TOOLKIT

QHP Certification

Health Insurance Marketplace

PY2022 QHP Certification State Toolkit

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

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PURPOSE OF THE TOOLKIT

The Qualified Health Plan (QHP) Certification State Toolkit for plan year (PY) 2022 is a series of consolidated resources to which states may refer 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.

The toolkit includes general guidance on the overall QHP certification process.

- Appendix A summarizes policy updates from the Notice of Payment & Benefit Parameters for 2022[2] and the 2022 Letter to Issuers (LTI) in the Federally-facilitated Exchanges (FFE).
- Appendix B describes the Plan Management (PM) Community functionality.
- Appendix C describes state flexibility for submission of Essential Health Benefits (EHB) benchmark plans.
- Appendix D provides the PY 2022 QHP certification timeline.
- Appendix E outlines, by Exchange type, states' responsibilities for QHP certification reviews.
- Appendix F describes each QHP certification review, roles by state Exchange type, and the applicable review tools.
- Appendix G provides a map of the PY 2022 Exchange models.

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

[2] Policies in the proposed 2022 Payment Notice that were not addressed by the January 19, 2021 final rule are "proposed" (for example, the proposed annual limitation on cost sharing). Issuers are responsible to ensure compliance with CMS regulations and guidance.

WHERE TO FIND HELP

- For technical questions related to HIOS, contact the Marketplace Service Desk (MSD) 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 PM Community, states can review the PM Community User Guide.
- For state-related questions, contact the Plan Management State Coordination (PMSC) mailbox at PlanManagementStateCoordination@cms.hhs.gov.
- For Form Filing reviews in direct enforcement states, contact FormFiling@cms.hhs.gov
- For Rate Review questions, contact RateReview@cms.hhs.gov.
- For general CCIIO information, see the CCIIO Fact Sheets and FAQs.
- For key documents related to QHP certification, reference the QHP certification website.

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 Exchanges (State-based Exchanges, or SBEs) or allow the Federal government to facilitate the Exchange in their state (Federally-facilitated Exchanges, or FFEs). Some states perform plan management functions in FFEs, and some State-based Exchanges use the federal platform (SBE-FPs). **Table 1** describes the different plan management responsibilities of each Exchange model. Appendix G provides a map illustrating 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 direct enforcement (FFE-DE) states (see Appendix G), enforces market-wide standards[3] under the PPACA. For FFE-DE states, 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 provision themselves.[4] 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 IT 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.

[3] Market-wide standards include Essential Health Benefits (EHBs) and actuarial value (AV) reviews.

[4] CMS enforces market-wide standards under the PPACA for direct enforcement states. 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 the table below. **Table 2** 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 - Guidance and Regulations - Application/Template Updates - Attend the Monthly PMSC Webinar Series **2. CMS collects QHP Applications via HIOS** - Review Letter to Issuers for changes for upcoming plan year - Review HIOS Manual **3. Confirm Initial List of Plans in the Plan Management (PM) Community** - Review and confirm plan list. Inform CMS of any discrepancies **4. Review Correction Notices** - Review notices displayed on the PM Community and reach out to CMS, as needed **5. Confirm Final List of Plans in the PM Community** - Review and confirm plan list	**1. Read General Information** - Guidance and Regulations - Application/Template Updates - Attend the Monthly PMSC Webinar Series **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 PY 2022 required supporting documents **3. Collect QHP Applications via SERFF** - Review SERFF Manual - Watch SERFF trainings **4. Review Plans** - Run review tools - Reach out to CMS Help Desk with questions as necessary at: CMS_FEPS@cms.hhs.gov **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 **7. Review Correction Notices** - 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	**1. Read General Information** - Guidance and Regulations - Application/Template Updates - Attend the Monthly PMSC Webinar Series **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 PY 2022 required supporting documents **3. Collect QHP Applications via SERFF and/or State System** - Review SERFF Manual - Watch SERFF trainings **4. Review Plans** - Run review tools - Reach out to CMS Help Desk with questions as necessary at: CMS_FEPS@cms.hhs.gov **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 **7. Review Correction Notices** - 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

QHP Application Data Collection

Issuers use two primary systems to submit QHP Application data: the Health Insurance Oversight System, or HIOS, and the System for Electronic Rate and Form Filing, or SERFF.[5] The system that issuers use depends on their state's Exchange model type. States can review their issuers' data within the corresponding system using the appropriate login credentials. The QHP certification website provides more detail on the systems that states are using for their QHP Application and plan data review.

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 this data. For more information on 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 (MSD) 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). This data is 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 SADP plans submitted to the state for certification. States can transfer plans through SERFF multiple times, and they are strongly encouraged to do so 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 on the QHP Application review tools, which are intended to help issuers and states use the review tools to check their QHP Application data.

