

Department of Health & Human Services

Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
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Frequently Asked Questions on Health Insurance Marketplace Standards

Q1: What standards for Medicaid managed care organizations are similar to Marketplace requirements for issuers of qualified health plans?

The Affordable Care Act (ACA) and applicable regulations establish that issuers must meet a number of standards in order to be certified as qualified health plans (QHPs). In several areas, federal law establishes comparable standards for entities that contract with states to provide coverage to beneficiaries enrolled in Medicaid. In order to assist Medicaid managed care organizations (Medicaid MCOs) that may be interested in offering Marketplace QHPs, we are offering a general overview of selected QHP certification standards that are comparable to federal Medicaid managed care standards.

Below are summaries of select QHP certification standards with comparisons to Medicaid managed care standards. Other requirements may be applicable to QHPs or Medicaid MCOs under federal or State law, a State Medicaid Plan, or a State contract for Medicaid managed care. In addition, in limited circumstances, CMS may consider providing States flexibility to allow greater continuity of coverage for certain populations that may transition between QHPs and Medicaid.

Licensure

- *Marketplace standard:* QHP issuers must be licensed and in good standing to offer health insurance coverage in each state in which the issuer offers health insurance coverage. (45 CFR 156.200(b)(4))
- *Comparable Medicaid managed care standard:* Many Medicaid MCOs may already be licensed by a state, or meet the solvency standard required for licensure, due to the requirements at 42 CFR 438.116.

Accreditation

- *Marketplace standard:* QHP issuers must be accredited on the basis of local performance in a timeframe established by the Marketplace. For the Federally-facilitated Marketplaces (FFMs), an issuer's QHP will be considered to meet the accreditation standard for the first three years of participation in the Marketplace if the QHP uses the

same policies and procedures as the issuer's accredited Medicaid product. (45 CFR 155.1045 and 156.275)

- *Comparable Medicaid managed care standard:* While there is no federal standard that requires a Medicaid MCO to be accredited, many states have established such a standard. Thirty-three states and the District of Columbia require some form of accreditation or use accreditation to deem compliance with certain Medicaid standards.¹ Medicaid MCOs must inform the state of their accreditation status, which the state must share on its website. (42 CFR 438.332)

Benefits

- *Marketplace standard:* QHPs provide ten categories of essential health benefits (EHB) that are substantially equal to the state's EHB-benchmark plan. (45 CFR 156.20, 156.115, 156.200(b)(3))
- *Comparable Medicaid managed care standard:* States may elect to provide an Alternative Benefit Plan (ABP) for some groups of Medicaid-eligible individuals, and individuals eligible for Medicaid as part of the ACA expansion eligibility group must receive benefits through an ABP. An ABP is defined by reference to a benchmark benefit plan and must also include EHB and the full Early and Periodic Screening, Diagnosis, and Treatment benefit for individuals under age 21. A state can determine EHB for an ABP using a different EHB-benchmark plan than the state's individual and small group market EHB-benchmark plan, but the ABP must cover the same ten categories of EHB. The common EHB requirement provides a significant amount of alignment between QHP benefit requirements and the benefits that a Medicaid MCO may already offer to beneficiaries, if it provides benefits through an ABP. (42 CFR 440.300, 440.330, 440.347)

Network Adequacy and Essential Community Providers

- *Marketplace standard:* QHP issuers that use a provider network must ensure that the network is sufficient in number and types of providers to assure that all services are accessible without unreasonable delay. In the FFMs, there are time and distance standards for certain provider types. Issuers that use provider networks must also ensure reasonable and timely access to a broad range of essential community providers (ECPs). (45 CFR 156.230-156.235)
- *Comparable Medicaid managed care standard:* Medicaid MCOs must currently maintain networks that are adequate to meet the needs of their enrollees and report on the adequacy of those networks (42 CFR 438.206 and 438.207). For rating periods beginning on or after July 1, 2018, Medicaid MCOs must maintain networks that meet state-defined time and distance standards for several provider types (42 CFR 438.68). Compliance with a state's time and distance standards for Medicaid managed care may

¹ NCQA, [State Use of NCQA Health Plan Accreditation for Medicaid](#) (April 2016).

allow an issuer to satisfy QHP network adequacy standards for the geographic area it serves.

- While no federal standard exists for ECPs in Medicaid networks, networks designed to serve low-income Medicaid managed care beneficiaries may already satisfy QHP ECP standards. Issuers of QHPs and MCOs should review state Medicaid standards and Marketplace QHP standards to determine if this is the case in each area.

Quality

- *Marketplace standard:* QHP issuers must submit data for a quality rating system (QRS) after participating in the Marketplace for at least one year. QHPs must contract with an HHS-approved enrollee satisfaction survey vendor to conduct and report the results of an enrollee satisfaction survey. QHP issuers participating in an Exchange for two or more consecutive years must implement and report on quality improvement strategies. (45 CFR 156.1120, 156.1125, 156.1130)
- *Comparable Medicaid managed care standard:* Medicaid managed care entities will be required to submit data for the state's Medicaid QRS. For the Medicaid QRS, states must either adopt the CMS-developed system that aligns with the QHP QRS or operate a CMS-approved alternative. (42 CFR 438.334)
- Issuers may be required to report similar data elements for both Medicaid managed care and QHPs. States are encouraged to align their Medicaid managed care quality improvement efforts with those underway for QHPs, while recognizing that differences in the types of populations served and benefits provided may require different approaches.

Q2: What resources are available for issuers, including Medicaid managed care organizations, seeking to offer QHPs in Health Insurance Marketplaces?

To encourage greater competition in Marketplaces and to provide greater choice for consumers, particularly those who may transition between insurance affordability programs, CMS seeks to support Medicaid MCOs interested in participating in the Federally-facilitated Marketplaces (FFMs), including the Small Business Health Exchange Marketplaces, by offering certified QHPs.

CMS Account Managers can provide organizations interested in offering QHPs in FFMs with information about QHP certification and answer questions about general FFM operations. Account Managers can also provide technical assistance and resources to Medicaid MCOs so they become more familiar with the FFMs. To learn more and connect with an Account Manager, interested entities, including Medicaid MCOs, are encouraged to contact Judith Flynn, Associate Regional Administrator, at judith.flynn@cms.hhs.gov.