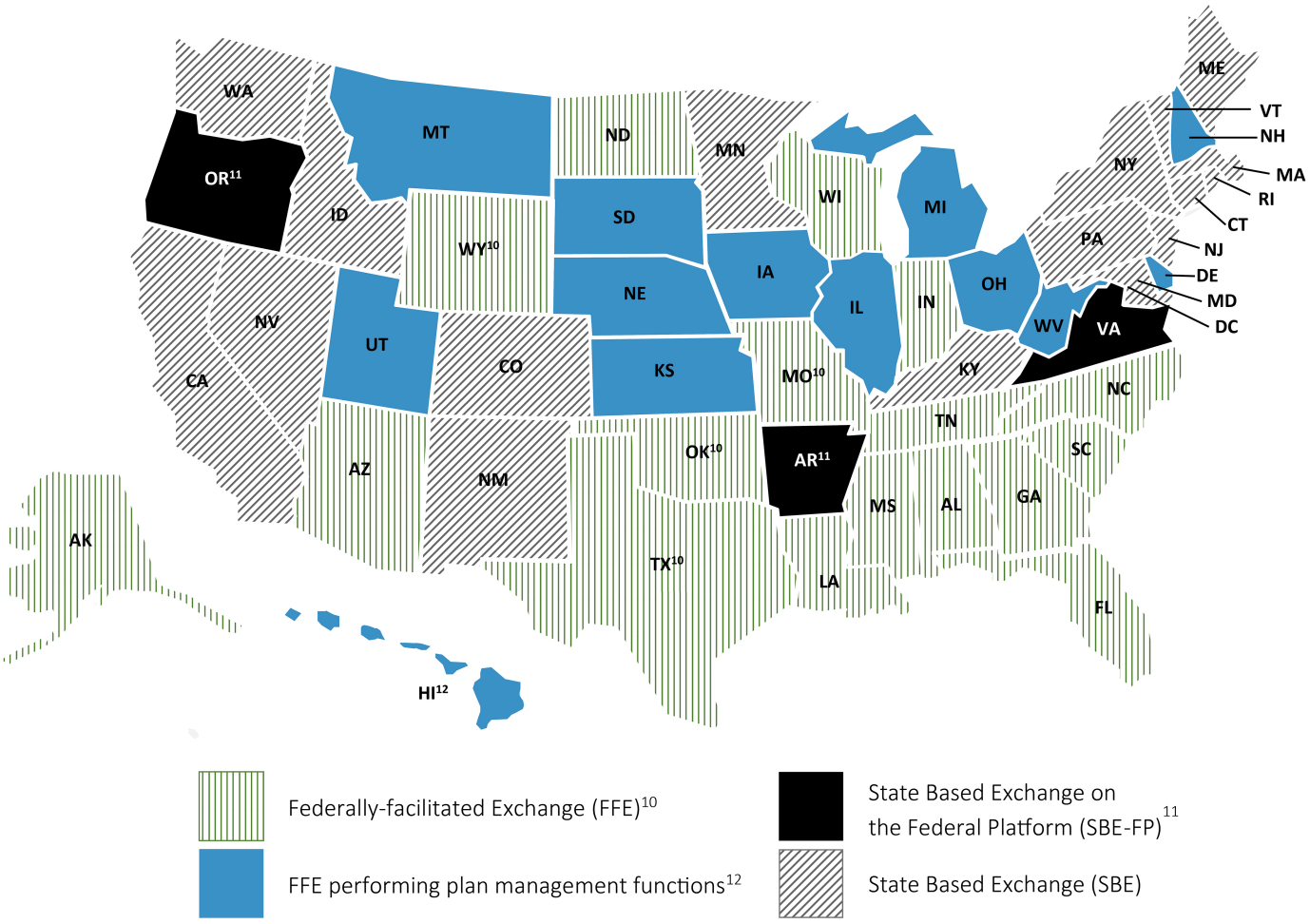
States that opt not to exercise this flexibility continue to use the same EHB-benchmark plan. States selecting an EHB-benchmark plan for Plan Year 2024 must submit required documentation to CMS by **May 6, 2022**.