Table 3. Tools for State QHP Certification Reviews

Review Tool	Description	Applicable Template(s)
Data Integrity Tool (DIT)	• 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 stand-alone dental plan (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, Essential Community Provider (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 backend functionality in the other automated review tools. • This tool 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 (MOOP) Review, Cost Sharing Reduction (CSR) 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. In other words, if the plan covers a major service using the copay, the enrollee would be liable for cost sharing equivalent to 50 percent coinsurance or less.	Plans & Benefits *Master Review Tool is required to use this tool*
Essential Community Providers (ECP) Tool	• Calculates the total number of ECPs an issuer has in each plan's network and compares this to the number of available ECPs in that service area. • Checks 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), to demonstrate satisfaction of the ECP inclusion standard specified at 45 C.F.R. 156.235.	Plans & Benefits; Service Area; ECP/NA *Master Review Tool is required to use this tool*
SADP Essential Community Providers (ECP) Tool	• Calculates the total number of SADP ECPs an issuer has in each plan's network and compares this to the number of available SADP ECPs in that service area. • Checks whether the percentage of the plan's network SADP ECPs is equal to or greater than the ECP threshold (as defined by federal or state regulators), to demonstrate satisfaction of the SADP ECP inclusion standard specified at 45 C.F.R. 156.235.	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*

Review Tool	Description	Applicable Template(s)
Formulary Review Suite	Includes the tools to run two reviews: • *Non-Discrimination Clinical Appropriateness Review*: Analyzes the availability of covered drugs associated with 10 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 (USP MMG).	Prescription Drug *Use of the Master Review Tool with Plans & Benefits data is recommended with this tool*
Plan ID Crosswalk Tool	Checks that the Plan ID Crosswalk Template has been completed accurately by ensuring that: • 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; and • 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 USP MMG v8 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*

Review Tool	Description	Applicable Template(s)
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' display to consumers before finalizing the plan data. • 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 Managers[6] to schedule this support. • A helpful resource is the Plan Preview User Guide.	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

QHP Application Corrections and Notices

Throughout the QHP Application submission process, CMS releases review results to issuers in the PM Community on a rolling basis. 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 B provides more information on the PM Community functionality.

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.

Table 4. Overview of QHP Notices

CMS will send notices to states throughout the certification process, some of which 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 Plan Management (PM) Community. States will send any questions or concerns to the MPMG State Coordination mailbox. 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 dropdown menus in the PM Community to complete plan confirmation for each plan.
Certification Notice	No	No

Plan Confirmation

States must confirm submitted plans at the end of the certification process. 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.[7]

What do states need to do?

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 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.
- Search the QHP certification website FAQs for answers to questions before contacting the CMS Help Desk.
- Attend state and issuer 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 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. This 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,[8] that the issuer is authorized to submit its Plan ID Crosswalk.

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

[8] 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?
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. In SBE-FPs, this activity 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. This activity will 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.

What do states need to do?
States that wish to direct this activity 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 Withdrawal

In this context, plan withdrawal refers to withdrawing a plan from certification (or consideration of certification) as a QHP to be offered through the Exchange. This 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 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 5** 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 5. Overview of Allowable Data Changes During the QHP Certification Cycle

Timeframe	Allowable Data Changes	Data Change Request Required?
Before the initial submission deadline	Issuers may make any changes to their data without CMS or state authorization, including adding or removing plans or changing plan type.	Data change request not required
Between the initial and final data submission deadlines	Issuers may not add plans or change plan type. A data change request to CMS is required for changes to service area, and plan withdrawal forms are required to remove plans. For all other changes, issuers are not required to submit data change requests or document the state or CMS Form Filing authorization to CMS.	Data change request required for service area changes only
After the final submission deadline	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.	Data change request required for data changes only.

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. Issuers may only change their service area after CMS approves the change. 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 and do not require a data change request to CMS. CMS requires state approval for issuers to update their URLs. However, CMS does not require issuers to submit a state authorization form. By submitting URL changes in the Supplemental Submission Module, 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 in to the HIOS State Evaluation Module and accessing the issuer's Supplemental Submission Module.

After the deadline for issuer changes to QHP Applications, issuers may 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 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 6** indicates, by Exchange model, which data change request documents need to be submitted to CMS.[9]

Table 6. 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
FFE-DE (QHP)	✓	None	✓
FFE-DE (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.

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

What do states need to do?
States performing plan management functions in 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. After notification, 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 has been refreshed on HealthCare.gov.

Appendix A: Key Updates for Plan Year 2022

Guidance from the HHS Notice of Payment & Benefit Parameters for 2022 and 2022 Letter to Issuers (LTI) in the Federally-facilitated Exchanges (FFE)

- **Plan ID Crosswalk:** Issuers are required to submit plan ID crosswalk data for each medical QHP and SADP that was certified for the 2021 plan year. The approach for 2022 certification with regard to 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 2021 Plan ID Crosswalk Template to SADPs in order to support automatic reenrollment for plans offered during the 2022 plan year.

- **Alternative Payment Models (APMs)**: In an effort to improve health outcomes and lower costs, CMS encourages issuers and states to advance efforts to support value-based care and value-based payments across the healthcare system, with a particular emphasis on the individual market population, and to share some possible pathways for adoption of such approaches.

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

- **Interoperability:** For plan year 2022, QHP issuers in FFEs, including FFEs in states performing plan management functions, are required to implement and maintain a patient access application programming interface (API) and complete related documentation requirements, or submit a narrative justification that meets the specifications at 45 CFR 156.221(h). To assess compliance with the requirements, QHP issuers will, as part of the regular QHP attestation requirements, attest that they are meeting these requirements or submit a justification as part of the QHP application.

- **Transparency in Coverage Reporting:** Beginning with plan year 2020, issuers were required to report the following plan-level data: claims received, claims denied, claims denied due to prior authorization or referral required, claims denied due to an out-of-network provider/claim, claims denied due to an exclusion of service, claims denied due to lack of medical necessity (including and excluding behavioral health), and claims denied for "other" reasons. In addition, starting with plan year 2021, the transparency in coverage data collection was integrated into the QHP certification data submission process, such that issuers submitted the transparency template in the same manner as other QHP certification templates. Submissions will no longer be collected

outside of the QHP certification timeline via an email box. Transparency in Coverage URL submissions should be made in the QHP Supplemental Submission Module.

- Summary of Benefits and Coverage (SBC): QHP issuers are required to provide the SBC in a manner compliant with the standards set forth at 45 CFR 147.200. On February 3, 2020, the Departments of Health and Human Services, Labor, and the Treasury released updated versions of the 2021 SBC Template and related materials. These versions replace the versions released on November 7, 2019. These updates ensure consistency across 2021 SBC materials and do not impact SBC guidelines and instructions.

  CMS also released a set of FAQs pertaining to the applicability date of the updated SBC Template, Calculator, and related materials. The SBC Calculator is used by plans and issuers to generate cost-sharing estimates for coverage to treat three hypothetical medical scenarios (maternity care, type II diabetes, and a simple foot fracture) that must be included in the SBC. Use of the Calculator is not required. Plans and issuers may create their own calculator using the Guide and Narratives provided by HHS, or modify the logic of the Calculator to provide their own method of calculating estimated out-of-pocket costs for the Coverage Examples, which may be more accurate based on their particular plan or policy design.

  The 2021 SBC Template and Instructions update the 2017 SBC Template and Instructions to include a new Minimum Essential Coverage (MEC) statement: "Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, certain Medicare and Medicaid coverage, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit."

- Medical Cost Scenarios: Consumer testing of the 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. In order to provide consumers greater cost transparency for plan year 2022, CMS will continue to analyze ways to provide additional medical cost scenarios to QHP customers.

- SADP – Annual Limitation on Cost Sharing: The SADP annual limitation on cost sharing for one covered child is $350 increased by the 9.303 percentage point increase of the Consumer Price Index (CPI) for dental services for 2020 of 500.970 over the CPI of 458.330 for dental services for 2016, increasing the annual limitation on cost-sharing for SADPs by $32.56. The regulation requires incremental increases to be rounded down to the next lowest multiple of $25; therefore, the annual limitation on cost sharing for SADPs for plan year 2022 will be $375 for one child and $750 for two or more children.

- Machine Readable: The Machine Readable file-posting deadline is August 18, 2021, which aligns with the deadline for issuers to change QHP Application data. This allows additional time for CMS to conduct any applicable technical assistance required to ensure that the Machine Readable files are available by Open Enrollment.

Appendix B: Plan Management Community Functionality

The Plan Management (PM) Community is an online platform designed to improve CMS communication and coordination with issuers and states around QHP certification. Federally-facilitated Exchanges (FFEs), states performing plan management functions in FFEs, and State-based Exchanges Using the Federal Platform (SBE-FP) use the PM Community to view qualified health plan (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 SBEs, 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 login 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 (MSD).

CMS requests that states identify up to three users (a minimum of two 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 certification. 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, including:

- Managing state contacts for QHP certification-related communications;
- Viewing issuer- and plan-level data for all issuers in the state;
- Finding resources about EHB and submitting their EHB-benchmark plan;
- Submitting withdrawal forms;
- Completing plan confirmation;
- Viewing issuers' crosswalk submissions;
- Accessing attachments, such as notices, from CMS; and
- Viewing corrections regarding their issuers' QHP Applications.

Appendix C: Plan Year 2022 State Flexibility for Essential Health Benefits (EHB)

Starting in plan year (PY) 2020, CMS provided states with greater flexibility to select their EHB-benchmark plan by providing three new options for selection:

Option 1

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

Option 2

Replacing 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

Selecting 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
- The State's EHB-benchmark Plan's Benefits and Limits
- EHB-benchmark Plan Formulary Drug List
- EHB-benchmark Plan Document

However, states have the flexibility to forgo these options, and may instead retain their current EHB-benchmark plans. States that opt not to exercise this flexibility continue to use the same EHB-benchmark plan. States selecting an EHB-benchmark plan for PY 2023 must submit required documentation to CMS by **May 7, 2021**.

