155.420(d)(8). Indians will be allowed to enroll in, or change enrollment in, standard health plans one time per month.

(b) Cost sharing. No cost sharing may be imposed on Indians under the standard health plan.

(c) Payments to providers. Equal to the protection extended to Indian health providers providing services to Indians enrolled in a QHP in the individual market through an Exchange at 45 CFR 156.430(g), BHP offerors may not reduce the payment for services to Indian health providers by the amount of any cost-sharing that would be due from the Indian but for the prohibition in paragraph (b) of this section.

(d) Requirement. Standard health plans must pay primary to health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations for services that are covered by a standard health plan.

§ 600.165 Nondiscrimination standards.

(a) The State and standard health plans, must comply with all applicable civil rights statutes and requirements, including Title VI of the Civil Rights Act of 1964, Title II of the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Section 1557 of the Affordable Care Act, and 45 CFR part 80, part 84, and part 91 and 28 CFR part 35.

(b) The State must comply with the nondiscrimination provision at 45 CFR 155.120(c)(2).

§ 600.170 Annual report content and timing.

(a) Content. The State must submit an annual report that includes any evidence of fraud, waste, or abuse on the part of participating providers, plans, or the State BHP agency known to the State, and a detailed data-driven review of compliance with the following:

(1) Eligibility verification requirements for program participation as specified in §600.345.

(2) Limitations on the use of Federal funds received by the BHP as specified in §600.705.

(3) Requirements to collect quality and performance measures from all participating standard health plans focusing on quality of care and improved health outcomes as specified in sections 1311(c)(3) and (4) of the Affordable Care Act and as further described in §600.415.

(4) Requirements specified by the Secretary at least 120 days prior to the date of the annual report as requiring further study to assess continued State compliance with Federal law, regulations and the terms of the State’s certified Blueprint, based on a Federal review of the BHP pursuant to §600.200, and/or a list of any outstanding recommendations from any audit or evaluation conducted by the HHS Office of Inspector General that have not been fully implemented, including a statement describing the status of implementation and why implementation is not complete.

(b) Timing. The annual reports, in the format specified by the Secretary, are due 60 days after the end of each operational year. Information that may be required to secure the release of funding for the subsequent year may be requested in advance.

Subpart C—Federal Program Administration

§ 600.200 Federal program compliance reviews and audits.

(a) Federal compliance review of the State BHP. To determine whether the State is complying with the Federal requirements and the provisions of its BHP Blueprint, HHS may review, as needed, but no less frequently than annually, the compliance of the State BHP with applicable laws, regulations and interpretive guidance. This review may be based on the State’s annual report submitted under §600.170, or may be based on direct Federal review of State administration of the BHP Blueprint through analysis of the State’s policies and procedures, reviews of agency operation, examination of samples of individual case records, and additional reports and/or data as determined by the Secretary.

(b) Action on compliance review findings. The compliance review will identify the following action items: