Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges

Introduction

The Affordable Care Act establishes Affordable Insurance Exchanges (Exchanges) to provide individuals and small business employees with access to health insurance coverage beginning January 1, 2014.[1] An Exchange is an entity that both facilitates the purchase of Qualified Health Plans (QHP) by qualified individuals and provides for the establishment of a Small Business Health Options Program (SHOP), consistent with Affordable Care Act 1311(b) and 45 CFR 155.20. Exchanges will provide competitive marketplaces for individuals and small employers to directly compare and purchase private health insurance options based on price, quality, and other factors. Exchanges are integral to the Affordable Care Act's goal of prohibiting discrimination against people with pre-existing conditions and insuring all Americans.

The Affordable Care Act provides States with significant flexibility in the design and operation of their Exchanges to best meet the unique needs of their citizens and their marketplace. States can choose to operate as a State-based Exchange, or the Secretary of the United States Department of Health and Human Services (HHS) will establish and operate a Federally-facilitated Exchange in any State that does not elect to operate a State-based Exchange. In a Federally-facilitated Exchange, the State may pursue a State Partnership Exchange, where a State may administer and operate Exchange activities associated with plan management and/or consumer assistance. States that elect to participate in a State Partnership Exchange will administer these functions in both the individual and the small group market.

Regulations implementing the Affordable Care Act require HHS to Approve or Conditionally Approve State-based Exchanges no later than January 1, 2013, for operation in 2014. In addition, the Affordable Care Act 1321(c)(1) (B)(ii)(I) directs the Secretary to make a determination regarding whether the State will operate reinsurance and/or risk adjustment programs or will use Federal government services for these activities. To receive HHS Approval or Conditional Approval for a State-based Exchange or a State Partnership Exchange, as well as reinsurance and risk adjustment programs[2], a State must complete and submit an Exchange Blueprint that documents how its Exchange meets, or will meet, all legal and operational requirements associated with the model it chooses to pursue. As part of its Exchange Blueprint, a State will also demonstrate operational readiness to execute Exchange activities.[3]

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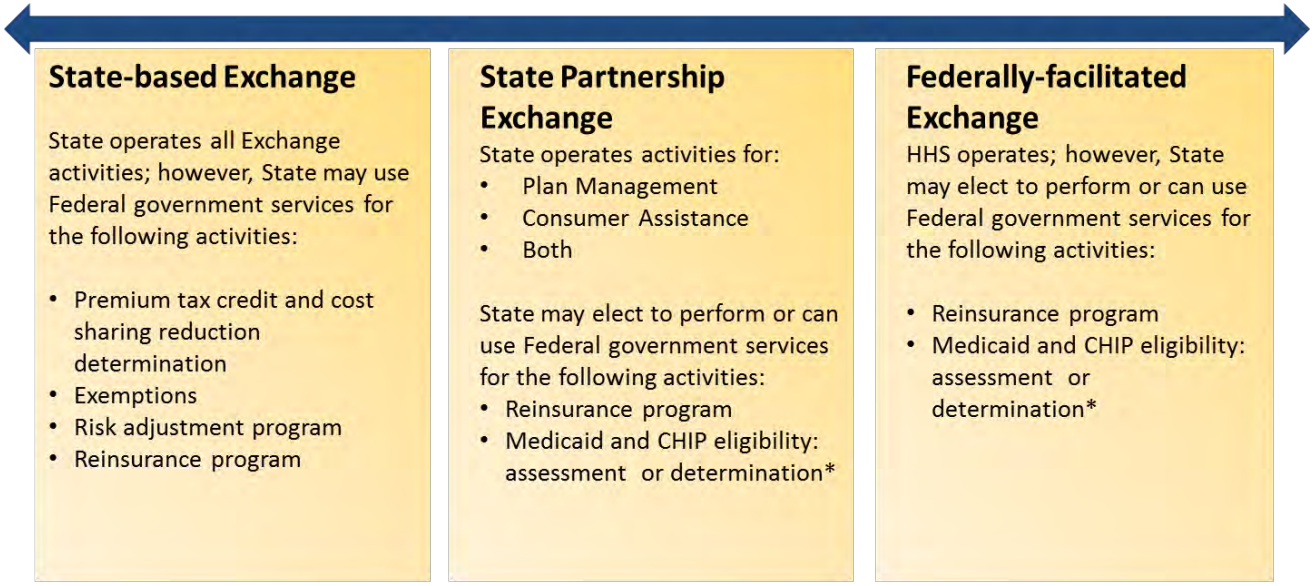
[1] Affordable Care Act 1311(b)(1)
[2] Additional requirements for Risk Adjustment will be provided in the HHS Notice of Benefit and Payment Parameters."
[3] 45 CFR 155.105, Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18310, 18446 (Mar. 27, 2012)

Flexible Exchange Options for States

In an effort to provide States with significant flexibility in the development of Exchanges to meet the needs of their citizens, HHS has developed a program that offers multiple Exchange models as well as a number of design alternatives within each model. A State also has the flexibility to transition between models annually (see page 4 for details). See Figure 1 for a representation of the Exchange models, and flexibility within those models.

Figure 1: Flexible Exchange Options for States



*Coordinate with Medicaid and CHIP Services (CMCS) on decisions and protocols

Exchanges will operate either as a State-based Exchange or a Federally-facilitated Exchange. A State may also operate in partnership with HHS as a State Partnership Exchange, which provides States with the option to administer and operate Exchange activities associated with plan management activities, some consumer-assistance activities, or both. HHS, as the party responsible for Exchange implementation, will provide as much flexibility as possible; however, HHS will need to ratify inherently governmental decisions made by the State Partner.

Technical Assistance and Establishment Grant funding under Section 1311(a) of the Affordable Care Act continues to be available to States through 2014 for State-based Exchanges, State Partnership Exchanges, and States that are building linkages to the Federally-facilitated Exchange.[4]

[4] http://www.grants.gov/search/search.do;jsessionid=0VqkQpTV3Z1fR74Z7rvnwjqf42vlsyw15Qp1FWKbqrQlJ8CQ7zJj!-1406353995?oppId=180734&mode=VIEW

State-based Exchange

The Exchange final rule outlines the activities required to operate a State-based Exchange. Within the required activities, a State-based Exchange has additional operational flexibility. It may choose to use Federal government services for the following activities:

- Determination of advance premium tax credit (APTC) and cost-sharing reduction (CSR)
- Individual responsibility requirement and payment exemption as defined in future rulemaking and guidance
- Reinsurance
- Risk adjustment

State Partnership Exchange

States have the option to operate as a State Partnership with HHS to administer and operate select Exchange activities. Specifically, a State Partnership Exchange may assume primary responsibility for activities including:

- Plan Management: In a Plan Management Partnership, a State will conduct all analyses and reviews necessary to support QHP certification, collect and transmit necessary data to HHS, and manage certified QHPs.
- Consumer Assistance: In a Consumer Assistance Partnership, a State will provide in-person application and other assistance to consumers. In-person assistance may include supporting consumers in filing an application, obtaining an eligibility determination, reporting a change in status, comparing coverage options, and selecting and enrolling in a QHP.
- Both Plan Management and Consumer Assistance**:** In a Plan Management and Consumer Assistance Partnership, a State will perform all of the Partnership activities described above.

In addition to Plan Management and Consumer Assistance Partnership activities, Partnership States may elect to perform the following Exchange activities:

- Reinsurance
- Medicaid and CHIP eligibility: A State may coordinate with the Center for Medicaid and CHIP Services (CMCS) on decisions and protocols for either an assessment or determination model for eligibility in the Exchange

Federally-facilitated Exchange without Partnership

For States that do not seek to operate a State-based Exchange or a Partnership with the Federally-facilitated Exchange, HHS will establish and operate a Federally-facilitated Exchange. In such instances, a State may elect to run reinsurance and may elect to coordinate with CMCS on decisions and protocols for either an eligibility assessment or eligibility determination model in the Federally-facilitated Exchange.