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 7, 2021** for PY 2023. 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.

APPENDIX D: QHP CERTIFICATION TIMELINE

The table below provides the plan year 2022 QHP certification timeline. States should review this timeline to prepare for certification, as detailed in the PY 2022 QHP Data Submission and Certification Timeline Bulletin.

Activity	Dates
Stand-alone Dental Plan Voluntary Reporting of Intent to Offer	2/15/21
QHP Application submission window opens	4/22/21
Optional Early Bird QHP Application submission deadline	5/19/21
CMS reviews Early Bird QHP Application data and releases results in the PM Community	5/20/21–6/11/21
HHS-approved QHP Enrollee Survey vendor securely submits QHP Enrollee Survey response data to CMS on behalf of QHP issuer	5/24/21
QHP issuer submits validated QRS clinical measure data, with attestation, to CMS via NCQA's Interactive Data Submission System (IDSS)	6/15/21
Machine-readable index URL submission deadline	6/16/21
Initial QHP Application deadline, including Transparency in Coverage and Plan ID Crosswalk data, Machine Readable Index File	6/16/21
CMS reviews initial QHP Applications and releases results in the PM Community	6/17/21–7/16/21
Initial deadline for QHP Application Rates Table Template; optional deadline to resubmit corrected QHP Application data	7/21/21
CMS reviews initial submission of Rates Table Template and resubmitted QHP Application data, and releases results in the PM Community	7/22/21–8/13/21
QHP issuers, Exchange administrators, and CMS preview the 2021 QHP quality rating information	Aug/Sep 2021
Service area data change request deadline	8/10/21
Issuers complete final plan confirmation and submit final Plan ID Crosswalk Templates in the PM Community	8/11/21–8/25/21
Deadline for issuers to change QHP Application, including Transparency in Coverage data	8/18/21
Deadline for issuers to submit marketing URL data in the HIOS Supplemental Submission Module (SSM)	8/18/21
CMS reviews QHP Applications and releases results in the PM Community	8/19/21–9/13/21
CMS sends QHP Certification Agreements to issuers	9/14/21

Issuers return signed QHP Certification Agreements to CMS	9/14/21–9/22/21
States complete final plan confirmation in the PM Community	9/14/21–9/22/21
Limited data correction window	9/16/21–9/17/21
New plan year machine-readable submission deadline	9/22/21
Deadline for marketing URLs to be live and active	9/22/21
CMS releases certification notice to issuers and states	10/4/21–10/5/21
Anticipated public display of QHP quality rating information	Mid-Oct 2021
Open Enrollment begins	**11/1/21**

APPENDIX E: PLAN YEAR 2022 STATE RESPONSIBILITY FOR QHP REVIEWS BY EXCHANGE MODEL

The table below outlines the reviews that states are generally responsible for conducting based on their Exchange Model.

Federally-Facilitated Exchange (FFE)	FFE in States Performing Plan Management Functions	State-Based Exchange Using the Federal Platform (SBE-FP)
• Licensure and Good Standing • Network Adequacy • Rate Outlier	• Accreditation • Data Integrity • Essential Community Providers • Interoperability • Licensure and Good Standing • Network Adequacy • Network Breadth* • 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 • SADP – Annual Limitation on Cost Sharing • SADP – 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 Breadth reviews are only conducted in pilot states—Maine, Tennessee, and Texas.

APPENDIX F: QHP CERTIFICATION REVIEW ROLES BY STATE EXCHANGE MODEL

The table below lists reviews for plan year (PY) 2022 that CMS, as administrator of the Federally-facilitated Exchanges (FFE), and states will conduct to ensure that issuers applying to offer QHPs through Exchanges meet and maintain applicable certification standards. State regulators should refer to this review table in preparation for PY 2022 QHP certification. CMS, as administrator of the FFEs, remains responsible for certifying QHPs for sale through the FFEs.

The **Review Area** and **Review Description** columns detail each standard with which issuers must comply to achieve QHP certification. The **Reference to Guidance** column directs states to existing guidance for states and issuers pertaining to this certification standard. The **Applicability by Type of QHP** column indicates whether the certification standard applies differentially to QHPs that are SADPs.

The **Reviewer** columns indicate the entity primarily responsible for reviewing QHP Application data to ensure its compliance with the applicable certification standard. If a state is the primary reviewer with CMS ratification, CMS intends to conduct a minimal review of the state's results of the QHP Application reviews and to communicate any outstanding deficiencies to issuers. If the state is the primary reviewer with no CMS ratification, CMS will accept the QHP Application data as submitted by the state without additional review. If CMS is the primary reviewer, no state review is expected.

