Date: **January 25, 2016**

From: **The Maryland Health Benefit Exchange**

To: **Issuers Seeking to Participate in Maryland Health Connection in 2017**

Title: **FINAL 2017 Letter to Issuers Seeking to Participate in Maryland Health Connection**

The Maryland Health Benefit Exchange (MHBE) is releasing this final 2017 Letter to Issuers (the Letter). This Letter provides operational and technical guidance to issuers seeking to offer qualified plans, which include Qualified Health Plans (QHP) and Stand-Alone Dental Plans (SADP), through Maryland Health Connection on the Individual and Small Business Health Options Program (SHOP) Marketplaces. Unless otherwise specified, references to the Marketplace include both the Individual and SHOP Marketplaces.

MHBE appreciates the public comments provided in response to the draft Letter. MHBE has reviewed all comments submitted and has incorporated many of the suggestions, particularly comments seeking clarification of a standard and/or operational procedure. MHBE is concurrently releasing a document that includes each public comment and MHBE's response to the comment. As noted for many comments, MHBE looks forward to further discussing the comment with MHBE stakeholders. MHBE is also in the process of promulgating regulations that will incorporate final 2017 carrier and plan certification standards, as appropriate.

Published rules concerning market-wide and QHP certification standards, eligibility and enrollment procedures, and other Marketplace-related topics, are defined in 45 C.F.R. Subtitle A, Subchapter B and the MHBE Interim Procedures on Carrier and Qualified Health Plan Certification, approved by the Board of Trustees on October 23, 2012. Supplemental guidance and other market rules applicable to issuers may be found in the most recent Maryland Health Connection Carrier Reference Manual[1]. MHBE expects issuers to consult all applicable regulations, in conjunction with this Letter, to ensure full compliance with the requirements of the Affordable Care Act and other applicable state and federal requirements. Throughout the plan year, qualified plans may be required to correct deficiencies identified in MHBE's post-certification activities, as a result of the investigation of consumer complaints, oversight by the Maryland Insurance Administration (MIA) or by MHBE, or an issuer's own industry-standard internal compliance and risk management program.

[1] MHBE Carrier Reference Manual, published October 2014 at http://www.marylandhbe.com/wp-content/uploads/2014/10/Carrier-Reference-Manual_2014b.pdf.

MHBE strives to ensure that Maryland Health Connection is a competitive marketplace offering consumers choices while balancing regulatory requirements and stakeholder input. MHBE sought stakeholder input through a variety of avenues, including the Standing Advisory Committee (SAC) and the Exchange Implementation Advisory Committee (EIAC), prior to presenting many of the new standards proposed in this Letter for 2017.[2] MHBE will continue to use these avenues to propose, discuss, and develop carrier and plan certification standards in the future. MHBE will also continue to monitor approaches taken in other marketplaces.

[2] MHBE has made an effort to respond to all substantive comments; however, comments regarding the structure of SHOP are outside the scope of this Letter. MHBE will address the structure and requirements pertaining to SHOP Administrators through the SHOP Request for Proposal ("RFP") during Quarters 2 and 3 of 2016.

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CHAPTER 1: ISSUER ANNUAL CERTIFICATION PROCESS AND STANDARDS

The Affordable Care Act, Sections 31-106 and 31-108 of the Insurance Article, Maryland Code, and the MHBE Interim Procedures on Carrier and Qualified Plan Certification (adopted by the MHBE Board of Trustees (Board) on Oct. 23, 2012) establish that issuers must meet a number of standards in order to be certified or recertified to operate within the Individual and SHOP Marketplaces. In accordance with these authorities, MHBE has established an Annual Certification Process for health and dental issuers to become certified to offer qualified plans (QHPs and SADPs) on the Individual and SHOP Marketplaces. Unless otherwise specified, the Marketplace refers to the Individual and SHOP Marketplaces.

The certification process will take place during calendar year 2016 for plans effective beginning in 2017. Applications for certification must be submitted annually. MHBE will review, and approve or deny, each application. The process is described in detail under sections A through C and E and F in this chapter. Table 1-A-1 provides an overview of the required submission dates for items included in the certification application. MHBE will review the application against the certification standards described in this chapter.

A. Submission of the Carrier Certification Application[3]

Annually, each issuer must submit a Carrier Certification Application to MHBE and be authorized by MHBE to participate in the Marketplace. The application is updated annually and posted to the MHBE partner website at www.marylandhbe.com. MHBE will also inform current participating issuers when the updated application is published on the partner website and the deadline for submission.

For the 2017 plan year, issuers who have been previously certified by MHBE will continue their certification under the terms of the First Restatement and Amendment of the Carrier Business Agreement effectuating January 1, 2016. The third cycle of carrier recertification will occur in 2017.

As part of the Carrier Certification Application, issuers must also provide the documents listed in Table 1-A-1. Additional information regarding the certification standard addressed by each of these documents is described in section D of this chapter. The table provides due dates for the required documentation and the location of the template for the item, which may be found on MHBE's partner website, CCIIO's issuer resources website or with the issuer.

Unless otherwise listed in Table 1-A-1, issuers must submit carrier certification data through the secure System for Electronic Rate and Form Filing (SERFF) Binders. Exceptions to this general rule are for biennial Amendments and Restatements of the Carrier Business Agreement and other legal documents that require submission of a physical copy to MHBE.

[3] *See* MHBE Carrier and Qualified Plan Certification Interim Procedures .03 "Application Procedures" at ¶¶ A-C.

Table 1-A-1. Carrier Certification Submission Dates

Item Name	Source for Item Template	Submission Location for Completed Item	Due Date to MHBE
Carrier Application	MHBE	mhbe.carriers@maryland.gov	June 1, 2016
Carrier Business Agreement – Attestation	MHBE	SERFF	July 1, 2016
Non-Exchange Entity Agreement – Attestation	MHBE	SERFF	July 1, 2016
Program Attestation for State-Based Marketplace Issuers	CCIIO	SERFF	July 1, 2016
Network Access Plan Amendments and Supplement	MHBE	mhbe.carriers@maryland.gov	June 1, 2016
Carrier Logo	Issuer	SERFF	July 1, 2016
List of Subcontractors	Issuer	SERFF	July 1, 2016
Accreditation Template (if applicable)	CCIIO	SERFF	July 1, 2016
Carrier Certification Review Period	MHBE		July 1 – August 15, 2016
Carrier Certification Approval/Denial Notice	MHBE	SERFF/Issuer Point-of-Contact	August 15, 2016

B. Review of Carrier Certification Applications & Certificate of Carrier Authorization[4]

MHBE must review a Carrier Certification Application submitted to MHBE by an issuer within 45 calendar days of receipt of the application. During the review period, MHBE may follow up with the issuer regarding any incomplete application items. After the 45-day period, all issuers will receive a Carrier Certification Approval or Denial Notice from MHBE. A Carrier Certification Approval Notice informs the issuer that they are eligible to submit plans for certification by MHBE for the plan year of 2017. Plans submitted to MHBE are required to meet the annual Plan Certification Process and Standards, which are described in Chapters 2 and 4, respectively, for 2017. Off-Exchange SADP Certification Process and Standards are described in Chapter 3 for 2017.

In such cases where an issuer is denied from participating in the Marketplace, MHBE will provide reasons for the denial and appeal rights to the issuer.

C. Carrier Certification Standards

In order to be certified to offer plans through the Marketplace, an issuer must meet certain standards. These standards are covered in this section and include licensure and accreditation, among other requirements.

[4] *See* MHBE Carrier and Qualified Plan Certification Interim Procedures .03 "Application Procedures" at ¶ D.

i. Maryland Insurance Administration Requirements for Marketplace Participation

To be certified to participate in the Marketplace, issuers must attest to MHBE that the issuer is licensed by the State of Maryland as a risk-bearing entity and is operating in good standing with MIA. Additionally, the issuer must continue to adhere to the applicable rules and standards in the Insurance Article of the Annotated Code of Maryland. Issuers should use the Carrier Application to meet this requirement.

ii. Requirement for Accreditation

To be certified to participate in the Marketplace, issuers participating must hold a current accreditation for 2017.

For issuers that offer health benefits only, this standard will be met if the issuer is accredited by the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC). MHBE will consider an issuer accredited if it has an accreditation status deemed acceptable under the federal accreditation standard described in Centers for Medicare & Medicaid Services (CMS) 2017 Letter to Issuers in the FFM. To meet this standard, these issuers must submit an Accreditation Template, developed by the federal Centers for Consumer Information and Insurance Oversight (CCIIO) and made available on the MHBE partner website, into their SERFF Binders.

For issuers that offer dental benefits only, this standard will be met if the issuer holds a current and valid MIA Certificate of Authority. To meet this standard, these issuers must submit a copy of the Certificate of Authority as a supporting document in their SERFF Binders.

iii. Requirement for an Active Carrier Business Agreement

To be certified to participate in the Marketplace, issuers must have an active Carrier Business Agreement (CBA) on file with MHBE. An active CBA is defined as the latest iteration of the CBA that is signed by MHBE and the issuer and on file with MHBE. In general, the CBA contains terms and conditions regarding compliance with MHBE policies and state and federal regulations. The CBA is automatically renewed biennially and is subject to restatement and amendment.