Regardless of a State's Exchange model, HHS intends to work in collaboration with States, where appropriate, to ensure the best, most effective experience for the State and its residents.

Overview of Exchange Approval Requirements

HHS may approve States that seek to operate a State-based Exchange or participate in a State Partnership Exchange based upon a State's submission of its Blueprint. A Blueprint is made up of two components:

- Declaration Letter (Section 1)
- Exchange Application (Section 2)

States seeking to operate a State-based Exchange or electing to participate in a State Partnership Exchange must submit a complete Exchange Blueprint no later than 30 business days prior to the required approval date of January 1 (November 16, 2012, for plan year 2014).

A State may submit its Declaration Letter at any time prior to this deadline. If a State's Declaration Letter is received more than 20 business days prior to the submission of its Blueprint, the State may request an Exchange Application consultation with CMS regarding preparation of its application for approval as a State-based Exchange or State Partnership Exchange.

States that plan to operate in the Federally-facilitated Exchange without Partnership that intend to operate their own reinsurance programs—should submit a Declaration Letter addressing how they meet or will meet the requirements of Section 5.2: Reinsurance program. They are invited to submit a Declaration Letter otherwise, but they do not need to complete the Exchange Application.

In particular, HHS strongly encourages States that are considering operating a State-based Exchange or a Plan Management Partnership to submit the Declaration Letter as soon as possible and to seek technical assistance and consultation with HHS to ensure State readiness to operate Plan Management activities in time for operational implementation.

States that seek HHS Approval to operate a State-based Exchange or State Partnership Exchange for coverage years beginning after January 1, 2014 (e.g., January 1, 2015, January 1, 2016) should submit an Exchange Blueprint in accordance with the same process and timeframe specified for those States seeking to operate an Exchange on January 1, 2014, for the applicable year (e.g., November 18, 2013 for plan year 2015; November 18, 2014 for plan year 2016).

Initial Exchange Approval Determinations

HHS will approve a State-based Exchange once the State has demonstrated the ability to satisfactorily perform all required Exchange activities.

HHS recognizes that States depend on HHS and other Federal agencies for guidance associated with their Exchange establishment. In this regard, particularly in the first year of the program (plan year 2014), approval of State-based Exchanges will take into account timelines for guidance and infrastructure development (e.g., Data Services Hub). Similarly, HHS expects that States will be in various stages of the Exchange-development lifecycle when Blueprints are submitted. Many State Exchange-development activities are likely to occur in 2013. HHS will utilize Conditional Approval for State-based Exchanges and Partnership States whose Exchange establishment is not complete at the time of Blueprint submission.

Conditional Approval will be granted for State-based Exchanges and Partnership Exchanges that do not meet all Exchange Approval requirements on January 1, 2013, but are making significant progress toward these requirements and will be operationally ready for the initial open enrollment period beginning October 1, 2013. HHS will work with each State that receives Conditional Approval to develop a comprehensive agreement that sets out expected future milestones and dates for operational readiness reviews. This will allow HHS and the State to work jointly to ensure that the Exchange continues to develop at a pace on track for operation during the initial open enrollment period beginning on October 1, 2013.

Conditional Approval will continue as long as a State continues to meet expected progress milestones and until a State successfully demonstrates its ability to perform all required Exchange activities. Provided that the State is meeting the milestones outlined in its Conditional Approval determination, a State Exchange can maintain Conditional Approval. In this capacity, an Exchange must be able to:

- Provide consumer support for coverage decisions
- Facilitate eligibility determinations for individuals
- Provide for enrollment in QHPs
- Certify health plans as QHPs
- Operate a SHOP

The technical assistance and grant funding available to States prior to Approval or Conditional Approval will continue to be available under the terms and requirements of those programs.

Questions Regarding the Exchange Blueprint and Technical Assistance

States should contact their CMS Center for Consumer Information and Insurance Oversight (CCIIO) State Officer for specific questions regarding their Exchange Blueprints. Additionally, all States are encouraged to contact CCIIO's State Exchange Group for information about technical assistance consultations, available resources, and funding opportunities available to States for Exchange-build activities. General questions may be directed to State.Exchange.Group@cms.hhs.gov.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1172. The time required to complete this information collection is estimated to average (211 hours) or (12,660 minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Section I: Declaration Letter

A State seeking to operate a State-based Exchange or participate in a State Partnership Exchange in plan year 2014 will declare the type of Exchange Model it intends to pursue through an Exchange Declaration Letter as part of its Exchange Blueprint. States that plan to operate in the Federally-facilitated Exchange without Partnership, and that intend to operate their own reinsurance programs, should submit a declaration letter addressing how they meet the requirements of Section 5.2: Reinsurance program. To facilitate coordination, States seeking to participate in a Federally-facilitated Exchange without Partnership and not electing to operate reinsurance are also invited, at their option, to complete a Declaration Letter.

A State's Declaration Letter must be signed by the State's Governor[5]. As described below, the Letter's contents should include basic information associated with its designated Exchange Model. The Letter should include a designation of the individual(s) (i.e., Designee(s)) who should serve as the primary point of contact for HHS regarding the Exchange. The individual(s) should be authorized to bind the State regarding the State's Exchange, as well as to complete and sign the Exchange Application. In the case of State-based Exchanges and State Partnership Exchanges, this should be the individual(s) authorized to electronically attest to the facts in the Exchange Application.

States are encouraged to submit their Exchange Declaration Letters early, but a Declaration Letter must be sent to the Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) at least 30 business days prior to the required Approval date of January 1 (November 16, 2012 for plan year 2014). Declaration Letters may be sent to the CMS Center for Consumer Information and Insurance Oversight (CCIIO), 200 Independence Avenue SW, Suite 739H, Washington DC, 20201. In addition, please email a copy to the State.Exchange.Group@cms.hhs.gov. To support HHS' goal of public transparency, States must post their Model Declaration Letter to the State (or other appropriate) website.

Contents of Exchange Declaration Letters

A State's Declaration Letter must include the following contents based on the Exchange Model that the State chooses to pursue.

State-based Exchange

- Confirmation of the State's intention to apply to operate a State-based Exchange
- Indication of whether the State intends to administer a risk adjustment program in the first year of operations or if it will be using Federal government services. If yes,
    - What is the State's risk adjustment entity?
    - Is the State planning to use the Federal risk adjustment methodology?

[5] CMS has been advised that in some States, the Governor does not have the authority to enter into a State Partnership Exchange. Please contact your CCIIO State Officer if the Governor of your State believes that another entity is the appropriate authority to sign the State's Model Declaration Letter so that we can work with your State on an appropriate arrangement.

    - What is the proposed data model (i.e., intermediate or distributed)?
- Indication of whether the State intends to administer its own reinsurance program by establishing or contracting with a nonprofit reinsurance entity. If yes, provide the name of the selected entity.
- Indication of whether the State-based Exchange will perform its Advance Premium Tax Credit (APTC)/Cost-Sharing Reduction (CSR) eligibility determinations or if it will use Federal government services for this activity.
- Designation of the individual(s) (i.e., Designee(s)) authorized to act as primary point of contact and authorized to bind the State with HHS regarding the State's Exchange, as well as to complete and sign the Exchange Application.

State Partnership Exchange

- Confirmation of the State's intention to participate in a State Partnership Exchange, including which Partnership the State intends to pursue:
    - Plan Management
    - Consumer Assistance
    - Plan Management and Consumer Assistance
- Indication of whether the State intends to administer its own reinsurance program by establishing or contracting with a nonprofit reinsurance entity. If yes, provide the name of the selected entity.
- Designation of the individual(s) (i.e., Designee) authorized to act as primary point of contact and authorized to bind the State with HHS regarding the State's Exchange, as well as to complete and sign the Exchange Application. The State Medicaid Director will be assumed to be the primary contact on issues related to eligibility determination and coordination, unless otherwise indicated by the State Governor or the authorized personnel in the Declaration Letter. In States with a separate Children's Health Insurance Program (CHIP), the State's CHIP Director will be assumed to serve as the point of contact for CHIP-related eligibility issues, unless otherwise indicated.

