QHP Certification Review Roles by State Exchange Model

The table below lists reviews for plan year (PY) 2023 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 and issuers should refer to this review table in preparation for PY 2023 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 review tools page of 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.	2023 Letter to Issuers (LTI) Page 18	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	CMS	*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

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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.	2023 LTI Pages 17-18	All QHPs	CMS	State (No CMS ratification)	State (No CMS ratification)[1]	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 (CMS Ratifies)	N/A	*No tool available*

[1] 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.

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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	The review assesses whether issuers meet the standard of “reasonable access” to a sufficient number and type of providers.	2023 LTI Pages 10-17	All QHPs	CMS	CMS	State (No CMS ratification)[2]	*No tool available*

[2] 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.

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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

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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

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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	CMS	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*

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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.	2020 LTI Page 15	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*

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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 are offered throughout each individual and FF-SHOP service area in which the QHP issuer offers coverage.	2018 LTI Page 23	Not applicable to SADPs	CMS	State (No CMS ratification)	State (No CMS ratification)	Master Review Tool

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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.	2023 LTI Page 21	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