The most recent iteration of the CBA was renewed for all issuers with a 2016 MHBE certification for two years effective January 1, 2016. An issuer that was certified in 2016 applying for 2017 certification must submit to MHBE a written notice, on issuer letterhead, attesting that the issuer has an active CBA. An issuer that was not certified in 2016 applying for 2017 certification must execute a CBA with MHBE. MHBE will provide the issuer a fillable PDF of the CBA at least 60 calendar days prior to the effective date of the CBA.

iv. Requirement for an Active Non-Exchange Entity Agreement

To be certified to participate in the Marketplace, issuers must have an active Non-Exchange Entity Agreement (NEEA). An active NEEA is defined as the latest iteration of the NEEA that is signed by MHBE and the issuer and that the signed NEEA is on file with MHBE. In general, the

NEEA is required by MHBE to ensure compliance with the requirements of the ACA, including 45 CFR § 155.260(b)(2) and 45 CFR § 155.270(a), regarding confidentiality, privacy, and security of data accessed by the issuer or exchanged between the issuer and MHBE. The NEEA replaces the previously used MHBE Trading Partner Agreement.

An active NEEA is on file with MHBE for all issuers that were certified by MHBE for 2016. An issuer certified in 2016 applying for 2017 certification must submit to MHBE a written notice, on issuer letterhead, attesting that the issuer has an active NEEA. An issuer that was not certified in 2016 applying for 2017 certification must execute a NEEA with MHBE. MHBE will provide the issuer a fillable PDF of the NEEA at least 60 calendar days prior to the effective date of the NEEA.

v. Requirement for Network Access Plan

To be certified to participate in the Marketplace, an issuer must annually submit a Network Access Plan using the template provided by MHBE for each of the issuer's networks. This template provides details about standards for network adequacy and the inclusion of Essential Community Providers and is used to review the numbers and types of providers in an issuer's internal network adequacy standards. This template is submitted in full every two years, in sync with the CBA renewal, and it is amended in off-cycle years. This template is different than network adequacy templates that HMOs may be required to submit to the Department of Health and Mental Hygiene.

For the 2017 plan year, MHBE will collect additional network information to supplement the Network Access Plans. MHBE will provide these additional templates. The issuer must submit the following templates to MHBE for certification for 2017:

1. Quantitative Standards Network Adequacy Reporting Template
2. Provider Accessibility Standards Template
3. Member Services Standards Template

These templates will not be shared publicly or be used to assess issuer network adequacy for the 2017 plan year, but will be used to inform MHBE of an issuer's internal network adequacy standards. This information, coupled with the other network/provider directory actions taken by issuers, will allow MHBE to better assess issuer performance with respect to the reported standards. MHBE will release all templates by the end of January 2016.

vi. Miscellaneous Other Requirements

To be certified to participate in the Marketplace, an issuer must also submit the below-listed items to MHBE:

1. **Carrier Logo**: The issuer must provide the logo in .jpg format and no larger than 140 x 50. The logo will be used for plan shopping on the Maryland Health Connection website.
2. **Program Attestation for SBM Issuers**: This attestation is collected annually and will be a part of the 2017 carrier recertification packet. This document must be completed by all issuers participating in a State-Based Marketplace (SBM) and will be provided to CCIIO.

3. **List of Subcontractors**: The issuer will provide a list of any material subcontractor who performs work related to Marketplace functions for the issuer, as addressed in the CBA. For 2017, a renewing issuer should provide any updates to their 2016 list on file with MHBE. If the issuer has no updates, the issuer must notify MHBE that the issuer has no updates to their previously filed list.

D. Waiver Authority[5]

MHBE, with the approval of the MHBE Board of Trustees, may grant a waiver to specific provisions described in this chapter. MHBE may grant the waiver with or without corresponding conditions. To request a waiver, the issuer should inquire with their MHBE Account Manager.[6]

E. Denial, Suspension and Revocation of Certification[7]

MHBE may deny, suspend, revoke or seek other remedies against the QHP issuer offering a plan under Section 31-115(k) of the Insurance Article, Maryland Code for failure to adhere to certification requirements.

Furthermore, MHBE may conduct compliance reviews of a plan during the plan benefit year. The scope of such compliance reviews extends to only include certification standards covered in Section 31-115(k) of the Insurance Article, Maryland Code. If, as result of such compliance reviews, MHBE finds an issuer to be non-compliant, MHBE will require the issuer to correct and meet compliance.

Any denial, suspension or revocation of certification and compliance review findings and corrective action plans are subject to appropriate remedies under state and federal laws and regulations

F. Post-Certification Requirements

To maintain its authorization to participate in the Marketplace for 2017, an issuer should also ensure that it complies with post-certification requirements included in this section.

i. Carrier and SHOP Reference Manuals & Requirement for Annual Review

The Carrier and SHOP Reference Manuals describe in detail Marketplace participation and business rules. These manuals provide supplemental guidance to this letter and corresponding federal and state requirements. Issuers are expected to review the manuals when released annually by MHBE.

[5] *See* MHBE Carrier and Qualified Health Plan Certification Interim Procedures .10 ”Waiver Authority.”

[6] The MHBE Account Manager is the issuer’s MHBE Point of Contact for all Plan Management/Operational initiatives. All issuers participating in Maryland Health Connection currently work with the MHBE Account Manager.

[7] *See* MHBE Carrier and Qualified Health Plan Certification Interim Procedures .08 “Qualified Plan Decertification.”

ii. MHBE Business Process Review Survey Response

The MHBE Business Process Review Survey is a tool that allows stakeholders to provide feedback on MHBE's processes and business operations. The members of the EIAC will be provided access to the survey and may voluntarily participate in the survey response. All issuers participating in the Marketplace for 2017 are required to respond regarding the 2016 Carrier Certification process. The timeline for development of the MHBE Business Process Review Survey will be discussed through the EIAC. The survey content will be open to public comment during the development phase. The results of the survey will be made public on the MHBE stakeholder website and shared with the MHBE Board.

CHAPTER 2: QUALIFIED HEALTH PLAN/STAND-ALONE DENTAL PLAN CERTIFICATION PROCESS

The Affordable Care Act, Section 31-115 of the Insurance Article, Maryland Code, and the MHBE Carrier and Qualified Health Plan Interim Procedures, approved by the Board on Oct. 23, 2012, establish that QHPs and SADPs must meet a number of standards in order to be certified or recertified to operate within the Marketplace. Several of these are market-wide standards that apply to plans offered in the individual market inside as well as outside of the Marketplace. The remaining standards are specific to qualified plans (QHPs and SADPs) seeking certification or recertification from the Marketplaces.

MHBE has established an Annual Certification Process for certification of qualified plans that a certified issuer would like to offer on the Marketplace. This chapter describes the Individual and SHOP Marketplaces Certification Process for a QHP or SADP to be certified to be offered in the Marketplace. Applicable requirements for SADPs have been clearly identified with "SADP." This timeline will be finalized pending any changes to federal or state requirements, such as in the MIA Bulletin on the 2017 Rate and Form Filing Deadline. Chapter 4 describes the certification standards for QHPs.

A. Submission Requirements for QHP/SADP Certification

For a QHP/SADP to be certified for sale through the Marketplace, the plan's issuer must submit the Plan Certification Application and all required templates for each plan for 2017. Additionally, the QHP/SADP must adhere to the certification standards addressed in Chapter 4. Finally, the issuer must also successfully participate in the plan data and display reconciliation process with MHBE addressed in this section in further detail.

i. Templates Required: The templates required as part of the Plan Certification Application are listed in Table 2-A-1. Additional information regarding the certification standard addressed by each of these documents is described in the table and Chapter 4. All templates will be located on the CCIIO website for issuer resources at http://www.marylandhbe.com/carriers-and-shop-administration/carriers/. All items must be submitted through the plan issuer's SERFF Binders. Starting April 1, 2016, the 2017 SERFF Binders will be available for use in document submission by issuers. Exceptions to this general rule are limited, and may be granted upon request by the issuer and approval by MHBE.

Table 2-A-1 includes an initial and final due date. Issuers are encouraged to submit completed templates and supporting documentation, especially if no extensive benefit modifications are expected, earlier than the dates outlined in the table.

For Individual QHP and SADPs, the entire suite of templates and supporting documentation must be uploaded into the 2017 SERFF Binders by July 1, 2016 for preliminary validation. From the period between July 1 and September 1, 2016, MHBE will engage with issuers (Individual QHP and SADP) to begin the data and plan display reconciliation process, called the Functionally Approved Template Submission Window, which is addressed in further detail in section B of this chapter. Issuers will be unable to view plan data in plan display of the online Maryland Health Connection portal during this period. From September 1 through September 9, 2016, issuers will participate in plan display testing in the Maryland Health Connection User Acceptance Testing Environment.

Issuers must have their final template suite and supporting documentation into their SERFF Binders by September 2, 2016 (for SHOP QHPs and SADPs) and September 12, 2016 (for Individual QHPs). Final certification in the SERFF portal will occur on September 26, 2016 for Individual QHPs and SADPs. From September 23, 2016 until the start of the 2017 Open Enrollment Period, all plan data for Individual QHP and SADPs will be frozen in production until the change request phase begins on November 1, 2016.

SHOP issuers are not required to submit CCIIO templates into their binders until MIA Rate and Form release (to be determined by MIA). Plan Management has scheduled the completion of SHOP Plan Certification for September 9, 2016. On September 12, 2016 Plan Management will provide the certified CCIIO templates to the SHOP Administrators to begin the Plan Data Reconciliation process. The Plan Data Reconciliation period is set to end on October 15, 2016. By October 15, 2016 all SHOP Administrators must submit their SHOP Administrator Attestation Form.