Federally-facilitated Exchange

- Confirmation of the State's intention to elect for the Secretary to establish and operate a Federally-facilitated Exchange.
- Designation of the State agency or official who is authorized by the State to collaborate with HHS on issues related to Exchange issues in that State's Federally-facilitated Exchange in that State. The State Medicaid Director will be assumed to be the primary contact on issues related to eligibility determination and coordination unless otherwise indicated by the State Governor or the authorized personnel in the Declaration Letter. In States with separate CHIP programs, the State's CHIP Director will be assumed to serve as the point of contact for CHIP-related eligibility issues unless otherwise indicated.
- Indication of whether the State intends to administer its own reinsurance program by establishing or contracting with a nonprofit reinsurance entity. If yes, indicate how the State meets or will meet the requirements of Section 5.2: Reinsurance program.

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If a Declaration Letter is not received 30 business days prior to January 1, 2013 (i.e., November 16, 2012), HHS will plan to implement a Federally-facilitated Exchange for the State. In the absence of a Declaration Letter, HHS will operate a Federally-facilitated Exchange for the State under the following assumptions:

- The State will not administer its own reinsurance program;
- The State's small group and individual markets will be merged in the Federally-facilitated Exchange only if the current individual and small-group markets are merged. If a State does not merge the individual and small-group-market risk pools, the SHOP will permit each qualified employee to enroll only in QHPs in the small-group market; and
- The State's current definition of "small-group" employer (e.g., "up to 50" or "up to 100" employees) will be followed, while the method of determining employer size will be based on full-time equivalent employees consistent with other Affordable Care Act policies.

Section II: Application for Approval of Affordable State-based and State Partnership Insurance Exchanges

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The Exchange Application must be completed online. Beginning September 14, 2012, the Exchange Application will be available for online completion and submission on CMS' Center for Consumer Information and Insurance Oversight's (CCIIO) State Exchange Resource and Virtual Information System (SERVIS) system https://servis.cms.gov.[6] *The online Exchange Application has been designed so only the questions relevant to the Exchange Model the State has selected will be presented to the applicant.*

[6] SERVIS and the Collaborative Application Lifecycle Tool (CALT) are password protected. To receive a CALT/SERVIS user ID and password please contact CALT_support@cms.hhs.gov or SERVIS_Support@cms.hhs.gov.

Application Instructions

Introduction

In addition to a Declaration Letter, a complete Exchange Blueprint requires submission of an Exchange Application. This Exchange Application is used to document a State's completion, or progress towards completion, of all Exchange requirements, either as a State-based Exchange or State Partnership Exchange.

Exchange Application: Overview of Exchange Activities

The Exchange Application is comprised of a list of activities that a State-based Exchange or State Partnership Exchange must perform to comply with the Affordable Care Act and associated regulations. In some instances, a State may use Federal services to perform an Exchange activity. Table 1 outlines all of the Exchange activities that an Exchange must perform and can serve as a roadmap for Exchange development.

States that are seeking Approval of their State-based Exchange or State Partnership Exchange should use Table 1 to complete the Application accordingly. Required activities within an Exchange model are designated with an "X." Select activities are also described as "if applicable," "can use Federal government services," "may elect to perform," and "optional." States may attest to activities being completed by the Exchange or a Designee—through contract, agreement, or other arrangement. However, the Exchange is ultimately responsible for successful performance of the activity.

Approval requirements for a State Partnership Exchange will mirror State-based Exchange Approval requirements for those activities a State elects to perform within a Federally-facilitated Exchange. Therefore, all States that seek Approval of a State-based Exchange or a State Partnership Exchange can use this list of activities and common elements as part of the Exchange Approval process. The activities associated with the State Partnership Exchanges are similarly designated in Table 1 below.

States that are applying to be State-based Exchanges are also encouraged to complete the subset of activities associated with the Partnership models. By also completing the Partnership activities, a State can assure that if it receives Conditional Approval but is ultimately unable to achieve operational milestones in other areas it will be able to participate as a State Partnership Exchange in plan year 2014.

If you are interested in additional requirements associated with a Regional or Subsidiary Exchange, please contact your State Officer or email CCIIO at State.Exchange.Group@cms.hhs.gov.

Table 1: Roadmap for Completing the Exchange Application

Section of Exchange Blueprint	Required Activities		
Exchange Activity	**State-based Exchange**	**State Partnership Exchange—Plan Management**	**State Partnership Exchange—Consumer Assistance**
1.0 Legal Authority and Governance			
1.1 Enabling authority for Exchange and SHOP	X		
1.2 Board and governance structure	X		
2.0 Consumer and Stakeholder Engagement and Support			
2.1 Stakeholder consultation plan	X		
2.2 Tribal-consultation plan	X *(if applicable)*		
2.3 Outreach and education	X		
2.4 Call center	X		
2.5 Internet website	X		
2.6 Navigators	X		
2.7 In-person assistance program	X *(if applicable)*		
2.8 Agents/brokers	X *(if applicable)*		
2.9 Web brokers	X *(if applicable)*		
3.0 Eligibility and Enrollment			
3.1 Single streamlined application(s) for Exchange and SHOP	X		
3.2 Coordination strategy with Insurance Affordability Programs and the SHOP	X		
3.3 Application, updates, acceptance, and processing, and responses to redeterminations	X		
3.4 Notices, data matching, annual redeterminations, and response processing	X		
3.5 Verifications	X		
3.6 Document acceptance and processing	X		
3.7 Eligibility determination	X		
3.8 Eligibility determinations for APTC and CSR	X *(can use Federal service)*		
3.9 Applicant and employer notification	X		
3.10 Individual responsibility requirement and payment exemption determinations	X *(can use Federal service)*		
3.11 Eligibility appeals	X		
3.12 QHP selections and terminations, and APTC/advance CSR information processing	X		
3.13 Electronically report results of eligibility assessments and determinations	X		

Exchange Activity	State-based Exchange	State Partnership Exchange—Plan Management	State Partnership Exchange—Consumer Assistance
3.14. In accordance with section 155.345(i) of the Exchange Final Rule, the Exchange must follow procedures established in accordance with 45 CFR 152.45 related to the Pre-Existing Condition Insurance Plan (PCIP) transition	X	*X (as applicable)*	*X (as applicable)*
4.0 Plan Management			
4.1 Appropriate authority to perform and oversee certification of QHPs	X	X	
4.2 QHP certification process	X	X	
4.3 Plan management system(s) or processes that support the collection of QHP issuer and plan data	X	X	
4.4 Ensure ongoing QHP compliance	X	X	
4.5 Support issuers and provide technical assistance	X	X	
4.6 Issuer recertification, decertification, and appeals	X	X	
4.7 Timeline for QHP accreditation	X	X	
4.8 QHP quality reporting	X	X	
5.0 Risk Adjustment & Reinsurance			
5.1 Risk adjustment program	X *(can use Federal service)*		
5.2 Reinsurance program	X *(can use Federal service)*	X *(may elect to perform or can use Federal service)*	X *(may elect to perform or can use Federal service)*
6.0 SHOP			
6.1 SHOP compliance with 45 CFR 155 Subpart H	X		
6.2 SHOP premium aggregation	X		
6.3 Electronically report results of eligibility assessments and determinations for SHOP	X		
7.0 Organization & Human Resources			
7.1 Organizational structure and staffing resources to perform Exchange activities	X		
8.0 Finance & Accounting			
8.1 Long-term operational cost, budget, and management plan	X		
9.0 Technology			
9.1 Compliance with HHS IT Guidance	X	X	
9.2 Adequate technology infrastructure and bandwidth	X	X	
9.3 IV&V, quality management and test procedures	X	X	
10.0 Privacy & Security			
10.1 Privacy and Security standards policies and procedures	X	X	X (*if applicable)*

