through physicians employed by the
issuer or through a single contracted
medical group may instead comply
with the alternate standard described
in paragraph (b) of this section.

(3) Nothing in this requirement shall
be construed to require any QHP to
provide coverage for any specific med-
ical procedure provided by the essen-
tial community provider.

(b) Alternate standard. A QHP issuer
described in paragraph (a)(2) of this
section must have a sufficient number
and geographic distribution of em-
ployed providers and hospital facilities,
or providers of its contracted medical
group and hospital facilities to ensure
reasonable and timely access for low-
income, medically underserved individ-
uals in the QHP’s service area, in ac-
cordance with the Exchange’s network
adequacy standards.

(c) Definition. Essential community
providers are providers that serve pre-
dominantly low-income, medically un-
derserved individuals, including pro-
viders that meet the criteria of para-
graph (c)(1) or (2) of this section, and
providers that met the criteria under
paragraph (c)(1) or (2) of this section on
the publication date of this regulation
unless the provider lost its status
under paragraph (c)(1) or (2) of this sec-
tion thereafter as a result of violating
Federal law:

(1) Health care providers defined in
section 340B(a)(4) of the PHS Act; and
(2) Providers described in section
1927(c)(1)(D)(I)(IV) of the Act as set
forth by section 22I of Public Law 111–
8.

(d) Payment rates. Nothing in para-
graph (a) of this section shall be con-
strued to require a QHP issuer to con-
tact with an essential community pro-
vider if such provider refuses to accept
the generally applicable payment rates
of such issuer.

(e) Payment of federally-qualified
health centers. If an item or service cov-
ered by a QHP is provided by a fed-
ernally-qualified health center (as defined
in section 1905(l)(2)(B) of the Act) to an
enrollee of a QHP, the QHP issuer must
pay the federally-qualified health cen-
ter for the item or service an amount
that is not less than the amount of
payment that would have been paid to
the center under section 1902(bb) of the
Act for such item or service. Nothing
in this paragraph (e) would preclude a
QHP issuer and federally-qualified
health center from mutually agreeing
upon payment rates other than those
that would have been paid to the cen-
ter under section 1902(bb) of the Act, as
long as such mutually agreed upon
rates are at least equal to the gen-
erally applicable payment rates of the
issuer indicated in paragraph (d) of this
section.

§ 156.245 Treatment of direct primary
care medical homes.

A QHP issuer may provide coverage
through a direct primary care medical
home that meets criteria established
by HHS, so long as the QHP meets all
requirements that are otherwise appli-
cable and the services covered by the
direct primary care medical home are
coordinated with the QHP issuer.

§ 156.250 Health plan applications and
notices.

QHP issuers must provide all applica-
tions and notices to enrollees in ac-
cordance with the standards described
in § 155.230(b) of this subtitle.

§ 156.255 Rating variations.

(a) Rating areas. A QHP issuer, in-
cluding an issuer of a multi-State plan,
may vary premiums by the geographic
rating area established under section
2701(a)(2) of the PHS Act.

(b) Same premium rates. A QHP issuer
must charge the same premium rate
without regard to whether the plan is
offered through an Exchange, or wheth-
er the plan is offered directly from the
issuer or through an agent.

§ 156.260 Enrollment periods for quali-
fied individuals.

(a) Individual market requirement. A
QHP issuer must:

(1) Enroll a qualified individual dur-
ing the initial and annual open enroll-
ment periods described in §155.410(b)
and (e) of this subchapter; and abide by
the effective dates of coverage estab-
lished by the Exchange in accordance
with §155.410(c) and (f) of this sub-
chapter; and

(2) Make available, at a minimum,
special enrollment periods described in
§155.420(d) of this subchapter, for QHPs