MHBE will release any new templates to issuers in January and February 2016. The timelines prescribed in this Letter are subject to MIA rate release schedule.

Table 2-A-1. Plan Certification Templates and Submission Dates

Item Name	QHP/SADP	Initial Submission Date to MHBE	Individual - Final Submission Date to MHBE	SADP – Final Submission Date to MHBE	SHOP -Submission Date to MHBE	Description of Item
Plan and Benefits Template	QHP/SADP	July 1, 2016	September 12, 2016	September 2, 2016	September 2, 2016	Template used to collect plan and benefit details.

Item Name	QHP/SADP	Initial Submission Date to MHBE	Individual - Final Submission Date to MHBE	SADP – Final Submission Date to MHBE	SHOP -Submission Date to MHBE	Description of Item
Unified Rate Review Template	QHP	July 1, 2016	September 12, 2016	Not Applicable	September 2, 2016	Provides information and data necessary for ERR Reasonableness Review, rate increase monitoring and Market Rating Rules Compliance Reviews by states and CMS
Prescription Drug Template	QHP	July 1, 2016	September 12, 2016	Not Applicable	September 2, 2016	Template to capture prescription drug tiers and cost-sharing structure
Network Template	QHP/SADP	July 1, 2016	September 12, 2016	September 2, 2016	September 2, 2016	Template to capture network ID numbers
Service Area Template	QHP/SADP	July 1, 2016	September 12, 2016	September 2, 2016	September 2, 2016	Information identifying a plan's geographic service area.
Rate Data Template	QHP/SADP	July 1, 2016	September 12, 2016	September 2, 2016	September 2, 2016	A table for entering plan rates based on rating area, age, and tobacco use
Rating Business Rules Template	QHP/SADP	July 1, 2016	September 12, 2016	September 2, 2016	September 2, 2016	This is a federal data collection template for the issuer specific business rules to calculate rates based on various factors
Plan Crosswalk Template	QHP/SADP	Not Applicable	July 1, 2016	September 2, 2016	September 2, 2016	Part of 2017 Plan Certification, used in the auto-renewal process to ensure appropriate transfer of enrollees in case of plan exit.
Program Attestation for SBM Issuers	QHP/SADP	Not Applicable	July 1, 2016	September 2, 2016	September 2, 2016	Part of 2017 Plan Certification, instructions will be provided to issuers by June 1st and due to SERFF by July 1st

Item Name	QHP/SADP	Initial Submission Date to MHBE	Individual - Final Submission Date to MHBE	SADP – Final Submission Date to MHBE	SHOP -Submission Date to MHBE	Description of Item
Part I: Unified Rate Review Template	QHP	Not Applicable	May 1, 2016	Not Applicable	September 2, 2016	Part of 2017 Plan Certification, submitted when issuer files Rates with the Maryland Insurance Administration
Part III: Actuarial Memorandum	QHP	Not Applicable	July 1, 2016	Not Applicable	September 2, 2016	Part of 2017 Plan Certification, provides actuarial written narrative describing and supporting the information provided in Part I.
Partial County Service Area Justification	QHP	Not Applicable	July 1, 2016	Not Applicable	September 2, 2016	Part of 2017 Plan Certification, justification from any issuer that submits a partial county service area.
Summary of Benefits and Coverage (QHP)/ Plan Marketing Brochures (SADP)	QHP/SADP	July 1, 2016	September 12, 2016	September 2, 2016	September 2, 2016	Part of 2017 Plan Certification, provides a summary of benefits for each plan and each plan variant. The plan management module requires that an SBC be provided for each plan variant created in the Cost Share Variances tab of the Plan Benefit Template.[8]

[8] The plan marketing name is pulled from the benefits package tab of the Plan and Benefits Template. MHBE recommends that carriers use the plan marketing name displayed in Maryland Health Connection when consumers contact the issuer's call center. Maryland Health Connection will continue to display the deductible (dynamic) and HSA eligibility (binary) for Open Enrollment 2017. Plan Services recommends that carriers remove the words "deductible" and "HSA" from silver level plan marketing names, and will continue to evaluate suggestions with stakeholders to determine effect on On- and Off-Exchange plans and to inform an MHBE proposal on plan marketing names for 2018 plan certification.

Item Name	QHP/SADP	Initial Submission Date to MHBE	Individual - Final Submission Date to MHBE	SADP – Final Submission Date to MHBE	SHOP -Submission Date to MHBE	Description of Item
						Additional requirements: For proper load into the Plan Management template the SBCs must follow a specific naming convention and be formatted as a PDF. <HIOS Issuer ID><State Abbreviation><Plan ID>-<Variant ID>_PlanDetails_<Plan Year>.<Extension> Ex: 12345MD1234567-01_PlanDetails_2015.pdf Do not use the plan marketing name in place of 'Plan Details', in order to pass validation the SBC must have "Plan Details" in the name.

ii. Plan Display Reconciliation

A major facet of plan certification is ensuring that the QHP/SADP displayed to consumers as part of the plan shopping process on Maryland Health Connection accurately displays plan benefits and cost sharing. This functionality requires an extensive reconciliation process between issuer inputs, including plan templates and SBCs, and the output of this items in plan shopping.

The Plan Data/Plan Display Reconciliation process occurs during the SERFF Template and MHBE Materials Resubmission Phase and the Plan Certification period as outlined in Tables 2-A-2 (Individual), 2-A-3 (SHOP), and 2-A-4 (SADP).

Additional details for QHP, SHOP and SADP plan display reconciliation are outlined below.

Individual QHP Display Reconciliation

The Plan Data/Plan Display Reconciliation process occurs over the SERFF Template/PM Materials Resubmission Phase and the Plan Certification period.

Table 2-A-2. Individual QHP

Event/Period	Entity Responsible for Event/Period	Date of Action	Action Description	Source/ Submission Format
Preliminary Template Submission	Issuers	July 1, 2016	Issuers submit full suite of Plan Management Templates	SERFF
Validation Analysis	MHBE	July 8, 2016	MHBE will analyze submitted templates for Plan Management Application Validation MHBE will provide actionable and specific required changes to ensure validation	SERFF Note to Filer
First Round Template Submission	Issuers	July 15, 2016	Issuers will submit full suite of Plan Management Templates with validation changes. OPTIONAL: Issuers will also submit a completed Plan Shopping Tile and Plan Compare Template for each of their plans and plan variants[9] Submissions that require no changes do not need to be resubmitted	SERFF
Extract Analysis + Feedback	MHBE	July 22, 2016	MHBE will deliver to Issuers Plan Management Module Extracts + Feedback MHBE will provide actionable and specific required changes to ensure an improved data extract	SERFF Note to Filer
Second Round	Issuers	July 29, 2016	Issuers will submit full suite of Plan Management Templates with extract changes.	SERFF

[9] This template allows issuers to identify data discrepancies between the MHBE plan shopping screenshot and the issuer's expected output. This process generally results in fewer template resubmissions.

Event/Period	Entity Responsible for Event/Period	Date of Action	Action Description	Source/ Submission Format
Template Submission				
Extract Analysis/Plan Display Print-outs	MHBE	August 5, 2016	MHBE will deliver to issuers Plan Management Module Extracts, Feedback, and Plan Display Print-outs MHBE will provide gap analysis between submitted Plan Shopping Tile and Plan Compare Templates and Plan Display Print-outs. MHBE will provide actionable and specific required changes to ensure an improved Plan Display	SERFF Note to Filer
Third Round Template Submission	Issuers	August 12, 2016	Issuers will submit full suite of Plan Management Template with plan display changes.	SERFF
Extract Analysis/ Plan Display Print-outs	MHBE	August 19, 2016	MHBE will deliver to issuers Plan Management Module Extracts, Feedback, and Plan Display Print-outs MHBE will provide gap analysis between submitted Plan Shopping Tile and Plan Compare Templates and Plan Display Print-outs. MHBE will provide actionable and specific required changes to ensure an improved Plan Display	SERFF Note to Filer
Live Module Data Review	Issuers/ MHBE	September 2, 2016	Issuers will perform data review in the Maryland Health Connection Anonymous Browsing UAT environment + Template Fixes and Submissions MHBE will provide actionable and specific required changes to ensure an improved Plan Display.	MHC Anonymous Browsing + SERFF + SERFF Note to Filer
Issuer Sign-off	Issuers	September 9, 2016	Issuers will sign-off on plans displayed in UAT environment	MHC Anonymous Browsing + SERFF Disposition
Final Binder Submission.	Issuers	September 12, 2016	Issuers will submit finalize Plan Management Template Suite into SERFF	SERFF

Event/Period	Entity Responsible for Event/Period	Date of Action	Action Description	Source/ Submission Format
Plan Upload into Production	MHBE	September 13, 2016	MHBE will upload the final templates into production by September 13	MHC Plan Management Module – Production

SHOP QHP Display Reconciliation

The Plan Data Reconciliation process occurs during the SHOP Administrator/Issuer Reconciliation Phase. For 2017 plan certification, issuers will work directly with the SHOP Administrators to resolve benefit/rate discrepancies. Issuers will notify the MHBE Account Manager as to when the final suite of templates is submitted to SERFF.