Exchange Activity	State-based Exchange	State Partnership Exchange—Plan Management	State Partnership Exchange—Consumer Assistance
10.2 Safeguards based on HHS IT guidance	X	X	
10.3 Safeguard protections for Federal information	X		
11.0 Oversight, Monitoring, & Reporting			
11.1 Routine oversight and monitoring of the Exchange's activities	X	X	X (*if applicable)*
11.2 Track/report performance and outcomes metrics related to Exchange activities	X	X	X (*if applicable)*
11.3 Uphold financial integrity provisions including accounting, reporting, and auditing procedures	X	X	X (*if applicable)*
12.0 Contracting, Outsourcing, and Agreements			
12.1 Contracting and outsourcing agreements	X	X	X *(if applicable)*
13.0 State Partnership Exchange Activities			
13.1 Plan Management	Optional	X	
13.2 Capacity to interface with the Federally-facilitated Exchange	Optional	X	X
13.3 Consumer Assistance	Optional		X

Relationship between Exchange Application and the Establishment Grant Review Process

HHS has developed an Establishment Review Process to monitor and assist States that have received grant(s) through the Cooperative Agreements for Establishment of Exchanges under the Affordable Care Act 1311(a). While the Establishment Review Process is intended to support States as they work toward Exchange Approval, the Establishment Review Process is independent of the Exchange Approval process. However, to streamline data collection requirements, HHS has aligned requirements so that a State may utilize information submitted during the Establishment Review Process to complete a State's Exchange Blueprint. If a State successfully completes a portion of an activity requirement during its Establishment Review, the State may waive out of re-submitting testing files or supporting documentation as part of the Exchange Application requirements. As referenced in the Exchange Application, a State may upload and submit a letter(s) from HHS confirming successful completion of documentation requirements instead of re-submitting documentation.

Completion of the Exchange Application

In completing the Exchange Application, States are asked to submit the elements described below.

Attestations

The individual(s) designated in the Declaration Letter (the Designee(s)) must attest, on behalf of the State, to either completion or expected completion of an Exchange activity. Specifically, the State can attest to their Exchange's current ability to meet specified Exchange requirements. Alternatively, if the

State is unable to meet requirements by the time of the Exchange Application submission date, the State may attest to expected completion and its expected ability to meet the specified activity requirements by a future date.

As appropriate, for attestations related to expected completion, the State should provide a timeline and work plan that includes key milestones, including any vendor-related agreements, so that HHS understands the State's expected ability to complete the activity by a future date. The State may choose to provide one comprehensive work plan that outlines all applicable activities or a set of work plans that logically bundle activities (e.g., a work plan for all Eligibility activities). However, the work plan(s) must clearly reference the specific activities required as part of the Exchange Application.

Supporting Documentation

For some activities, supporting documentation is required. States must upload requested documentation associated with the Exchange activity. Alternatively a State may submit a letter(s) from HHS confirming successful demonstration of the associated supporting document through the Establishment Review process. In such cases, the State does not need to provide documentation/descriptions, and HHS will confirm the State's submitted documentation from the Establishment Review.

Testing Files

As part of a standard systems development process, States and their vendors will develop and implement testing and validation plans. For some activities, the Application requires submission of these files.

Three different types of testing files may be required:

- **Summary of results of State-developed testing:** These summaries should document State-defined and executed system testing, including details of Exchange activities tested, the scope of testing activities conducted, and metrics detailing the results of that testing as it relates to each designated Exchange Application requirement.
- **Results of State execution of HHS-developed test scenarios:** HHS, in collaboration with States, developed test scenarios to confirm implementation of those Exchange activities that require standardization across all State Exchanges. These scenarios will be released to a central Test Library on the Collaborative Application Lifecycle Tool (CALT)[7]. For CALT login and password assistance, please send a request to CALT_Support@cms.hhs.gov.
- **Summary of Independent Verification & Validation (IV&V) of applicable system components:** A report by an independent third party which provides verification and validation that designated Exchange activities are built and operating as designed and in compliance with documented requirements.

[7] Test scenarios will be available on the Collaborative Application Lifecycle Tool (CALT) site (https://calt.hhs.gov); a more specific link to the site will be provided at a future date

Upload Relevant Files

Files are requested to be uploaded, as applicable. The files should be clearly labeled with the appropriate activity or activities). Activities requiring additional documentation in the form of uploaded files are specifically identified in the Exchange Application. Depending on the Exchange activity being tested, a given document or file may encompass multiple activities. In such cases, please note any file cross-referencing and clearly label the activities within the attachments. States do not need to upload the same file multiple times. Instead referencing, will allow HHS to identify files provided, as appropriate.

- Supporting Documentation
- Testing Files
- Letter(s) from HHS allowing an applicant to waive out of any requirements successfully completed in an Establishment Review(s)
- Expected Completion Work Plan

Operational Readiness Assessment and Additional Information Requests

In addition to reviewing the completed Exchange Application, HHS may conduct on-site or virtual Exchange assessments as part of its verification of an Exchange's Operational Readiness. Operational Readiness entails HHS' and its Federal agency partners' assessment to determine the capacity of an Exchange to conduct Exchange business. The objective of the Operational Readiness assessment is to assure that an Exchange's policies, procedures, operations, technology, and other administrative capacities have been implemented and scaled to meet the needs of the State's Exchange population. HHS will use the information in a State's Exchange Application, including results from a State's Testing Files, to determine the need for, and timing of, an on-site or virtual Operational Readiness assessment.

In addition, the State may be asked to provide supplemental information after the Exchange Application has been submitted, as determined necessary by HHS and its Federal agency partners.

Public Transparency

The Affordable Care Act envisions a significant role for consumers and other stakeholders in the design, implementation and on-going operations of Exchanges. For example, an Exchange that is an independent State agency or a non-profit established by a State will include consumer representatives on its board and hold regular public governing board meetings. In addition, Exchanges will develop and implement a comprehensive stakeholder engagement plan that includes meaningful engagements with consumers, advocates, employers, and members of Federally-recognized Tribes (where applicable).

In that spirit, as part of a State's Approval or Conditional Approval decision, States should post the following sections (excluding test data) of a State's Exchange Application on the appropriate State website within ten (10) business days of an Approval or Conditional Approval decision:

- Section 1.2: Exchange board and governance structure
- Section 2.1: Stakeholder consultation plan
- Section 2.2: Tribal consultation policy
- Section 2.3: Outreach and education plan
- Section 2.6: Navigators
- Section 2.7: Role of in-person assistance programs

- Section 2.8: Role of agents and brokers
- Section 2.9: Role of Web agents and brokers
- Section 3.1: State-developed single-streamlined application (if applicable)
- Section 3.2: Coordination strategy
- Section 3.14: Pre-Existing Condition Insurance Plan (PCIP) transition
- Section 4.4: Integration between Exchange and other State entities with respect to QHP-issuer oversight
- Section 8.1: Long-term operational cost plan

If a State is concerned that the publication of the above information may jeopardize an active procurement process, it may contact their State Officer or email CCIIO at State.Exchange.Group@cms.hhs.gov to discuss the timing of the publication of this information.

Application Format and Availability

The Exchange Application will be electronically available for States to complete on HHS' Center for Consumer Information and Insurance Oversight's (CCIIO) State Exchange Resource and Virtual Information System (SERVIS) system (https://servis.cms.gov) beginning September 14, 2012.

Attestation

ON THIS DATE, I ATTEST THAT THE STATEMENTS AND INFORMATION CONTAINED IN THIS EXCHANGE BLUEPRINT AND DOCUMENTS SUBMITTED IN CONJUNCTION WITH THIS EXCHANGE BLUEPRINT ACCURATELY REPRESENT THE STATUS OF MY STATE'S INSURANCE EXCHANGE BEING DEVELOPED UNDER TITLE I OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 (Pub. L. 111-148), AS AMENDED BY THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (Pub. L. 111-152), AND REFERRED TO COLLECTIVELY AS THE AFFORDABLE CARE ACT; AND REGULATIONS AT 45 CFR PARTS 153, 155, AND 156.