Finally, the table indicates whether an applicable **review tool** is available. Applicable review tools can be found on the QHP certification website.

	Review Area	Review Description	Reference to Guidance	Applicability by Type of QHP	Reviewer: Federally-Facilitated Exchange (FFE)	Reviewer: FFE in States Performing Plan Management Functions	Reviewer: State-Based Exchange Using the Federal Platform (SBE-FP)	Review Tool
1	**Accreditation**	The review examines issuers' existing accreditation to determine whether a QHP satisfies the accreditation requirements.	2022 Letter to Issuers (LTI) Page 9	Not applicable to SADPs	CMS	State (No CMS ratification)	State (No CMS ratification)	*No tool available*
2	**Administrative**	The review ensures that issuers provide the contact information (e.g., phone number, address, URL) that appears on HealthCare.gov for consumer use.	2014 LTI Page 45	All QHPs	CMS	CMS	State (No CMS ratification)	*No tool available*
3	**Cost Sharing Reduction Plan Variation**	The review ensures that all plans on the Exchange offer cost sharing reduction plan variations that meet the standards for QHP certification, if applicable. The required plan variations are the limited and zero cost sharing plan variations and three silver plan variations. The limited and zero cost sharing variations are available to Indians, and the silver plan variations are available to eligible enrollees with household incomes between 100 and 250 percent of the federal poverty level. All plan variations reduce cost sharing for the consumer. This review also checks whether plans labeled "catastrophic" or "expanded bronze" meet certain plan design requirements.	2019 LTI Page 18	Not applicable to SADPs	CMS	State (CMS ratifies)	State (No CMS ratification)	Cost Sharing Tool

	Review Area	Review Description	Reference to Guidance	Applicability by Type of QHP	Reviewer: Federally-Facilitated Exchange (FFE)	Reviewer: FFE in States Performing Plan Management Functions	Reviewer: State-Based Exchange Using the Federal Platform (SBE-FP)	Review Tool
4	Data Integrity	The review identifies critical data errors within and across templates that result in incorrect display of plan information to consumers, prevention of plan display to consumers, or regulatory noncompliance. The review also flags data as warnings, prompting the issuer to double-check that the flagged data are correct.	2018 LTI Page 50	All QHPs	CMS	State (CMS ratifies)	State (CMS ratifies)	Data Integrity Tool
5	Essential Community Providers	The review determines whether the issuers' provider networks are adequate with respect to inclusion of ECPs. ECPs include providers that serve predominantly low-income and medically underserved individuals. Inclusion of ECPs in issuer networks helps to ensure reasonable and timely access to a broad range of ECPs for enrollees in issuer service areas.	2018 LTI Pages 30-33	All QHPs	CMS	State (No CMS ratification)	State (No CMS ratification)	QHP ECP and SADP ECP Tools
6	Interoperability	QHP issuers in FFEs, including FFEs in states performing plan management functions, must implement and maintain a patient access application programming interface (API) and related documentation requirements, or submit a narrative justification that meets the specifications. QHP issuers will, as part of regular QHP attestation requirements, attest that they are meeting these requirements or submit a justification as part of the QHP application.	2022 LTI Page 11	All QHPs	CMS	State (No CMS ratification)	N/A	*No tool available*

	Review Area	Review Description	Reference to Guidance	Applicability by Type of QHP	Reviewer: Federally-Facilitated Exchange (FFE)	Reviewer: FFE in States Performing Plan Management Functions	Reviewer: State-Based Exchange Using the Federal Platform (SBE-FP)	Review Tool
7	**Licensure and Good Standing**	The review ensures that issuers have provided documentation that shows they have satisfied licensure and good standing requirements for the proposed QHP markets, service areas, and products.	2018 LTI Page 21	All QHPs	State (No CMS ratification)	State (No CMS ratification)	State (No CMS ratification)	*No tool available*
8	**Machine Readable**	The review includes an evaluation of the accuracy of MR data files (plan, provider, and formulary) submitted by QHPs and SADPs to the Federally-facilitated Exchange (FFE) in the JSON format by the pre-Open Enrollment deadline each year (SADPs do not have to update formulary files). Additionally, the review includes an evaluation of the accuracy and consistency of the monthly MR data files submitted by QHPs and SADPs to the Federally-facilitated Exchange (FFE).	Formulary MR – 45 CFR 156.122(i)(1)(2) Provider MR – 45 CFR 156.230(c)	All QHPs	CMS	CMS	CMS	*No tool available*
9	**Network Adequacy[10]**	The review assesses whether issuers meet the standard of "reasonable access" to providers of covered services. In states that do not perform sufficient network adequacy reviews, CMS will rely on an issuer's accreditation from an HHS-recognized accrediting entity or will review access plans for issuers without accreditation.	2018 LTI Pages 23-26	All QHPs	State/CMS (No CMS ratification)	State/CMS (No CMS ratification)	State (No CMS ratification)[11]	*No tool available*

[10] State/CMS indicates in the Exchange Stabilization Final Rule that states will conduct the review when CMS determines that the state performs sufficient network adequacy reviews; otherwise, CMS will conduct the review.