For SHOP Plan Certification and SHOP Administrator/Issuer Reconciliation Phases, SERFF will be used to hold all versions of the plan templates, which may be updated upon the discovery of any data errors. Issuers and SHOP Administrator teams must work collaboratively to ensure that plans are displayed and quoted appropriately to consumers. Issuer and SHOP Administrators may directly communicate with each other with template updates, so long as template are concurrently updated within SERFF. The Issuer is not required to notify MHBE of submissions that are not finalized.

To reduce confusion and to encourage a streamlined process, all parties are required to submit an Issuer/Administrator Point of Contact for Template Error Resolution to MHBE. This information must include: Legal Entity/Issuer, Name, Title, Phone Number and Email. This information is due to MHBE Plan Management by September 1, 2016. An email to mhbe.carriers@maryland.gov is sufficient to provide this information.

Additionally, per the SHOP Plan Management II memorandum issued February 9, 2015[10], SHOP issuers and administrators must follow these rules:

i. For the purposes of quoting and rate testing, partner issuers and SHOP Administrators must use the Standardized Quoting Scenario set.
ii. Issuers must notify MHBE Plan Management of any forthcoming rate changes that are different from the quarterly rates indicated in the submitted Rate Data Template. If no notice is given to MHBE Plan Management, the SHOP Administrators will use the data already provided to inform their quoting engines. These notices should be provided in a protected .pdf and submitted to mhbe.carriers@maryland.gov.

[10] Available at http://www.marylandhbe.com/carriers-and-shop-administration/shop-administrators/.

iii. MHBE SHOP and MHBE Plan Management will allow issuers to submit documentation requesting an exemption from the SERFF Template Rule for specific benefit structures that cannot be accurately described in the CCIIO Templates. Issuers and SHOP Administrators may then correct the displayed benefits using appropriate means. Exemption requests should be provided to MHBE Plan Management in a protected .pdf to mhbe.carriers@maryland.gov.

After partner issuers have determined that their plans are displayed and quoted correctly on SHOP Administrator portals, the SHOP Administrator must submit the SHOP Administrator Attestation Form to Plan Management to finalize reconciliation and approve the plans for sale.

SADP Display Reconciliation

The Plan Data/ Plan Display Reconciliation process occurs over the SERFF Template/PM Materials Resubmission Phase and the Plan Certification period.

Table 2-A-4. SADP

Event/Period	Entity Responsible for Event/Period	Date of Action	Action Description	Source/ Submission Format
Preliminary Template Submission	Issuers	July 1, 2016	Issuers submit full suite of Plan Management Templates	SERFF
Validation Analysis	MHBE	July 8, 2016	MHBE will analyze submitted templates for Plan Management Application Validation MHBE will provide actionable and specific required changes to ensure validation	SERFF Note to Filer
First Round Template Submission	Issuers	July 15, 2016	Issuers will submit full suite of Plan Management Templates with validation changes. Issuers will also submit a completed Plan Shopping Tile and Plan Compare Template for each of their plans. Submissions that require no changes do not need to be resubmitted	SERFF
Extract Analysis + Feedback	MHBE	August 1, 2016	MHBE will deliver to issuers Plan Management Module Feedback. MHBE will leverage map how benefits will be	SERFF Note to Filer

Event/Period	Entity Responsible for Event/Period	Date of Action	Action Description	Source/ Submission Format
			displayed in the plan shopping module and will match them accordingly MHBE will provide actionable and specific required changes to ensure an improved data extract	
Second Round Template Submission	Issuers	August 8, 2015	Issuers will submit full suite of Plan Management Templates with identified required changes	SERFF
Extract Analysis + Feedback	MHBE	August 15, 2016	MHBE will deliver to issuers Plan Management Module Extracts, Feedback, and Plan Display Print-outs MHBE will provide gap analysis between submitted Plan Shopping Tile and Plan Compare Templates and Plan Display Print-outs. MHBE will provide actionable and specific required changes to ensure an improved Plan Display	SERFF Note to Filer
Live Module Data Review	Issuers/MHBE	September 2, 2016	Issuers will perform data review in the Maryland Health Connection Anonymous Browsing UAT environment + Template Fixes and Submissions MHBE will provide actionable and specific required changes to ensure an improved Plan Display.	MHC Anonymous Browsing + SERFF + SERFF Disposition
Final Binder Submission.	Issuers	September 12, 2016	Issuers will submit finalize Plan Management Template Suite into SERFF	SERFF
Issuer Sign-off	Issuers	September 9, 2016	Issuers will sign-off on plans displayed in UAT environment	MHC Anonymous Browsing + SERFF Disposition
Plan Upload into Production	MHBE	September 13, 2016	MHBE will upload the final templates into production by this date	MHC Plan Management

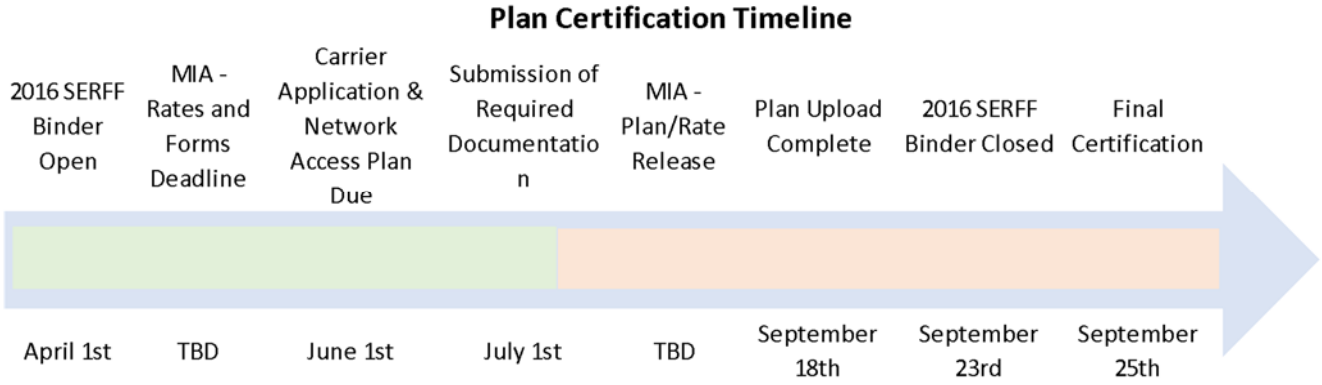
B. Review of Plan Certification Applications & Certificate of Plan Certification[11]

MHBE must review a Plan Certification Application submitted to MHBE by an issuer within 45 calendar days of receipt of the application. During the review period, MHBE may follow up with the plan's issuer regarding any incomplete application items. After the 45-day period, all issuers will receive a Plan Certification Approval or Denial Notice from MHBE. A Plan Certification Approval Notice informs the issuer that they are eligible to offer the plan for sale through the Marketplace for the plan year of 2017.

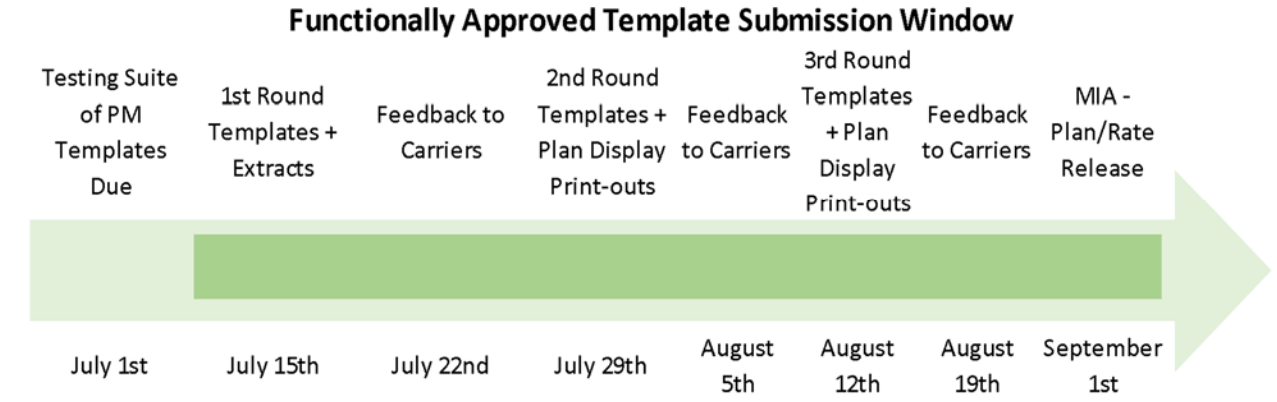
SADPs participating in the SHOP Marketplace will use the same processes, timelines, and submission requirements outlined in Table 2-A-1 and Table 2-A-3.

For the 2017 plan year, MHBE will follow the following dates for plan certification. The Plan Certification process is delineated by two phases, the Functionally Approved Template Submission Window and the Plan Certification period. *Some the dates below have also been addressed, where applicable, above in Tables 2-A-1 through 4.*

Table 2-B-1. Individual QHP



[11] *See* MHBE Carrier and Qualified Plan Certification Interim Procedures .03 "Application Procedures" at ¶ D.