State: _____

(Name of State)

_____

(Signature of Governor Designee of the State, Date Signed)

State Background Information for Application Submission

1. STATE NAME

2. DESIGNATED EXCHANGE OFFICIAL(S) TO COMPLETE EXCHANGE APPLICATION & CONTACT INFORMATION

NAME:
TELEPHONE:
EMAIL ADDRESS:

NAME:
TELEPHONE:
EMAIL ADDRESS:

3. STATE EXCHANGE MODEL (Can check more than one. States applying for a State-based Exchange are encouraged to also select and complete partnership requirements.)

__STATE-BASED EXCHANGE

__STATE PARTNERSHIP EXCHANGE

__PLAN MANAGEMENT

__CONSUMER ASSISTANCE

4. If you are pursuing a State-based Exchange, indicate if you will be using any of the following Federal services: (check all that apply)

__3.8 Eligibility determinations for APTC and CSR
__3.10 Individual responsibility requirements and payment exemption determinations
__5.1 Risk adjustment program
__5.2 Reinsurance program

5. If you are pursuing a State Partnership Exchange, indicate if you will be using any of the following Federal services:

__5.2 Reinsurance program

Legend: Blank fields require response from applicant	Shaded fields require no response from applicant
* Supporting Documentation and Testing Files eligible for waive out given an applicant's successful completion of an Establishment Review(s)	

	Exchange Activity	Attestation		Testing Files*			Supporting Documentation*	HHS Approval Letter for Waive Out (X)
		Completed (X)	Expected Completion (date)	State Summary (X)	HHS-Developed (X)	IV&V (X)		
1.0 Legal Authority and Governance								
1.1	The State has enabling authority to operate an Affordable Insurance Exchange, including a Small Business Health Options Program (SHOP), compliant with Affordable Care Act Section 1321(b) and implementing regulations.						Copy of current law and/or regulation that indicates that the State has necessary legal authority to establish an Exchange or that establishes the Exchange. ***OR*** Other legislation or general authority (e.g., Executive Order) that the State has determined provides the necessary legal authority to establish an Exchange. *Note: If the SHOP was separately authorized from the Exchange, pursuant to Affordable Care Act § 1321(b),* provide documentation demonstrating that the State has enabling authority to establish and operate a SHOP. ***AND*** *If authority is not clear on its face*, provide a Statement from the legal counsel of the office of the applicant, the Governor's legal counsel, or the State's Attorney General's Office (correspondence or a formal legal opinion) certifying that the State is authorized to establish an Exchange under State law.	
1.2	The Exchange has been established in compliance with Affordable Care Act 1311(d) and 45 CFR 155.110. **If State agency, please proceed to Section 2.**						Brief description of governance structure (e.g., State agency, nonprofit organization). **If State agency, please proceed to Section 2.**	

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1.2a	The Exchange board and governance structure has been established in compliance with Affordable Care Act 1311(d) and 45 CFR 155.110.						Brief description of board composition, including board members' affiliations and any consumer representation. Note any differences in board composition and governance structure for SHOP.	
1.2b	The Exchange has a formal, publicly-adopted charter or bylaws.							
1.2c	The Exchange has established governance policies in compliance with 45 CFR 155.110(d) and obtained conflict of interest disclosures from board members, including disclosures of financial interest.							
1.2d	The governing board has at least one voting member who is a consumer representative, and does not have a majority of voting representatives with a conflict of interest.							
1.2e	The majority of the voting members have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the individual and small group markets and the uninsured.							
1.2f	The Exchange holds regular, public governing-board meetings that are announced in advance.							

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2.0 Consumer and Stakeholder Engagement and Support								
2.1	The Exchange has developed and implemented a stakeholder consultation plan and has consulted with, and will continue to consult with, consumers, small businesses, State Medicaid and CHIP agencies, agents/brokers, employer organizations, and other relevant stakeholders as required under 45 CFR 155.130.						Brief description of the stakeholder consultation plan that addresses how consultation will occur on an ongoing basis with consumers, small businesses, State Medicaid and CHIP agencies, agents/brokers, employer organizations, and other relevant stakeholders as required under 45 CFR 155.130.	
2.2	*Applicable only to States with Federally-recognized Tribes*: The Exchange, in consultation with the Federally-recognized Tribes, has developed and implemented a Tribal consultation policy or process, which has been submitted to HHS.							
2.3	The Exchange provides culturally and linguistically appropriate outreach and educational materials to the public, including auxiliary aids and services for people with disabilities, regarding eligibility and enrollment options, program information, benefits, and services available through the Exchange, the Insurance Affordability Program(s), and the SHOP. In addition, the Exchange has an outreach plan for populations including: individuals, entities with experience in facilitating enrollment such as agents/brokers, small businesses and their employees, employer groups, health care providers, community-based organizations, Federally-recognized Tribal communities, advocates for hard-to-reach populations, and other relevant populations as outlined in 45 CFR 155.130.						Brief description of the outreach plan(s) and targeted efforts that address each population or type of stakeholder, including those identified in 45 CFR 155.130.	

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2.3a	The Exchange has developed and provides culturally and linguistically appropriate outreach and educational materials and auxiliary aids and services to people with disabilities (including information in alternate format), regarding eligibility and enrollment options, program information, benefits, and services available through the Exchange, SHOP, and other Insurance Affordability Programs, as required in 45 CFR 155.205(c).							
2.3b	The Exchange has an outreach plan for populations including: individuals, entities with experience in facilitating enrollment such as agents/brokers, small businesses and their employees, employer groups, health care providers, community-based organizations, Federally-recognized Tribal communities, advocates for hard-to-reach populations, and other relevant populations as outlined in 45 CFR 155.130.							
2.4	The Exchange provides for the operation of a toll-free telephone hotline (call center) to respond to requests for assistance from the public, including individuals, employers, and employees, at no cost to the caller as specified by 45 CFR 155.205(a).						Brief description of the call center's strategy for managing call volume, plan for translation services, and toll-free telephone number.	
2.4a	The Exchange provides for the operation of a toll-free telephone hotline (call center) which acts as a central line to handle seamless application support, coordinates with other Insurance Affordability Program(s) and with other State and Federal agencies, and responds to requests for assistance from the public, including individuals, employers, and employees, at no cost to the caller as specified by 45 CFR 155.205(a).							
2.4b	The Exchange provides translation and oral interpretation services and auxiliary aids and services to the public, including individuals, employers, and employees, at no cost to the caller.							

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2.4c	The Exchange provides adequate training and resources to operate the call center, including an operating plan and procedures.							
2.5	The Exchange has established and maintains an up-to-date Internet Web site that provides timely and accessible information on Qualified Health Plans (QHPs) available through the Exchange, Insurance Affordability Program(s), and the SHOP, and includes requirements specified in 45 CFR 155.205(b).						Internet Web site URL address for the Exchange and the SHOP, if different.	
2.5a	The Exchange has established and maintains an up-to-date Internet Web site that provides timely and accessible information on Qualified Health Plans (QHPs) available through the Exchange, Insurance Affordability Program(s), and the SHOP, and includes requirements specified in 45 CFR 155.205(b).							
2.5b	The Exchange's Internet Web site provides information on premium and cost-sharing, QHP comparison, metal level of QHP coverage, transparency of coverage measures, and a provider directory.							
2.5c	The Exchange's Internet Web site provides information in a manner that is accessible to individuals with disabilities and individuals with limited English proficiency, as required in 45 CFR 155.205(b) and (c).							

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2.6	The Exchange has established or has a process in place to establish and operate a Navigator program that is consistent with the applicable requirements of 45 CFR 155.210, including the development of training and conflict of interest standards, and adherence to privacy and security standards specified in 45 CFR 155.210 and 45 CFR 155.260.						Brief description of Exchange's plan to operate a Navigator program, including documentation outlining the Exchange's progress in developing conflict of interest and training standards; how it will ensure Navigators are appropriately trained and meet the Exchange's conflict of interest, privacy and security standards; and a timeline and strategy for funding for the Navigator program and making the program fully operational.	
2.6a	The Exchange has established or has a process in place to establish and operate a Navigator program that is consistent with the applicable requirements specified in 45 CFR 155.210 and 45 CFR 155.260.							
2.6b	The Exchange has a plan for the ongoing funding of an Exchange Navigator program, in order to award at least two (2) types of entities, one of which is a community or consumer-focused organization or non-profit entity. Grant agreements ensure that Navigator grantees ("Navigators") will conduct the five (5) duties outlined in 45 CFR 155.210(e).							
2.6c	The Exchange has begun to develop training and conflict of interest standards for Navigators.							

