of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal;

(2) In cases where a provider is terminated without cause, allow an enrollee in an active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates.

(i) For the purposes of paragraph (d)(2) of this section, active course of treatment means:

(A) An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;

(B) An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits;

(C) The second or third trimester of pregnancy, through the postpartum period; or

(D) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

(ii) Any QHP issuer decision made for a request for continuity of care under paragraph (d)(2) of this section must be subject to the health benefit plan's internal and external grievance and appeal processes in accordance with applicable State or Federal law or regulations.

(e) *Out-of-network cost-sharing.* Beginning for the 2018 and later benefit years, for a network to be deemed adequate, each QHP must:

(1) Notwithstanding §156.130(c), count the cost sharing paid by an enrollee for an essential health benefit provided by an out-of-network ancillary provider in an in-network setting towards the enrollee's annual limitation on cost sharing; or

(2) Provide a written notice to the enrollee by the longer of when the issuer would typically respond to a prior authorization request timely submitted, or 48 hours before the provision of the benefit, that additional costs may be incurred for an essential health benefit provided by an out-of- network ancillary provider in an in-network setting, including balance billing charges, unless such costs are prohibited under State law, and that any additional charges may not count toward the in-network annual limitation on cost sharing.

(f) [Reserved]

[77 FR 18469, Mar. 27, 2012, as amended at 80 FR 10873, Feb. 27, 2015; 81 FR 12349, Mar. 8, 2016; 86 FR 6178, Jan. 19, 2021; 87 FR 27391, May 6, 2022; 88 FR 25922, Apr. 27, 2023]

§ 156.235 Essential community providers.

(a) *General ECP standard.* (1) A QHP issuer must include in its provider network a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas within the QHP's service area, in accordance with the Exchange's network adequacy standards.

(2) A plan applying for QHP certification to be offered through a Federally-facilitated Exchange has a sufficient number and geographic distribution of ECPs if it demonstrates in its QHP application that—

(i) The QHP issuer's provider network includes as participating providers at least a minimum percentage, as specified by HHS, of available ECPs in each plan's service area collectively across all ECP categories defined under paragraph (a)(2)(ii)(B) of this section, and at least a minimum percentage of available ECPs in each plan's service area within certain individual ECP categories, as specified by HHS. Multiple providers at a single location will count as a single ECP toward both the

available ECPs in the plan's service area and the issuer's satisfaction of the ECP participation standard. For plans that use tiered networks, to count toward the issuer's satisfaction of the ECP standards, providers must be contracted within the network tier that results in the lowest cost-sharing obligation. For plans with two network tiers (for example, participating providers and preferred providers), such as many preferred provider organizations (PPOs), where cost-sharing is lower for preferred providers, only preferred providers will be counted towards ECP standards; and

(ii) The issuer of the plan offers contracts to—

(A) All available Indian health care providers in the service area, applying the special terms and conditions required by Federal law and regulations as referenced in the recommended model QHP addendum for Indian health care providers developed by HHS; and

(B) At least one ECP in each of the eight (8) ECP categories in each county in the service area, where an ECP in that category is available and provides medical or dental services that are covered by the issuer plan type. The ECP categories are: Federally Qualified Health Centers, Ryan White Program Providers, Family Planning Providers, Indian Health Care Providers, Inpatient Hospitals, Mental Health Facilities, Substance Use Disorder Treatment Centers, and Other ECP Providers. The Other ECP Providers category includes the following types of providers: Rural Health Clinics, Black Lung Clinics, Hemophilia Treatment Centers, Sexually Transmitted Disease Clinics, Tuberculosis Clinics, and Rural Emergency Hospitals.

(3) If a plan applying for QHP certification to be offered through a Federally-facilitated Exchange does not satisfy the ECP standard described in paragraph (a)(2) of this section, the issuer must include as part of its QHP application a narrative justification describing how the plan's provider network provides an adequate level of service for low-income enrollees or individuals residing in Health Professional Shortage Areas within the plan's service area and how the plan's provider network will be strengthened toward satisfaction of the ECP standard prior to the start of the benefit year.