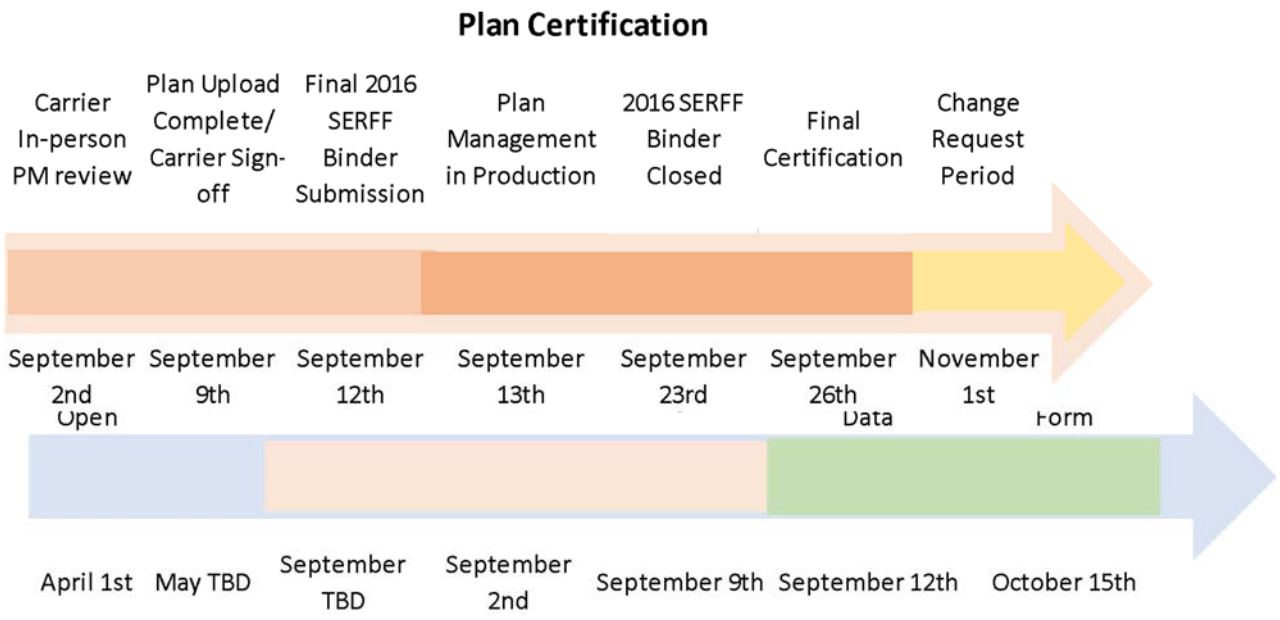
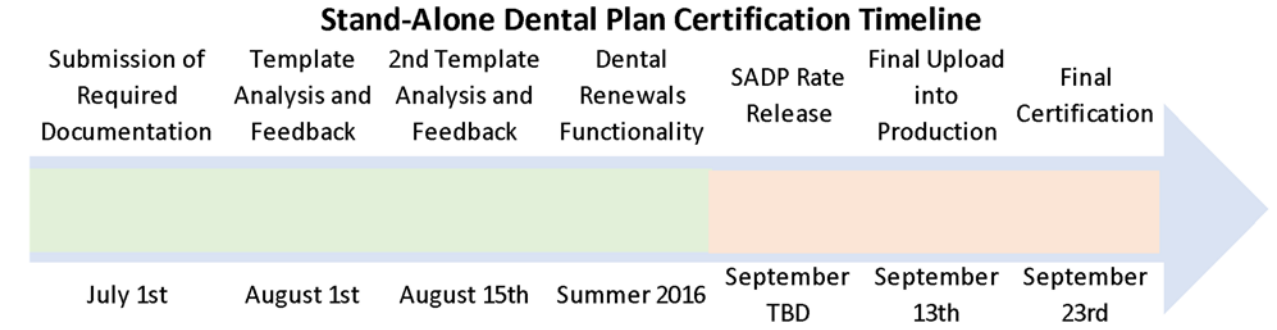


Table 2-B-3. SADP



C. Waiver Authority[12]

MHBE, with the approval of the MHBE Board, may grant a waiver to a specific provisions described in this chapter. MHBE may grant the waiver with or without corresponding conditions. To request a waiver, the issuer should inquire with their MHBE Account Manager.[13]

D. Denial, Suspension and Revocation of Certification[14]

A critical role MHBE serves in Maryland is plan oversight. MHBE may deny, suspend, revoke or seek other remedies against the QHP/SADP issuer offering a plan under Section 31-115(k) of the Insurance Article, Maryland Code.

Furthermore, MHBE may conduct compliance reviews of a plan during the plan benefit year. The scope of such compliance reviews extends to only include certification standards covered under Section 31-115(k) of the Insurance Article, Maryland Code. Any denial, suspension or revocation of certification and compliance review findings and corrective action plans are subject to appropriate remedies under state and federal laws and regulations.

If, as result of such compliance reviews, MHBE finds a QHP/SADP to be non-compliant, MHBE will require the QHP/SADP issuer to correct and meet compliance.

If an issuer chooses not to offer a plan in the Exchange or the plan is decertified by MHBE, the issuer shall follow Plan Management Guidance, released on July 15, 2015, on decertification of a qualified plan, and other operational procedures as specified by MHBE.

CHAPTER 3. OFF-EXCHANGE SADP CERTIFICATION PROCESS AND STANDARDS

MHBE will continue to certify Off-Exchange Stand-Alone Dental Plans (SADPs). Issuers must complete an application after receiving rate and form approval from MIA.

A. Off-Exchange SADP Submission Requirements & Submission Timeline

SADPs that participate in the Exchange-Certified program are required to submit an Off-Exchange Dental Carrier Application and provide MHBE with notice of intent to participate after they have been approved by MIA. Exchange certification of the plan can occur any time, prospectively, or within, an eligible plan year.

[12] *See* MHBE Carrier and Qualified Health Plan Certification Interim Procedures .10 "Waiver Authority."

[13] *See* Footnote 6.

[14] *See* MHBE Carrier and Qualified Health Plan Certification Interim Procedures .08 "Qualified Plan Decertification."

Unless otherwise directed by MHBE, issuers must submit plan certification data through the secure System for Electronic Rate and Form Filing (SERFF) Binders. Exceptions to this general rule are limited, and non-allowable before rate release by MIA.

MHBE has 45 calendar days from the beginning of the plan certification period to notify the issuer of approval or denial to offer qualified plans on the Marketplace. In such cases where a single plan or a product-type is denied to participate on the Marketplace, MHBE will provide to the issuer the reasons for denial and instructions to reapply or appeal.

B. Certification Standards

In order to be certified as an Off-Exchange SADP, plans are required to:

1. Cover the State benchmark pediatric dental essential health benefits;
2. Comply with annual limits and lifetime limits applicable to essential health benefits;
3. Comply with annual limits on cost sharing applicable to stand-alone dental plans under 45 CFR § 156.150; and
4. Meet the same actuarial value requirements for the pediatric dental essential health benefits that is required for a qualified dental plan.

CHAPTER 4: QUALIFIED PLAN (QHP AND SADP) CERTIFICATION STANDARDS

The Affordable Care Act, Sections 31-106 and 31-108 of the Insurance Article, Maryland Code, and the MHBE Interim Procedures on Carrier and Qualified Plan Certification, adopted by the Board on Oct. 23, 2012, establish that QHPs and SADPs must meet a number of standards in order to be certified or recertified as QHPs and SADPs for sale in the Individual and SHOP Marketplaces. Several of these are market-wide standards that apply to plans offered in the individual and small business markets inside as well as outside of the Marketplace. The remaining standards are specific to QHPs or SADPs seeking certification or recertification from the Marketplace. Each section of this chapter describes MHBE's planned approach for evaluating QHPs or SADPs against a certain standard when MHBE is reviewing a plan for certification for 2017.

MHBE continues to review its Marketplace participation policies to determine if they continue to meet the needs for supporting consumer choice. MHBE must certify QHPs that are in the interest of qualified individuals as determined by MHBE pursuant to the Affordable Care Act § 1311(e)(1)(B), 45 CFR §155.1000(c)(2), and Insurance Article, § 31-115(b)(7), Maryland Code.

Additionally, MHBE will develop a timeline that it will use to review the Maryland Health Progress Act's continuity of care policies. MHBE will develop with stakeholder input, if determined to be of need, additional continuity of care proposals.

The plan certification application process for the Individual Marketplace is described in Chapter 2 and for the SHOP Marketplace in Chapter 3.

A. Maryland Insurance Administration Requirements for Marketplace Participation

For a plan to be considered for plan certification, the issuer must comply with the Rate and Form Review procedures established by MIA in its annual bulletin to issuers. Issuers must respond to MIA form and rate inquiries in a timely fashion without unreasonable delay. MHBE will provide MIA with issuer Marketplace data, upon request, to support the rate and form review process.

For any premium rate increase for a qualified plan sold on the Marketplace, the issuer will provide to MHBE the associated Preliminary Justification Forms I and II filed with MIA, in accordance with 45 CFR § 155.1020, and will notify MHBE of the final disposition of the premium rate increase request at least 45 calendar days before its effective date.

B. Rating Requirements

All issuers, including SADPs[15], participating in the Marketplace must cap dependent premium rating at three dependents under 21. The premiums for no more than the three oldest covered children must be taken into account in determining the total family premium, in accordance with 45 CFR §147.102(c)(1). For example, an enrollment group with four dependents under 21 may only be billed for the first three dependents.

C. Marketing and Benefit Design of QHPs

Continuing in 2017, in accordance with 45 CFR §156.225, MHBE will require plan attestation that the plan's issuer: 1) complies with any applicable laws and regulations regarding marketing by health insurance issuers; and, 2) does not employ marketing practices or benefit designs have the effect of discouraging the enrollment of individuals with significant health needs in QHPs. The attestation is required to be submitted as part of the issuer's SERFF Binders.