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2.7	*If applicable:* The Exchange has established an in-person assistance program distinct from the Navigator program and has a process in place to operate the program consistent with the applicable requirements of 45 CFR 155.20(c), (d), and (e).						Brief description of Exchange's plan to operate an in-person assistance program distinct from the Navigator program, which provides in-person assistance to consumers, including documentation outlining the Exchange's progress in developing conflict of interest and training standards; how it will ensure in-person assistance program staff are appropriately trained and meet the Exchange's conflict of interest, accessibility, and privacy and security standards; and a timeline and strategy for funding for the in-person assistance program and making the program fully operational.	
2.8	*If applicable:* If the State permits activities by agents and brokers pursuant to 45 CFR 155.220(a), the Exchange has clearly defined the role of agents and brokers including evidence of licensure, training, and compliance with 45 CFR 155.220(c)-(e). The Exchange will have agreements with agents/brokers consistent with 45 CFR 155.220(d), which address agent/broker registration with the Exchange, training on QHP options and Insurance Affordability Program(s), and adherence to privacy and security standards, as specified in 45 CFR 155.260.						*If applicable:* Brief description of the strategy, including the Exchange's compensation policy for agents/brokers, including web brokers, as it relates to their enrollment of individuals through the Exchange. ***AND*** *If applicable:* Brief description of the Exchange's policy for ensuring compliance with 45 CFR 155.220(d) and (e), including how it will ensure agents/brokers are appropriately trained and meet the Exchange's privacy and security standards.	
2.8a	*If applicable:* The Exchange has a process to verify that agents/brokers are in compliance with State law, including licensure requirements consistent with 45 CFR 155.220(e).							
2.9	*If applicable:* If the State permits activities by agents and brokers pursuant to 45 CFR 155.220(a), the Exchange has clearly defined the role of web brokers including evidence of licensure, training, and compliance with 45 CFR 155.220(c)-(e). Specifically, the Exchange has agreements with web brokers						*If applicable:* Brief description of how the Exchange's Internet Web site will interface with web brokers' Web sites. ***AND***	

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	consistent with 45 CFR 155.220(d), which address agent/broker registration with the Exchange, training on QHP options and Insurance Affordability Program(s), and adherence to privacy and security standards, as specified in 45 CFR 155.260.						*If applicable:* Brief description of Exchange's policy for ensuring compliance with 45 CFR 155.220(c)(3),(d) and (e), including how it will ensure web brokers are appropriately trained and meet the Exchange's privacy and security standards.	
2.9a	*If applicable:* The Exchange has a process to verify that web brokers are in compliance with State law including licensure requirements consistent with 45 CFR 155.220(e).							
2.9b	*If applicable:* The Exchange has agreements with web brokers, consistent with 45 CFR 155.220(d), which address web broker registration with the Exchange, training on QHP options and Insurance Affordability Program(s), and adherence to privacy and security standards, as specified in 45 CFR 155.260.							
3.0 Eligibility and Enrollment								
3.1	The Exchange has developed and will use an HHS-approved single, streamlined application for the individual market – or will use the HHS-developed application – to determine eligibility and collect information that is necessary for enrollment in a QHP for the individual market and for Insurance Affordability Programs as specified in 45 CFR 155.405. The Exchange has developed and will use an HHS-approved application for SHOP or will use the HHS-developed application for SHOP employers and employees as specified in 45 CFR 155.730.						*If applicable:* State-developed single-streamlined application to determine eligibility for the individual market. ***AND*** *If applicable:* State-developed single-streamlined application to determine eligibility for the SHOP.	

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3.1a1	The Exchange has developed and will use a HHS-approved single, streamlined application for the individual market to determine eligibility and collect information that is necessary for enrollment in a QHP and for Insurance Affordability Programs as specified in 45 CFR 155.405. ***OR***							
3.1a2	The Exchange will use the HHS-developed single, streamlined application for the individual market to determine eligibility and collect information that is necessary for enrollment in a QHP and for Insurance Affordability Programs as specified in 45 CFR 155.405.							
3.1b1	The Exchange has developed and will use HHS-approved applications for SHOP employers and employees as specified in 45 CFR 155.730. ***OR***							
3.1b2	The Exchange will use the HHS-developed applications for SHOP employers and employees as specified in 45 CFR 155.730.							
3.2	The Exchange has developed and documented a coordination strategy with other agencies administering Insurance Affordability Programs and the SHOP that enables the Exchange to carry out the eligibility and enrollment activities.						Brief description of the Exchange's coordination strategy with other agencies administering Insurance Affordability Programs and the SHOP related to eligibility and enrollment activities.	
3.3	The Exchange has the capacity to accept and process applications, updates, and responses to redeterminations from applicants and enrollees, including applicants and enrollees who have disabilities or limited English proficiency, through all required channels, including in-person, online, mail, and phone.							

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3.3a	The Exchange has the capacity to accept and process applications, updates, and responses to redeterminations from applicants and enrollees in-person.							
3.3b	The Exchange has the capacity to accept and process applications, updates, and responses to redeterminations from applicants and enrollees online.							
3.3c	The Exchange has the capacity to accept and process applications, updates, and responses to redeterminations from applicants and enrollees via mail.							
3.3d	The Exchange has the capacity to accept and process applications, updates, and responses to redeterminations from applicants and enrollees via phone.							
3.3e	The Exchange has the capacity to conduct the activities set out in 3.3a – 3.3d for applicants and enrollees who have disabilities or limited English proficiency.							
3.4	The Exchange has the capacity to send notices, including notices in alternative formats and multiple languages; conduct periodic data matching; and conduct annual redeterminations and process responses in-person, online, via mail, and over the phone pursuant to 45 CFR 155, subpart D.						If the Exchange will conduct additional periodic data matching in accordance with 45 CFR 155.330(d)(2), provide brief description of the data sources to be used.	
3.4a	The Exchange has the capacity to generate and send notices, including notices in alternative formats and multiple languages, pursuant to 45 CFR 155, subpart D.							
3.4b	The Exchange has the capacity to conduct periodic data matching pursuant to 45 CFR 155, subpart D and act on the results of the data matching.							

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3.4c	The Exchange has the capacity to conduct annual redeterminations and process responses through all channels pursuant to 45 CFR 155, subpart D.							
3.5	The Exchange has the capacity to conduct verifications pursuant to 45 CFR 155, subpart D, and is able to connect to data sources, such as the Data Services Hub, and other sources as needed.						Comprehensive list of data sources that the State is connecting to or interfacing with, including a description of the data types and information associated with each source (including data sources that are used as primary verification methods or are used when information is not reasonably compatible). ***AND*** Brief description of how verifications will be conducted in the following areas: residency, citizenship and immigration status, incarceration, household income, family/household size, whether an individual is an Indian, enrollment in an eligible employer-sponsored plan (if applicable), eligibility for qualifying coverage in an eligible employer-sponsored plan, and eligibility for non-employer-sponsored minimum essential coverage. If applicable, describe any of the verifications listed above that may require the support of Federal agencies.	
3.6	The Exchange has the appropriate privacy protections and capacity to accept, store, associate, and process documents received from individual applicants and enrollees electronically, and the ability to accept, image, upload, associate, and process paper documentation received from applicants and enrollees via mail and/or fax.							
3.6a	The Exchange has the appropriate privacy protections and capacity to accept, store, associate, and process documents received from applicants and enrollees electronically.							