(4) Nothing in paragraphs (a)(1) through (3) of this section requires any QHP to provide coverage for any specific medical procedure.

(5) A plan that provides a majority of covered professional services 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.

(b) *Alternate ECP standard.* (1) A plan described in paragraph (a)(5) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities, to ensure reasonable and timely access for low-income individuals or individuals residing in Health Professional Shortage Areas within the plan's service area, in accordance with the Exchange's network adequacy standards.

(2) A plan described in paragraph (a)(5) of this section applying for QHP certification to be offered through a Federally-facilitated Exchange has a sufficient number and geographic distribution of employed or contracted providers if it demonstrates in its QHP application that—

(i) The number of its providers that are located in Health Professional Shortage Areas or five-digit zip codes in which 30 percent or more of the population falls below 200 percent of the Federal poverty level satisfies a minimum percentage, specified by HHS, of available ECPs in each plan's service area collectively across all ECP categories defined under paragraph (a)(2)(ii)(B) of this section, and at least a minimum percentage of available ECPs in each plan's service area within certain individual ECP categories, as specified by HHS. Multiple providers at a single location will count as a single ECP toward both the available ECPs in the plan's service area and the issuer's satisfaction of the ECP participation standard. For plans that use tiered networks, to count toward the issuer's satisfaction of the ECP standards, providers must be contracted within the network tier that results in the lowest cost-sharing obligation. For plans with

two network tiers (for example, participating providers and preferred providers), such as many PPOs, where cost sharing is lower for preferred providers, only preferred providers would be counted towards ECP standards; and

(ii) The issuer's integrated delivery system provides all of the categories of services provided by entities in each of the ECP categories in each county in the plan's service area as outlined in the general ECP standard, or otherwise offers a contract to at least one ECP outside of the issuer's integrated delivery system per ECP category in each county in the plan's service area that can provide those services to low-income, medically underserved individuals.

(3) If a plan does not satisfy the alternate ECP standard described in paragraph (b)(2) of this section, the issuer must include as part of its QHP application a narrative justification describing how the plan's provider networks provide an adequate level of service for low-income enrollees or individuals residing in Health Professional Shortage Areas within the plan's service area and how the plan's provider network will be strengthened toward satisfaction of the ECP standard prior to the start of the benefit year.

(c) *Definition.* An essential community provider is a provider that serves predominantly low-income, medically underserved individuals, including a health care provider defined in section 340B(a)(4) of the PHS Act; or described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Pub. L. 111–8; or a State-owned family planning service site, or governmental family planning service site, or not-for-profit family planning service site that does not receive Federal funding under special programs, including under Title X of the PHS Act, or an Indian health care provider, unless any of the above providers has lost its status under either of these sections, 340(B) of the PHS Act or 1927 of the Act as a result of violating Federal law.

(d) *Payment rates.* Nothing in paragraph (a) of this section may be construed to require a QHP issuer to contract with an ECP if such provider refuses to accept the same rates and contract provisions included in contracts accepted by similarly situated providers.

(e) *Payment of Federally qualified health centers.* If an item or service covered by a QHP is provided by a Federally-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 center 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) precludes a QHP issuer and Federally-qualified health center from agreeing upon payment rates other than those that would have been paid to the center under section 1902(bb) of the Act, as long as that rate is at least equal to the generally applicable payment rate of the issuer described in paragraph (d) of this section.

[80 FR 10873, Feb. 27, 2015, as amended at 88 FR 25922, Apr. 27, 2023]

§ 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 applicable and the services covered by the direct primary care medical home are coordinated with the QHP issuer.

§ 156.250 Meaningful access to qualified health plan information.

A QHP issuer must provide all information that is critical for obtaining health insurance coverage or access to health care services through the QHP, including applications, forms, and notices, to qualified individuals, applicants, qualified employers, qualified employees, and enrollees in accordance with the standards described in § 155.205(c) of this subchapter. Information is deemed to be critical for obtaining health insurance coverage or access to health care services if the issuer is required by law or regulation to provide the document to a qualified individual, applicant, qualified employer, qualified employee, or enrollee.

[80 FR 10874, Feb. 27, 2015]