During 2017, MHBE plans to further review new federal proposed requirements and will conduct a detailed analysis of plan benefits following the FFM approach to determine if specific plan certification standards are needed to address discriminatory benefit design in future years.[16] This is a new standard starting in 2017.

D. Service Area Standards

For the 2017 plan year, issuers may serve an area smaller than one county if they demonstrate that boundaries are not designed to discriminate against individuals excluded from the service area. Issuers

[15] This standard reflects MHBE's current operational process and IT system capabilities that were accepted by carriers in 2016 plan templates and testing. MHBE will assess the time and resources necessary to alter its system and processes to allow for SADP rating without the cap in future years.

[16] MHBE has authority under ACA § 1557 and 45 C.F.R. § 156.200 to review QHP benefit plans for discriminatory effect as part of plan certification. Additionally, under State law, fair marketing standards are developed jointly by the Exchange and the MIA Commissioner. See Ins. § 31-115(k)(2)(x).

servicing an area smaller than one county must submit a detailed Partial County Service Area Justification as a part of their application. Issuers that offer non-statewide plans must submit data on the demographics of the areas served by each qualified plan the issuer offers for sale within the SHOP Exchange or Individual Exchange, in accordance with 45 CFR §155.1055(b).

MHBE will permit service area changes by the issuer after the initial data submission by petition for limited reasons, such as an issuer's inability to secure enough providers or MHBE's request to serve an unmet need, as determined by the MIA or MHBE. No service area changes will be permitted after the final data submission (September 12, 2016) unless the change constitutes an expansion of the service areas rather than contractions of the service area.

E. Plan Offering Limitation Standards

For the 2017 plan year for QHPs, MHBE will require that issuers continue to meet the four-benefit designs maximum per metal level requirement. MHBE will continue to revisit the limitation standard yearly to determine if the standard continues to meet expectations for promoting consumer choice. MHBE will further review the utility of additional limitation standards – such as the proposed federal standards including standardized plan designs and limits on total number of unique plans offered – with stakeholders and the SAC for consideration in future standards.

For the 2017 plan year for SADPs, MHBE will require that issuers continue to meet the single benefit design per coverage type per tier per product type requirement (i.e. 1 benefit design per tier, 1 per level of coverage, and 1 per product type = 8 total plans allowed).

F. Meaningful Difference

Starting with the 2017 plan year, MHBE will require that issuers adopt the Federally-facilitated Marketplace (FFM) "meaningful difference" standard as described in 45 CFR §156.298 for non-cost-sharing variations of all QHPs offered in the Marketplace. MHBE will utilize the meaningful difference tools provided by CCIIO to ensure plans are compliant with the federal standard.

During 2017, MHBE will consider whether it may be appropriate to expand the meaningful difference standards to apply to other cost-sharing variations and across metal levels for the 2018 plan year, and will review the standards with stakeholders for future years.

G. Consumer Support and Service Transparency Requirements

Transparency and accessibility of information is an important piece of fulfilling one of MHBE's guiding principles of improving accessibility to health care to all Marylanders. For 2017, plan issuers must follow a number of standards related to transparency, accessibility and accuracy of information provided to consumers about the plan. MHBE is requiring new standards in this area for 2017. While CMS has proposed that FFM issuers must comply with certain quantitative network adequacy standards, MHBE has not taken this approach. In lieu of quantitative standards, MHBE is requiring carriers to report

metrics that foster transparency of information for consumers. As a certifying agency, MHBE has authority to address inconsistencies or non-compliance with these requirements.[17]

i. Standards of Network Management

QHP issuers must provide to MHBE for public release, their Standards for Network Management information reported for 2016 NCQA Accreditation for public release on MHBE's website. This item will be listed as a separate Supporting Document in the Supporting Documentation Tab of the Network Access Plan. Carriers may provide their Standards for Network Management information to MHBE after 2016 renewal surveys are conducted, but will be required to submit the addendum thereafter. URAQ-accredited carriers must also submit standards information. MHBE will issue further guidance regarding the specific information and documentation required from carriers with NCQA and URAQ accreditation.

ii. Treatment Cost Examples

MHBE will not require carriers to include additional treatment cost examples in the SBC. Instead, MHBE will engage stakeholders during the 2016 plan year to determine appropriate examples for Outpatient/Inpatient Substance Use Disorder Treatment Costs and Outpatient/Inpatient Mental Health Treatment Costs; a uniform template and criteria for determining and reporting treatment costs; and an appropriate location to share the information in the future.

iii. Additional Information within SBC Link

Carriers should adhere to SBC parameters as governed by federal laws and regulations. Per FFM issuer standards, QHP Issuers will include a URL that links to each QHP's complete benefits or terms through a policy contract or an in-depth plan document on the Summary of Benefits and Coverage form.[18] The URL must link the consumer directly to this information without further navigation beyond the initial page. No standards in this section should be interpreted to include requirements beyond the FFM standard.

iv. Network Adequacy Metrics

To assist consumers in assessing issuer provider networks, QHP issuers must report certain quantitative provider network metrics. Issuers must share these metrics with MHBE as part of its plan certification materials. MHBE will post this information on its website. For 2017, these metrics will include:

[17] HHS proposes that the FFM establish quantitative, county-specific time and distance standards for access to providers (the specific standards will be announced in guidance). Furthermore, HHS says it will defer to state network adequacy standards enforced by insurance regulators that meet certain minimum requirements (also to be announced in guidance). 80 FR 75488.

[18] The Maryland Health Benefit Exchange (HBX) platform was built to hold issuer PDFs in plan shopping. MHBE will consider enhancing the platform in the future to implement the FFM approach allowing issuers to submit dynamic URLs instead of static PDFs.

a. Average wait time for Primary Care Providers (PCP) and Mental Health (MH) providers;
b. Average drive distance and time to PCPs and MH providers;
c. Percent of PCPs and MH providers in network accepting new patients;
d. Consumer Assessment of Healthcare Providers and Systems scores; and
e. OPTIONAL: Additional metrics for any other specialist categories of the issuer's choosing.[19]

MHBE will provide a template that carriers must use to provide the requested information to MHBE. The template will delineate and require reporting for specific types of providers that fall under the "Primary Care Provider", and "Mental Health Provider" categories. MHBE will also encourage carriers to report metrics for a separate category of "Substance Use Disorder" providers or, if the carrier chooses not to report such metrics, an explanation of why it intends not to share this information (which MHBE will not publicly share but use to review whether this metric should be included in future years). The template will include a category requiring carriers to report wait times based upon two broad categories of appointments: Well Appointments (specifically, appointments billed under zero-cost sharing for preventive services); and Sick Appointments (specifically, appointments billed under cost sharing for Primary Care Visit for Illness or Sickness).

Furthermore, in line with the draft 2017 FFM issuer standards, the template will require carriers to report average driving distances and times by geographical setting/population density, along with the carrier's definitions for the presented indicators (i.e. definition of "urban", "suburban", "rural", etc.). The template will be drafted to gather network information for each specific plan by HIOS ID and product type (i.e. "Issuer 1 HMO - Network Information 1 - HIOS ID 1"). MHBE will provide additional guidance on how to complete the template, including how to calculate driving distances and times, by the end of January 2016.

MHBE intends to collect this data from QHP issuers during 2016 to determine if quantitative network adequacy standards are necessary for the 2018 plan year. MHBE will engage stakeholders further to discuss the utility of certain metrics such as driving time and distance and to determine if certain network adequacy metrics or standards would benefit consumers enrolled in SADPs.

In addition to the required one-time submission of this information with its 2017 plan certification materials, a carrier may provide updated information to MHBE more frequently, specifically on a quarterly basis.

v. CRISP Provider Data Submission

[19] Carriers are encouraged to provide an explanation of any additional metrics reported.

For the 2017 plan year, MHBE will continue the Chesapeake Regional Information System for our Patients (CRISP) Provider Directory submission requirements covered in further detail in the Carrier Reference Manual. Requirements for the provider directory data submission format will be determined by CRISP. However, MHBE clarifies that issuers must submit provider directory data to CRISP at least once every 15 calendar days (in lieu of the previous twice a month standard). The provider directory data must be current, accurate, and complete. In addition, starting in 2017, issuers must also provide, in a form and manner to be defined by MHBE, provider information on "Accepting New Patients" status.

In 2016, MHBE will also allow carriers to voluntarily submit information to CRISP and MHBE regarding program and community health center names, providers' affiliations with certain facilities, programs and centers, and any other information that may assist consumers search for specific programs or centers by name. MHBE will review what resources may be required to share and store this information, and will engage stakeholders to discuss a potential requirement to include this information for the 2018 plan year.

vi. Provider Directory Availability on Issuer Website

Pursuant to 45 CFR §156.230(b), Issuers must make available, in a manner to be determined by the issuer, provider directory information on their website without requiring a login. MHBE approval of the location of a directory on a carrier's website and compliance with the location accessibility requirements under 45 CFR 156.230 will be required in the 2017 plan year.

MHBE will also require that a provider directory meet FFM information and accessibility standards established in the Final 2016 Letter to Issuers Participating in the Federally-facilitated Marketplaces[20] and comply with any new requirements contained in the FFM's final 2017 Letter to Issuers (to be published at a later date).

Navigation to the provider directory from the issuer landing page website must be reasonable, i.e. within five clicks from an issuer landing page. All issuers participating in Maryland Health Connection currently meet the navigation standard.

To ensure accuracy of provider directories, the directory information on an issuer site must be updated to match the information on CRISP within 15 calendar days of submitting provider directory information to CRISP, i.e. prior to the next submission of directory information to CRISP.[21]

[20] Published Feb. 20, 2015, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf.

[21] This timeline replaces the draft proposal that the provider directory must be within a reasonable degree of variance of the CRISP information.

Additionally, for 2017, MHBE is removing the previous requirement for issuers to develop machine-readable provider directory files in the format specified by CCIIO. The format already developed for the CRISP Provider Directory submissions is deemed sufficient for this purpose.

vii. Provider Directory Improvement Strategy and Transparency Requirements

MHBE will further address provider directory accuracy through a multi-step, multi-year process starting in 2016 as part of the 2017 plan year certification requirements. MHBE will collaborate with MIA to update the proposed requirements in this subsection and in subsection (vi) to align with any relevant legislation, if enacted and if necessary, and to ensure consistency and avoid adverse selection between On- and Off-Exchange plans.

Step 1: In 2016, issuers will assess the accuracy of their provider directories in preparation for their 2017 certification applications. Issuers may use an assessment method of their own choosing. The assessment should attempt to determine whether the provider information currently in the issuer's directory is accurate, which MHBE defines as an accurate depiction of the provider's current status as a provider in the issuer's network and, if the provider remains in network, the provider's current name, address, phone number, facility affiliations (if included), specialty, and acceptance of new patients. An issuer should include in their assessment a review of any steps the issuer has taken to address the accuracy of the provider directory, such as outreach to providers and established methods for providers to update the issuer of changes in their directory information.

Step 2: As part of its 2017 plan certification applications, the issuer will provide information to MHBE about the accuracy of the provider directory, including details about the carrier-selected method of assessment, the issuer's accuracy assessment, and steps by the issuer taken to improve accuracy (e.g. provider contracting requirements).

Step 3: During 2016, MHBE, with EIAC input, will propose a standard assessment methodology, baseline target, and requirements for accuracy improvements to the MHBE Board. Accuracy improvement options that MHBE may consider include: (i) a process and/or tool to be determined that facilitates easy, real-time feedback from consumers to notify carriers and/or MHBE of directory inaccuracies; (ii) the use of billing data to improve directory accuracy; and (iii) approaches taken by the FFM/Medicaid Advantage, including quarterly audits of directories. MHBE will request that the Board adopt standards for methodology, baseline target, and requirements for accuracy improvements for the 2018 plan year.

Step 4: During 2017, in preparation for its 2018 plan certification applications, issuers will use the Board-adopted standard assessment methodology in order to assess the accuracy of its provider directories. The issuer will include the assessment outputs in their 2018

application. The issuer will be required to meet the baseline target set by the Board for plan year 2018.

Additionally, during 2016, MHBE will explore with stakeholders the option of implementing penalties for failure to meet these standards in the 2018 plan year.[22]

H. Essential Community Providers

Pursuant to 45 CFR § 156.235, issuers are required to include Essential Community Providers (ECP) within the plan's provider network. This section describes MHBE's approach to the definition of ECP, ECP network inclusion standards, the methodology for determining compliance with the inclusion standard, and the evaluation of ECP inclusion in SADPs.

i. Essential Community Provider Definition

For plan years beginning in 2017, MHBE defines an ECP as a provider that is: an ECP defined under 45 CFR § 156.235(c), a local health department, an outpatient mental health center or substance use disorder treatment provider, as described at COMAR 10.09.80.03.B(1) & B(3), that is licensed or approved by DHMH as programs or facilities, or a school-based health center. These types of providers are included in Table 4-H-1 below. In collaboration with DHMH, MHBE will provide a comprehensive list of the types of providers to be included in the state-ECP expansion group by the end of January 2016.

Additionally all providers that fall in these ECP categories must also meet the issuer's credentialing certification standards in order to be considered an ECP for that issuer. MHBE strongly encourages carriers to use inclusive, objective, transparent, and Parity Act-compliant standards that do not effectively exclude any type of ECP MHBE will continue to review with stakeholders whether a credentialing standard is necessary in future years.

Table 4-H-1. ECP Categories

ECP Category	ECP Provider Types Included in Category
Family Planning Providers	Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics
Federally Qualified Health Centers (FQHC)	FQHC and FQHC "Look-Alike" Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations
Hospitals	Disproportionate Share Hospital (DSH) and DSH-eligible Hospitals, Children's Hospitals, Rural Referral Centers, Sole Community Hospitals,

[22] MHBE has authority under §31-115(k)(3) of the Insurance Article, Maryland Code to impose penalties for failure to comply with standards of certification.

	Free-standing Cancer Centers, Critical Access Hospitals
Indian Health Care Providers	Indian Health Service (IHS providers), Indian Tribes, Tribal organizations, and urban Indian Organizations
Ryan White Providers	Ryan White HIV/AIDS Program Providers
Other ECP Providers	STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, Community Mental Health Centers, Rural Health Clinics, and other entities that serve predominantly low-income, medically underserved individuals.
2016 Expansion Providers	Local health departments, outpatient mental health centers, and substance use disorder treatment providers, as described at COMAR 10.09.80.03.B(1) & B(3), licensed or approved by DHMH as programs or facilities, and school-based health centers.

ii. ECP Network Inclusion Standards

For plan years beginning in 2017, MHBE adopts the following ECP network inclusion standards for all QHP plans and carrier networks:

a. The issuer must contract with at least 30% of available ECPs in each plan's service area as part of each plan's provider network. MHBE will allow a write-in option and an alternative standard for issuers to meet this requirement addressed in further detail below.

b. Issuers must offer contracts in good faith to the following provider types:

- all available Indian Health Care Providers in service area,
- any willing Local Health Department in the plan's service area, and
- at least one ECP in each ECP category in each county in service area, where an ECP in that category is available and provides medical or dental services by issuer plan type.

Offering a contract in "good faith" will be met if the issuer offers the same contract terms that a willing, similarly-situated, non-ECP provider would accept or has accepted from the issuer. MHBE requires that issuers be able to provide verification of such offers if MHBE requests the contracts to verify good-faith compliance.

Due to the expanded list of ECPs and change in ECP calculation methodology for ECPs as described below, issuers will not be able to rely entirely on the federal CMS ECP template. MHBE will provide a calculation tool and additional guidance in February 2016 to assist carriers in meeting this requirement.

During 2017, MHBE will assess whether a separate threshold standard is needed for specialties, such as mental health or substance use disorder providers, for future plan certification standards.

iii. Calculation Methodology for ECP Network Inclusion Standard:

MHBE will determine whether the issuer meets the ECP inclusion standard using the calculation methodology described in the Final 2016 Letter to Issuers in Federally-facilitated Marketplaces.[23] However, MHBE will amend this methodology to include the State-provider expansion of the federal ECP definition as part of the denominator. In addition, MHBE will count individual providers located at one physical location each as a provider for the denominator.

To account for denominators that may vary between issuers depending on the number of providers offered a contract in good faith that also meet the issuer's credentialing requirements, the issuer may need to follow the alternative ECP network inclusion standard instead. MHBE will provide stakeholders with further clarification and guidance on calculation of the both numerator and denominator of 30% network inclusion standard.

iv. ECP Write in Option

Issuers will be permitted to write in ECPs not included on the non-exhaustive federal (http://cciio.cms.gov/programs/exchanges/qhp.html) or Maryland-specific ECP lists. Write in ECPs must otherwise meet the eligibility criteria as an ECP, such as eligible non-participants in 340B Public Health Service Act programs. Furthermore, issuers must include the following information for each write-in ECP:

a. The provider's zip code reflecting provider location within a low-income zip code or Health Professional Shortage Areas included on the "Low-Income and Health Professional Shortage Area Zip Code Listing" located at http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html;
b. The provider's street address (P.O. Box is not sufficient); and
c. The National Provider Identifier (NPI) number, if the provider has an NPI number.

v. Alternative ECP Network Inclusion Standards

[23] Published Feb. 20, 2015, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf.

If an issuer cannot meet the general ECP standard, the issuer may satisfy this standard under an alternative justification. MHBE believes that two groups of issuers in particular, as discussed below, may qualify for the alternative standard.

First, QHP issuers that provide a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group qualify to comply with an alternative standard for ECP network inclusion. Issuers that qualify for the alternative standard must demonstrate through a narrative that low-income members receive appropriate access to care and satisfactory service. Such issuers must submit to MHBE provider quality and patient satisfaction metrics to MHBE, including either National Quality Forum (NQF)-endorsed or submitted for endorsement by NQF. These metrics are used by the FFM for the Quality Rating System.

The narrative explanation should describe the extent to which the issuer's provider sites are accessible to, and have services that meet the needs of, specific underserved populations, including:

a. Individuals with HIV/AIDS (including those with comorbid behavioral health conditions);
b. American Indians and Alaska Natives (AI/AN);
c. Low-income and underserved individuals seeking women's health and reproductive health services; and
d. Other specific populations served by ECPs in the service area.

MHBE will continue to engage stakeholders for feedback on the selected quality and patient satisfaction metrics. Within the scope for consideration are CAHPS, HEDIS, and other metrics reported to accrediting organizations.

Second, QHP issuers that do not provide a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may also qualify for the alternative standard if the issuer is unable to meet the 30% standard because of the volume of providers that are unable to meet the issuer's credentialing requirements. In these cases, the issuer should also provide a written narrative that includes the items addressed above.