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3.6b	The Exchange has the appropriate privacy protections and capacity to accept, image, upload, associate, and process paper documentation received from applicants and enrollees via mail and/or fax.							
3.7	The Exchange has the capacity to determine individual eligibility for enrollment in a QHP through the Exchange and for employee and employer participation in the SHOP. In addition, the Exchange has the capacity to assess or determine eligibility for Medicaid and CHIP based on Modified Adjusted Gross Income (MAGI).							
3.7a	The Exchange has the capacity to determine individual eligibility for enrollment in a QHP through the Exchange.							
3.7b1	The Exchange has the capacity to determine eligibility for Medicaid and CHIP based on MAGI. ***OR***							
3.7b2	The Exchange has the capacity to assess eligibility for Medicaid and CHIP based on MAGI.							
3.7c	The Exchange has the capacity to determine eligibility for employee and employer participation in SHOP.							
3.7d	The Exchange has the capacity to accept and process applications that have been transferred from other agencies administering Insurance Affordability Program(s).							

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3.8	The Exchange has the capacity to determine eligibility for Advance Payments of the Premium Tax Credit (APTC) and Cost Sharing Reductions (CSR), including calculating maximum APTC, independently or through the use of a Federally-managed service.						*If the Exchange is using Federally-managed Services:* Provide a description of the end-to-end process, including activities conducted by the Exchange and integration points with the Federally-managed service.	
3.9	The Exchange has the capacity to independently send notices, as necessary, to applicants and employers pursuant to 45 CFR 155, subpart D that are in plain language, address the appropriate audience, and meet content requirements.							
3.10	The Exchange has the capacity to accept applications and updates, conduct verifications, and determine eligibility for individual responsibility requirement and payment exemptions independently or through the use of Federally-managed services.						*If the Exchange is using Federally-managed Services*: Provide brief description of the end-to-end process, including activities conducted by the Exchange and integration points with the Federally-managed service.	
3.11	The Exchange has the capacity to support the eligibility appeals process and to implement appeals decisions, as appropriate, for individuals, employers, and employees.							
3.12	The Exchange and SHOP have the capacity to process QHP selections and terminations in accordance with 45 CFR 155.400 and 155.430, compute actual APTC, and report and reconcile QHP selections, terminations, and APTC/advance CSR information in coordination with issuers and CMS. This includes exchanging relevant information with issuers and CMS using electronic enrollment transaction standards.							
3.12a	The Exchange has the capacity to process QHP selections and terminations using electronic enrollment transaction standards in coordination with issuers and CMS.							

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3.12b	The Exchange has the capacity to compute actual APTC.							
3.12c	The Exchange has the capacity to report and reconcile QHP selections, terminations, and APTC/advance CSR information in coordination with issuers and CMS.							
3.12d	The SHOP has the capacity to process QHP selections and terminations, including reporting and reconciling selection and termination information.							
3.13	The Exchange has the capacity to electronically report results of eligibility and exemption assessments and determinations, and provide associated information to HHS, IRS, and other agencies administering Insurance Affordability Programs, as applicable. This includes information necessary to support administration of the APTC and CSR as well as to support the employer responsibility provisions of the Affordable Care Act.							
3.14	In accordance with section 155.345(i) of the Exchange Final Rule, the Exchange must follow procedures established in accordance with 45 CFR 152.45 related to the Pre-Existing Condition Insurance Plan (PCIP) transition.							
4.0 Plan Management								
If applying for Plan Management Partnership, the appropriate State entity, rather than the "Exchange," will complete this section.								
4.1	The Exchange has the appropriate authority to perform the certification of QHPs and to oversee QHP issuers consistent with 45 CFR 155.1010(a).						Citation of the State's applicable statutory and/or regulatory authority(ies).	

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4.2	The Exchange has a process in place to certify QHPs pursuant to 45 CFR 155.1000(c) and according to QHP certification requirements contained in 45 CFR 156.						Brief description of how the Exchange will ensure that the issuers and health plans meet each of the QHP certification standards. Include the process that the Exchange will use to evaluate issuers and health plans against each of the QHP certification standards, including any differences specific to SHOP. ***AND*** Brief description of entities responsible for QHP certification and briefly describe the roles and responsibilities of each entity as they relate to each of the QHP certification standards. ***AND*** Brief description of the integration between the Exchange and the State Department of Insurance.	
4.2a	The Exchange has the capacity to certify QHPs in advance of the annual open enrollment period pursuant to 45 CFR 155.1010(a) (1).							
4.2b	The Exchange has the capacity to ensure QHPs comply with the QHP certification standards contained in 45 CFR 156 including, but not limited to, standards relating to licensure, solvency, service area, network adequacy, essential community providers, marketing and discriminatory benefit design, accreditation, and consideration of rate increases.							

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4.2c	The Exchange has the capacity to collect, analyze, and if required, submit to the Federal government for review QHPs' plan variations for cost-sharing reductions, advance payment estimates for such reductions, and any supporting documentation needed to ensure compliance with applicable regulations and accuracy of the cost-sharing reduction advance payments.							
4.2d	The Exchange has the capacity to ensure QHPs meet actuarial value and essential health benefit standards in accordance with applicable regulations and guidance.							
4.2e	The Exchange has the capacity to ensure QHPs' compliance with market reform rules in accordance with applicable regulations and guidance.							
4.3	The Exchange uses a plan management system(s) or processes that support the collection of QHP issuer and plan data; facilitate the QHP certification process; manage QHP issuers and plans; and integrate with other Exchange business areas, including the Exchange Internet Web site, call center, quality, eligibility and enrollment, and premium processing.						Brief description of the anticipated number of health plans expected to participate in the Exchange. ***AND*** Brief description of the collection method and applicable systems that will be used to support the business operations of Plan Management.	
4.3a	The Exchange has the capacity to collect and analyze information on plan rates, covered benefits, and cost-sharing requirements pursuant to 45 CFR 155.1020.							
4.3b	The Exchange has the capacity to use plan rate data and rules for purposes such as generating consumer-facing premiums and determining the second-lowest cost silver plan for premium tax credit calculations.							

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4.4	The Exchange has the capacity to ensure QHPs' ongoing compliance with QHP certification requirements pursuant to 45 CFR 155.1010(a)(2), including a process for monitoring QHP performance and collecting, analyzing, and resolving enrollee complaints.						Brief description of approach to ensuring QHP compliance and monitoring of QHP performance, including any integration between Exchange and other State entities.	
4.4a	The Exchange has the capacity to ensure QHPs' ongoing compliance with QHP certification requirements pursuant to 45 CFR 155.1010(a) (2) and Exchange operational requirements.							
4.4b	The Exchange has a process to monitor QHP performance and to collect, analyze, and resolve enrollee complaints in conjunction with any applicable State entities (e.g., State Department of Insurance, consumer assistance programs, and ombudsmen).							
4.5	The Exchange has the capacity to support issuers and provides technical assistance to ensure ongoing compliance with QHP issuer operational standards.						Description of issuer technical assistance and support activities to be provided by the Exchange and examples where applicable.	
4.6	The Exchange has a process for QHP issuer recertification, decertification, and appeal of decertification determinations pursuant to 45 CFR 155.1075 and 155.1080.						Brief description of the process for transitioning enrollees to new QHPs in the event of a QHP decertification, including any differences specific to SHOP. ***AND*** Brief description of general approach for decertification, recertification, and appeals of decertification.	
4.6a	The Exchange has a process for recertification of QHP issuers and QHPs including the annual receipt and review of QHP rate,							

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	benefit, and cost sharing information pursuant to 45 CFR 155.1020(c).							
4.6b	The Exchange has a process for decertification of QHPs and QHP issuers and a process for transitioning enrollees into new QHPs pursuant to 45 CFR 155.1080.							
4.6c	The Exchange has a process for the QHP issuer appeal of a decertification of a QHP pursuant to 45 CFR 155.1080 and any necessary appeal of QHP certification determinations consistent with any applicable State laws or regulations.							
4.7	The Exchange has set a timeline for QHP issuer accreditation in accordance with 45 CFR 155.1045. The Exchange also has systems and procedures in place to ensure QHP issuers meet accreditation requirements (per 45 CFR 156.275) as part of QHP certification in accordance with applicable rulemaking and guidance.							
4.8	The Exchange has systems and procedures in place to ensure that QHP issuers meet the minimum certification requirements pertaining to quality reporting and provide relevant information to the Exchange and HHS pursuant to Affordable Care Act 1311(c)(1), 1322(e)(3), and as specified in rulemaking.							
5.0 Risk Adjustment and Reinsurance								
Additional requirements for Risk Adjustment will be provided in the HHS Notice of Benefit and Payment Parameters."								
5.1	The State has the legal authority to operate the risk adjustment program per 45 CFR 153 and Affordable Care Act 1343, if the State chooses to administer its own risk adjustment program.							