States also have the option to permit issuers to substitute benefits between benefit categories, pursuant to 45 CFR 156.115(b)(2)(ii). States opting to permit substitutions must notify CMS via the PM Community by **May 6, 2022**, for Plan Year 2024. Instructions on how to submit required documentation for selecting an EHB-benchmark plan or notify CMS of a state's decision to opt in to allow EHB substitution between EHB categories can be found in the PM Community. Additional information about EHBs can be found under data resources on the CMS CCIIO Webpage.

APPENDIX A: PLAN YEAR 2023 EXCHANGE MODEL

Consumers and small businesses have access to Health Insurance Exchanges through the Patient Protection and Affordable Care Act (PPACA). The map below outlines the Exchange model that each state maintains.

Plan Year 2023 Exchange Models Map



[10] Texas, Oklahoma, Wyoming, and Missouri do not enforce PPACA market-wide requirements. Additionally, Oklahoma and Wyoming do not have effective rate review programs.

[11] Individual Market is SBE-FP; SHOP Market is SBE

[12] Hawaii 1332 waiver for small-group coverage to be available directly from issuers.

APPENDIX B: QHP CERTIFICATION TIMELINE

The following table provides the plan year 2023 Qualified Health Plan (QHP) certification timeline. States should review this timeline to prepare for certification, as detailed on the QHP Certification Website.

Activity	Dates
QHP Application submission window opens	4/21/22
Optional Early Bird QHP Application submission deadline	5/18/22
Centers for Medicare & Medicaid Services (CMS) reviews Early Bird QHP Application data and releases results in the Plan Management (PM) Community	5/19/22–6/10/22
Health and Human Services–approved QHP Enrollee Survey vendor securely submits QHP Enrollee Survey response data to CMS on behalf of QHP issuer	5/20/22
QHP issuer submits validated Quality Rating System (QRS) clinical measure data, with attestation, to CMS via the National Committee for Quality Assurance's Interactive Data Submission System	6/15/22
Machine-readable index URL submission deadline	6/15/22
Initial QHP Application deadline, including Transparency in Coverage and Plan ID Crosswalk data, Machine Readable Index File, Formulary Directories	6/15/22
CMS reviews initial QHP Applications and releases results in the PM Community	6/16/22–7/15/22
Initial deadline for QHP Application Rates Table Template; deadline to submit Summary of Benefit and Coverage (SBC) Templates; optional deadline to resubmit corrected QHP Application data	7/20/22
CMS reviews initial submission of Rates Table Template and resubmitted QHP Application data and releases results in the PM Community	7/21/22–8/12/22
QHP issuers, Exchange administrators, and CMS preview the 2022QHP quality rating information	Aug/Sep 2022
Issuers complete final plan confirmation and submit final Plan ID Crosswalk Templates in the PM Community	8/10/22–8/24/22
Deadline for issuers to change QHP Application, including Transparency in Coverage data	8/17/22
Deadline for issuers to submit plan documentation URLs in the Health Insurance Oversight System Supplemental Submission Module	8/17/22
CMS reviews QHP Applications and releases results in the PM Community	8/18/22–9/12/22
CMS sends QHP Certification Agreements to issuers	9/13/22
Issuers return signed QHP Certification Agreements to CMS	9/13/22–9/21/22
States complete final plan confirmation in the PM Community	9/13/22–9/21/22
Limited data correction window	9/15/22–9/16/22
New plan year machine-readable submission deadline	9/21/22
Deadline for plan documentation URLs to be live and active	9/21/22
CMS releases certification notice to issuers and states	10/4/22–10/5/22
Anticipated public display of QHP quality rating information	11/1/22

APPENDIX C: PLAN YEAR 2023 STATE RESPONSIBILITY FOR QHP REVIEWS, BY EXCHANGE MODEL

The following table outlines the reviews that states are generally responsible for conducting, based on their Health Insurance Exchange model.