[11] In the 2019 Payment Notice Final Rule, CMS eliminated the requirement for SBE-FPs to enforce the FFE standards for Network Adequacy and Essential Community Providers (ECPs) and deferred to state authority for enforcement. For more information, please see pages 22-23 of the 2019 Letter to Issuers in the Federally-facilitated Exchanges.

	Review Area	Review Description	Reference to Guidance	Applicability by Type of QHP	Reviewer: Federally-Facilitated Exchange (FFE)	Reviewer: FFE in States Performing Plan Management Functions	Reviewer: State-Based Exchange Using the Federal Platform (SBE-FP)	Review Tool
10	Non-Discrimination – Cost Sharing	To ensure non-discrimination in QHP benefit design, CMS will perform an outlier analysis on QHP cost sharing (e.g., co-payments and co-insurance) as part of the QHP certification application process. QHPs identified as outliers may be given the opportunity to modify cost sharing for certain benefits if CMS determines that the cost sharing structure of the plan that was submitted for certification could have the effect of discouraging the enrollment of individuals with significant health needs. In states where CMS performs this review, CMS's outlier analysis will compare benefit packages with comparable cost sharing structures to identify cost sharing outliers with respect to specific benefits.	2019 LTI Page 17	Not applicable to SADPs	CMS	State (No CMS ratification)	State (No CMS ratification)	*Non-Discrimination Cost Sharing Review Tool*
11	Organization Charts/ Compliance Plans	The review examines compliance plans that issuers submit to ensure that appropriate processes are in place to maintain adherence to applicable regulations and guidelines, as well as to prevent fraud, waste, and abuse. The organizational chart review ensures that the Compliance Officer reports to the board of directors (or other senior governing body).	2018 LTI Page 55	All QHPs	CMS	State (No CMS ratification)	State (No CMS ratification)	*No tool available*

	Review Area	Review Description	Reference to Guidance	Applicability by Type of QHP	Reviewer: Federally-Facilitated Exchange (FFE)	Reviewer: FFE in States Performing Plan Management Functions	Reviewer: State-Based Exchange Using the Federal Platform (SBE-FP)	Review Tool
12	**Plan ID Crosswalk: General Crosswalk Requirements**	The Plan ID Crosswalk review for general crosswalk requirements includes cases in the individual market where an issuer renews coverage, consistent with the guaranteed renewability standards specified at 45 CFR 147.106(e) and 155.335(j)(1). This review also includes cases in the individual market where an issuer non-renews or discontinues coverage, or continues the product but no longer serves one or more enrollees, consistent with §147.106(c) and 155.335 (j)(2), and selects a plan under a different product offered by the issuer for those enrollees who do not make another plan selection. In all cases, issuers must comply with applicable federal and state law.	2018 LTI Pages 18-19	All QHPs	CMS	State (CMS ratifies)	State (CMS ratifies)	Plan Crosswalk Tool
13	**Plan ID Crosswalk: Alternate Enrollments**	The Plan ID Crosswalk review for alternate enrollments includes cases in the individual market where an issuer non-renews or discontinues coverage consistent with 45 CFR 155.335(j)(3) and does not provide an enrollment option for affected enrollees for the upcoming plan year.	2018 LTI Page 19	Beginning in PY 2020, CMS applied the processes established for the 2020 Plan ID Crosswalk Template to SADPs to support automatic re-enrollment.	State unless state defers to CMS (CMS ratifies)	State unless state defers to CMS (CMS ratifies)	State unless state defers to CMS (CMS ratifies)	Plan Crosswalk Validation Tool