<u>vi. Dental ECP Inclusion Standard</u>

MHBE will follow the FFM approach for evaluation of ECP Network Inclusion for SADPs. SADPs will be considered compliant with the ECP standard if, in their application, they offer a contract in good faith to at least 30% of available ECPs in each plan's service area to participate in the plan's provider network and offer a contract in good faith to all available Indian health care providers in the plan's service area. MHBE considers the ECP category per county service area requirement not applicable to SADPs, but strongly encourages SADP issuers to contract with at least one FQHC and any willing LHDs. MHBE will work with stakeholders to determine if an ECP category per county service area requirement should be imposed in future plan years.

I. Expanded Primary Care Benefits

In consultation with MIA, the SAC, and stakeholder groups, MHBE will review and, if deemed appropriate, develop a proposal to present to the Board regarding expanded consumer access to Primary Care Benefits. Specifically, MHBE will explore the possibility of requiring an increased number of primary care visits without cost.

J. Optional Embedded Pediatric Dental Benefit

Starting in 2017, a QHP may or may not include embedded pediatric dental benefits. QHP issuers intending to offer plans without embedded pediatric dental benefits must inform MHBE of such intent and identify the affected plan by HIOS ID.

K. Prescription Drugs

For 2017, the certification standards for prescription drug coverage will remain consistent with the previous year's requirements. Specifically:

> i. Prescription drugs covered under the plan's medical benefit must be identified in the plan's MIA filings and the issuer must continue certifying compliance with MIA's filing requirements under 45 CFR 156.122(a)(1);
> ii. The drug formulary Internet link provided by the issuer must link directly to the list of covered drugs without requiring further navigation. This formulary drug list URL link should be the same direct formulary drug list link for obtaining information on prescription drug coverage in the SBC, in accordance with 45 CFR 147.200(a)(2)(i)(L). The formulary drug link must include tiering and be up-to-date, accurate, and complete. Issuers must make the formulary drug list available on their website in a standard machine readable format as specified by HHS;
> iii. Issuers have the option of identifying a drug as a "preventive drug" covered at zero cost; and
> iv. Issuers must have in place or create a drug exception process for standard situations that are not emergency circumstances by which an enrollee can request access to a drug not on the plan's formulary. The issuer must notify the enrollee of its coverage decision no more than 72 hours after receipt of the exception request. Issuers must have an external review process by an independent review organization for denied requests. The external review organization must complete its review and provide a decision within 72 hours of receiving the review request. In addition to carrier internal and IRO processes, the existing external review process by MIA under Title 15, Subtitle 10A of the Insurance Article will satisfy this requirement.

Additionally, for 2017, plans must meet new standards included to improve consumer usability of issuer formulary directories, to determine the necessity of an MHBE continuity of care standard, and to determine issuer compliance with the standards contained herein. Specifically:

> i. For QHP issuer formulary directories, the tier descriptive category (i.e. generic, preferred brand, etc.) must be made clear for each drug in the formulary. Where the tier descriptive categories may not be added to the formulary directory, i.e. "Tier I" is unable to be changed to

"Generic," a legend that explicitly relates a tier's numeric category (0, I, II, III, etc.) with the its descriptive category (Preventive, Generic, Preferred Brand, Brand, etc.) may be included with the directory, with MHBE approval, as an additional option to meet this requirement. Issuers that choose the legend option must have the legend clearly displayed on each viewable section of the formulary. MHBE recognizes that drugs may move from brand to generic tiers during the plan year, and it is expected that issuers update their formularies to reflect such changes expeditiously.

ii. The issuer will continue to keep account of member drug exceptions processed during the plan year and provide summary metrics on processed member drug exceptions to MHBE if requested. MHBE will provide further guidance on how to meet this requirement if necessary.

In addition, MHBE will work with stakeholders to determine if the collection and release of additional information would be useful to consumers for future years.

L. Post-Certification Standards

To maintain its certification to participate in the Marketplace for 2017, an issuer should also ensure that it complies with post-certification requirements for each plan included in this section.

i. Enrollment Reconciliation Standards

In 2017, MHBE will establish enrollment reconciliation timeline standards that issuers must meet in order to maintain plan certification approval status. QHP/SADP issuers shall reconcile enrollment files with MHBE no less than once a month in accordance with 45 CFR §155.400(d). This standard may be waived for a given month, on a case by case basis, with the provision of a reconciliation waiver request describing the cause for the issuer's inability to comply.

ii. Broker and SHOP Administrator Payments

Issuers must pay the same broker compensation for plans offered through the Marketplace that the issuer pays for similar plans offered in the State outside the Marketplace. "Similar plan" means a plan with the same HIOS ID. This standard does not apply to payments made to Third-Party Administrators (TPA) in their role as SHOP Administrators. This issue will be dealt with separately and in more detail through the SHOP Request for Proposal (RFP).

iii. Quality Reporting

QHP issuers must comply with federal standards, processes and requirements related to quality reporting through the implementation of the Quality Rating System (QRS) and the Enrollee Satisfaction Survey (ESS). Issuers are also required to continue to provide quality data and Race, Ethnicity, Language, Interpreter Need, and Cultural Competency (RELICC) data to the Maryland Health Care Commission (MHCC).

Beginning in 2016, with the Open Enrollment Period for 2017, MHBE must display QHP quality rating information on its website. MHBE will determine a final approach for its MHBE-specific issuer quality reporting system in 2016.

QHP issuers that have offered plans on MHC for at least two (2) years will submit a quality improvement strategy (QIS) for 2017 in functional areas determined by MHBE oversight and compliance staff. Any questions regarding the QIS federal process or QRS technical requirements should be directed to CMS.

iv. Member Level Reporting Requirement

Participating issuers must provide a Member Level Report (MLR) to MHBE at least once per month. With appropriate reasonable notice (defined as within two weeks), MHBE may request additional MLRs in a month. Annually, and with reasonable advance notice for field requirements, MHBE will review issuer MLRs to determine if they continue to meet the needs, as supplemental information, for MHBE to adjudicate the appropriate corrective actions for consumer enrollment and eligibility errors.

Carriers already meet this requirement and the required fields for the 2017 plan year will be the same fields indicated in the memorandum to issuers released by MHBE on July 16, 2015 *RE: MLR Standardization Requirements* and described in further detail in the *Member Level Reporting Field Clarification* guidance issued on August 5, 2015.

Annual changes to issuer MLRs must be reflected in the first report issued during the Open Enrollment Period before the effective plan year. MHBE may reconsider this Member Level Reporting Requirement if it is found to be duplicative of processes currently in place between MHBE and issuers, such as monthly reconciliation.

v. Enrollment Administration Standards for Enrollees with Eligible Third-Party Entity Payments

Pursuant to 45 CFR § 156.1250, an issuer must accept premium and cost-sharing payments from the following third-party entities on behalf of plan enrollees:

a. Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
b. Indian tribes, tribal organizations or urban Indian organizations; and
c. State and Federal Government programs.

MHBE will follow the definition and approach to third party payments proposed in the draft 2017 FFM Issuer Letter, subject to any changes in the final Letter. No provision in this subsection should be construed to exceed the FFM definition. MHBE will develop an operational methodology for meeting this standard through the EIAC and will work with carriers individually if operational impediments arise.

vi. Requirement to Continue Accumulators When Primary Insured Is Terminated for Outstanding Citizenship/Immigration Verifications

For the 2017 plan year, MHBE will require seamless continuation of coverage and application of household of costs applied towards out of pocket accumulators, regardless of which household member(s) accumulated the costs, when the primary insured is terminated for outstanding citizenship or immigration status terminations per 45 CFR §§ 155.315(f)(5). Under this standard, the issuer must apply all amounts contributed to the deductible and out-of-pocket costs under the original contract regardless of who in the household accrued the cost (including from the initial primary subscriber), to the new contract for the remaining eligible members. The administration of the new contract should appear seamless to the enrollee group (i.e. no binder payment).

It is anticipated that, in most situations, the members of the enrollment group who remain eligible for coverage through MHBE will constitute an enrollment group that can be accommodated by the existing coverage and contract. For example, if two parents and two children are in an enrollment group and one parent loses eligibility for coverage through MHBE for an outstanding citizenship verification, the remaining three family members could still constitute a valid enrollment group. However, there may also be situations in which the removal of one or more members from an enrollment group will result in a remaining group of enrollees not constituting a valid enrollment group per the issuer's business rules. For example, some issuers may not cover two children without an adult on a single family policy. In such situations, members of the invalid enrollment group will receive a 60-day SEP to either select the same qualified plan (i.e., the same 14-digit QHP ID) select a corresponding self-only qualified plan, or any combination thereof.

In an invalid enrollment group scenario, the issuer is still expected to apply any amounts previously paid toward deductibles and out-of-pocket limits to the members' continued group or individual plan accumulators. To prevent a gap in coverage, the enrollment group will receive an effective start date for the first of the month following the effective termination date specified in the 834 termination transaction.

MHBE will provide additional operational guidance and work with carriers to implement both the continued coverage and accumulator application requirements under this standard. The standard applies only to an MHBE-initiated redetermination due to an outstanding citizenship or immigration verification under 45 CFR 155.315(f)(5), similar to the FFM, and does not apply when the primary member is being terminated for non-payment of premium, fraud or material misrepresentation. Lastly, MHBE will work with stakeholders to consider expanding this requirement for certain voluntary terminations, such as new Medicare eligibility, in the future.