Federally Facilitated Exchange (FFE)	FFE in States Performing Plan Management Functions	State-Based Exchange Using the Federal Platform
• Licensure and Good Standing • Rate Outlier	• Accreditation • Data Integrity • Essential Community Providers • Interoperability • Licensure and Good Standing • Network Adequacy* • Non-Discrimination—Cost Sharing • Organizational Charts/Compliance Plans • Plan ID Crosswalk • Prescription Drug Non-Discrimination—Clinical Appropriateness • Prescription Drug Non-Discrimination—Formulary Outlier • Program Attestations • Quality Improvement Strategy • Rate Outlier • Stand-Alone Dental Plan (SADP)—Annual Limitation on Cost Sharing • SADP—Essential Health Benefit (EHB) Benchmark • SADP—EHB Supporting Documentation and Justification • Service Area • Silver/Gold Review	• Accreditation • Administrative • Cost-Sharing Reduction Plan Variation • Data Integrity • Essential Community Providers • Licensure and Good Standing • Network Adequacy • Non-Discrimination—Cost Sharing • Organizational Charts/Compliance Plans • Plan ID Crosswalk • Prescription Drug Non-Discrimination—Clinical Appropriateness • Prescription Drug Non-Discrimination—Formulary Outlier • Program Attestations • Quality Improvement Strategy • Quality Reporting • Rate Outlier • SADP—Annual Limitation on Cost Sharing • SADP—EHB Benchmark • SADP—EHB Supporting Documentation and Justification • Service Area • Silver/Gold Review

* Network Adequacy reviews are only conducted by states performing plan management functions if the state elects to perform their own reviews, so long as 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 C.F.R. 156.230, and that reviews are conducted prior to QHP certification.

APPENDIX D: PLAN MANAGEMENT COMMUNITY FUNCTIONALITY

The Plan Management (PM) Community is an online platform designed to improve Centers for Medicare & Medicaid Services (CMS) communication and coordination with issuers and states regarding Qualified Health Plan (QHP) certification. Federally Facilitated Exchanges (FFEs), states performing plan management functions in FFEs, and State-Based Exchanges using the federal platform use the PM Community to view QHP Application data for issuers in their state, access content such as notices and other documents from CMS, submit plan withdrawal forms, and complete state plan confirmation. All states, including State-Based Exchanges, also use the PM Community to perform activities related to essential health benefit (EHB) benchmark selection.

The PM Community User Guide, available in the PM Community, includes detailed descriptions of the PM Community contents, as well as instructions for performing QHP certification-related state activities within the portal. In addition, the PM Community includes instructional videos to help states learn more about various features in the PM Community, such as how to manage contacts, how to access and upload files, and how to submit a withdrawal form. These resources can be found under the QHP Certification Resources tab.

State users access the PM Community via the Salesforce Enterprise Integration (SEI) Portal. To request access to the PM Community, new state users should follow the requisite steps, including registering using the New User Registration button available on the SEI Portal log-in screen. Once users have access to Salesforce in the SEI Portal, they can request access to the PM Community. If users require more detailed instructions or have any questions about access, they should contact the Marketplace Service Desk.

CMS requests that states identify up to three users (a minimum of two users is recommended) to access the PM Community for their organization. When selecting users, states should identify individuals who conduct hands-on work related to their issuers' QHP certifications. Users who access the PM Community to perform EHB activities count toward the cap of three users. States can designate different users throughout the course of the year as needed, as long as they do not exceed the maximum of three users at any point in time.

PM Community Features for States

State users are able to use the PM Community to see information about each issuer that has applied for certification of QHPs in their state. State users can perform a number of activities in the PM Community, which include the following:

- Managing state contacts for QHP certification-related communications
- Viewing issuer- and plan-level data for all issuers in the state, which now includes viewing essential community provider and network adequacy Justification Forms
- Finding resources about EHB and submitting an EHB-benchmark plan
- Submitting withdrawal forms
- Completing plan confirmation
- Viewing issuers' crosswalk submissions
- Accessing attachments, such as notices, from CMS
- Viewing corrections regarding issuers' QHP Applications