	Review Area	Review Description	Reference to Guidance	Applicability by Type of QHP	Reviewer: Federally-Facilitated Exchange (FFE)	Reviewer: FFE in States Performing Plan Management Functions	Reviewer: State-Based Exchange Using the Federal Platform (SBE-FP)	Review Tool
14	**Prescription Drug Non-Discrimination – Clinical Appropriateness**	The review ensures that issuers offer sufficient numbers and types of drugs to effectively treat high-cost and chronic medical conditions and do not restrict access by lack of coverage or inappropriate use of utilization management techniques. Drug lists are created using nationally ranked clinical guidelines.	2019 LTI Page 17	Not applicable to SADPs	CMS	State (No CMS ratification)	State (No CMS ratification)	Formulary Review Suite
15	**Prescription Drug Non-Discrimination – Formulary Outlier**	The review focuses on utilization management measures that an issuer may use, and it identifies and flags outlier plans that have an unusually low number of drugs that are unrestricted—not subject to prior authorization or step therapy requirements—in particular USP categories and classes.	2019 LTI Page 17	Not applicable to SADPs	CMS	State (No CMS ratification)	State (No CMS ratification)	Formulary Review Suite
16	**Program Attestations**	The review confirms that issuers agree to comply with FFE requirements and standards.	2018 LTI Page 9	All QHPs	CMS	State (No CMS ratification)	State (No CMS ratification)	*No tool available*
17	**Quality Improvement Strategy**	The review examines issuers' Quality Improvement Strategy (QIS) submissions to ensure that issuers have appropriately completed the QIS Implementation Plan and Progress Report forms, and assesses whether they meet the QIS requirements as part of their QHP Applications.	2018 LTI Page 40	Not applicable to SADPs	CMS	State (CMS ratification)	State (No CMS ratification)	*Master Review Tool*
18	**Quality Reporting**	The review ensures that issuers have submitted their quality data and enrollee satisfaction survey results.	2018 LTI Pages 38-40	Not applicable to SADPs or child-only plans	CMS	CMS	State (No CMS ratification)	*No tool available*

	Review Area	Review Description	Reference to Guidance	Applicability by Type of QHP	Reviewer: Federally-Facilitated Exchange (FFE)	Reviewer: FFE in States Performing Plan Management Functions	Reviewer: State-Based Exchange Using the Federal Platform (SBE-FP)	Review Tool
19	Rate Outlier	Issuers with rates that are significantly lower than the rest of the rates in the Exchange may indicate issuers that are at risk for financial insolvency, which could create market instability. These low rates are identified using an outlier analysis for plans in the same geographic region and metal level.	2019 LTI Page 16	Not applicable to SADPs	State rate review process (No CMS ratification)	State rate review process (No CMS ratification)	State rate review process (No CMS ratification)	*No tool available*
20	**SADP – Annual Limitation on Cost Sharing**	The review ensures that the maximum out-of-pocket amount for all dental plans is within the required limit.	2022 LTI Page 13	SADPs only	CMS	State (No CMS ratification)	State (No CMS ratification)	Cost Sharing Tool
21	**SADP – EHB Benchmark**	The review consists of comparing an issuer-submitted benefit package with the benefits covered by the applicable EHB benchmark plan (state and federal benchmarks). The compliance review for additional benefits not considered EHB, and for associated attestations, consists of additional checks of these benefits to ensure they comply with applicable standards defined in the PPACA.	2018 LTI Page 52	SADPs only	CMS	State (No CMS ratification)	State (No CMS ratification)	*No tool available*
22	**SADP – EHB Supporting Documentation and Justification**	The review examines supporting documentation submitted by issuers who have changed their EHBs by substitution and verifies that the new benefit is actuarially equivalent to the original EHB and meets the standards of the EHB and the PPACA.	2018 LTI Page 52	SADPs only	CMS	State (No CMS ratification)	State (No CMS ratification)	*No tool available*

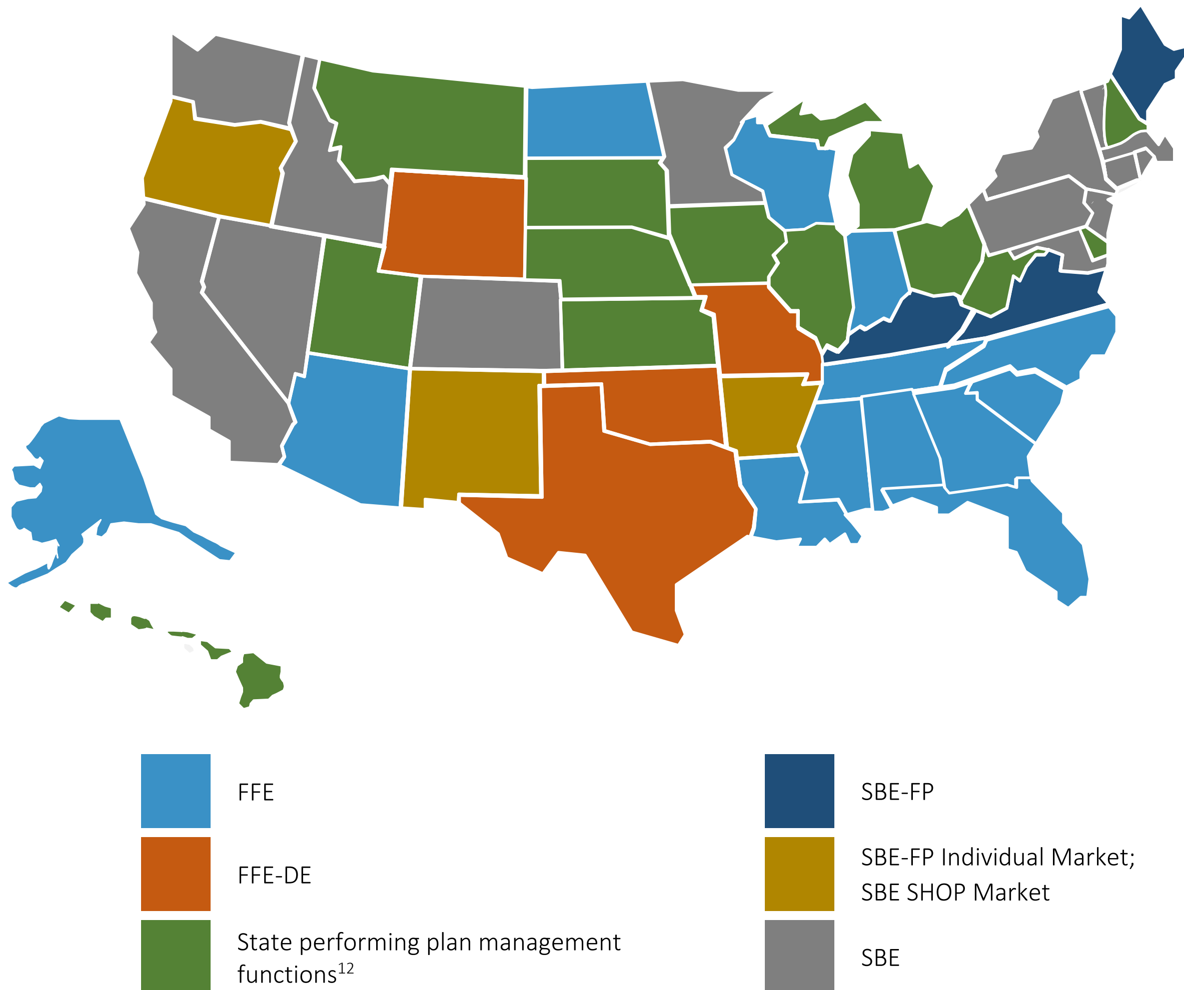
	Review Area	Review Description	Reference to Guidance	Applicability by Type of QHP	Reviewer: Federally-Facilitated Exchange (FFE)	Reviewer: FFE in States Performing Plan Management Functions	Reviewer: State-Based Exchange Using the Federal Platform (SBE-FP)	Review Tool
23	Service Area	The review confirms that issuers have established a service area that covers a minimum geographic area that is at least the entire geographic area of a county. If the issuer proposed a service area smaller than a full county, the review ensures that the issuer is doing so because partial county coverage is necessary, non-discriminatory, and in the best interest of potential enrollees.	2018 LTI Page 22	All QHPs	CMS	State (No CMS ratification)	State (No CMS ratification)	*No tool available*
24	Silver/Gold	The regulation requires that an issuer offering QHPs through an Exchange offer at least one QHP on the silver coverage level and at least one QHP in the gold coverage level throughout each service area in which the issuer applying for certification offers coverage through the Exchange. The FFEs will apply this certification standard by ensuring that both a silver and gold level QHP (and/or Multi-State Plan options) are offered throughout each individual and FF-SHOP service area in which the QHP issuer offers coverage. An issuer could meet this standard by offering Multi-State Plan options certified by the Office of Personnel Management (OPM) in both silver coverage and gold coverage levels throughout each service area in which it offers QHPs through an Exchange.	2018 LTI Page 23	Not applicable to SADPs	CMS	State (No CMS ratification)	State (No CMS ratification)	Master Review Tool

	Review Area	Review Description	Reference to Guidance	Applicability by Type of QHP	Reviewer: Federally-Facilitated Exchange (FFE)	Reviewer: FFE in States Performing Plan Management Functions	Reviewer: State-Based Exchange Using the Federal Platform (SBE-FP)	Review Tool
25	Transparency in Coverage	The review confirms if issuers have reported the following plan level data: claims received, claims denied, claims denied due to prior authorization or referral required, claims denied due to an out-of-network provider/claim, claims denied due to an exclusion of service, claims denied due to lack of medical necessity (including and excluding behavioral health), and claims denied for "other" reasons. Starting with the 2021 plan year, the transparency in coverage data collection was integrated into the QHP certification data submission process, such that issuers submitted the transparency template in the same manner as other QHP certification templates. Issuers are also required to submit an active and compliant Transparency in Coverage Claims Payment Policies URL upon initial QHP Application submission.	2022 LTI Page 12	All QHPs	CMS	CMS	CMS	No tool available
26	URL Reviews	CMS performs checks on URLs submitted in an issuer's QHP Application to ensure that URLs are live and functional prior to QHP Agreement signing and through the end of the plan year. CMS also reviews URLs to ensure they contain accurate data and adhere to CMS guidelines.	QHP URL Validation and Reviews Checklist	All QHPs	CMS	CMS	CMS	No tool available

Appendix G: Plan Year 2022 Exchange Models

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 2022 Exchange Models Map



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