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5.1a	*If applicable:* **<Insert government agency or other entity name>** will be overseeing the risk adjustment program. This risk adjustment entity must meet the requirements outlined in 45 CFR 155.110 and can include Departments of Insurance (DOIs). Note: The entity cannot be a health insurance issuer. Options include DOI, Medicaid, or "Other Entity."						*If the State plans to administer its own risk adjustment program*: Indicate the entity(s) that will be operating the risk adjustment program, and provide a brief description.	
5.2	The State operates its own reinsurance program per 45 CFR 153 and Affordable Care Act 1341.							
5.2a	*If applicable:* The reinsurance entity will be a not-for-profit entity and will have the legal authority and capacity to receive self-insured market reinsurance contributions from HHS, determine payment amounts, distribute payments, and perform data collection and auditing functions regarding reinsurance payments.							
5.2b	*If the entity collects contributions in the fully insured market in the State*: The reinsurance entity will have the legal authority and capacity to identify all issuers in the State's fully insured market that owe reinsurance contributions, determine appropriate contribution amounts from issuers, and ensure the collection of reinsurance contributions.						Brief description of how the State's reinsurance entity intends to collect contributions from the fully insured market and identify sub-contractors that will be involved in collecting contributions from the fully insured market. *Note*: State must inform HHS of its intent to collect contributions from the fully insured market no later than December 1, 2012. HHS will collect contributions from the self-insured market.	

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5.2c	*If the State opts to modify the Federal reinsurance parameters, collect reinsurance contributions in the fully-insured market, collect additional reinsurance contributions, modify HHS requirements for data collection or collection frequency for issuers receiving reinsurance payments, and/or use more than one reinsurance entity:* The State will publish its reinsurance modifications in a State notice of benefit and payment parameters by March 1, 2013.						Timeline under which the State will submit its modifications in the State notice of benefit and payment parameters.	
6.0 Small Business Health Options Program (SHOP)								
6.1	The SHOP is compliant with regulatory requirements pursuant to 45 CFR 155 Subpart H.						Brief description of how the size of a small business is determined in the Exchange and whether the small group market includes employers with 51 to 100 employees in 2014 and 2015.	
6.1a	The SHOP has capacity to allow a qualified employer to select a level of coverage as described in the Affordable Care Act 1302(d) (1), in which all QHPs within that level are made available to the qualified employees of the employer.							
6.1b	The SHOP has capacity to ensure that all QHP issuers make rate changes at a uniform time that is either quarterly, monthly, or annually, and has the capacity to prohibit all QHP issuers from varying rates for a qualified employer during the employer's plan year.							
6.1c	The SHOP has capacity to offer small employers only QHPs that meet the requirements for the State's small group market.							

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6.1d	If the SHOP decides to implement minimum participation requirements, the SHOP has capacity to authorize uniform group participation rules for the offering of health insurance coverage in the SHOP.							
6.1e	The SHOP has established a premium calculator, as described in 45 CFR 155.205(b) (6), to facilitate the comparison of available QHPs after the application of any applicable employer contribution in lieu of any advance payment of the premium tax credit and any cost-sharing reductions.							
6.2	The Exchange has the capacity for SHOP premium aggregation pursuant to 45 CFR 155.705.							
6.2a	The Exchange has the systems in place for billing employers, receiving employer and employee contributions toward premiums, and making aggregated premium payments to issuers.							
6.2b	The Exchange has a process for managing non-payment or late premiums; including how and when notices are sent to employers.							
6.3	The SHOP Exchange has the capacity to electronically report information to the IRS for tax administration purposes.							

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7.0 Organization and Human Resources								
7.1	The Exchange has an appropriate organizational structure and staffing resources to perform Exchange activities.						Organizational chart ***AND*** Brief description of the hiring strategy that addresses competencies, roles, and responsibilities needed to perform key Exchange activities.	
7.1a	The Exchange has an organizational structure that includes leadership/key staff and encompasses key Exchange activities.							
7.1b	The Exchange has a hiring strategy that addresses competencies, roles, and responsibilities needed to perform key Exchange activities.							
8.0 Finance and Accounting								
8.1	The Exchange has a long-term operational cost, budget, and management plan.						Brief description of the methods the Exchange will use to generate revenue and how the Exchange will address any financial deficits. ***AND*** Model budget entailing expected operating costs, revenues, and expenditures.	
8.1a	The Exchange has a long-term operational budget and management plan, monitors its finances, and is able to track its costs and revenues.							

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8.1b	The Exchange has defined methods for generating revenue (e.g., user fees) pursuant to Affordable Care Act 1311(d) (5) (A), and has the appropriate legal authority.							
9.0 Technology								
9.1	The Exchange technology and system functionality complies with relevant HHS information technology (IT) guidance.						Brief description of any areas of significant variation between Exchange technology and system functionality and HHS IT guidance.	
9.2	The Exchange has the adequate technology infrastructure and bandwidth required to support all of the Exchange activities.							
9.3	The Exchange effectively implements IV&V, quality management, and test procedures for Exchange-development activities and demonstrates it has achieved HHS-defined essential functionality for each required activity.						Brief description of the front-end system engineering work including IT, quality assurance processes and IV&V services used to validate requirements, business processes and development of the Exchange.	
10.0 Privacy and Security								
10.1	The Exchange has established and implemented written policies and procedures regarding the Privacy and Security standards set forth in 45 CFR 155.260(a) – (g).							
10.2	The Exchange has established and implemented safeguards that (1) ensure the critical outcomes in 45 CFR 155.260(a) (4), including authentication and identity proofing functionality, and (2) incorporates HHS IT requirements as applicable.							
10.3	The Exchange has adequate safeguards in place to protect the confidentiality of all Federal information received through the Data Services Hub, including but not limited to Federal tax information.							
10.3a	The Exchange has adequate safeguards in place to protect the							

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	confidentiality of all Federal information received through the Data Services Hub, including but not limited to Federal tax information.							
10.3b	The Exchange has developed and received a letter of acceptance from the IRS on its Safeguard Procedures Report related to the protection of Federal tax information.							
11.0 Oversight and Monitoring								
11.1	The Exchange has a process in place to perform required activities related to routine oversight and monitoring of Exchange activities (and will supplement those policies and procedures to implement regulations promulgated under the Affordable Care Act 1313).						Brief description of the oversight and monitoring plan for the Exchange, including any specific protocols for quality monitoring of Exchange activities (e.g., Eligibility and Enrollment, Plan Management).	
11.1a	The Exchange has in effect policies and procedures for performing routine oversight and monitoring of Exchange activities.							
11.1b	The Exchange has in effect quality controls as part of oversight and monitoring of Exchange activities.							
11.2	The Exchange has the capacity to track and report performance and outcome metrics related to Exchange Activities in a format and manner specified by HHS necessary for, but not limited to, annual reports required by Affordable Care Act 1313(a).						Brief description of data-collection and reporting processes and Exchange activity-related performance metrics that the Exchange intends to track for internal purposes as part of ongoing quality controls and improvement plan.	

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11.3	The Exchange has instituted procedures and policies that promote compliance with the financial integrity provisions of Affordable Care Act 1313 (and will supplement those policies and procedures to implement regulations promulgated under the Affordable Care Act 1313), including the requirements related to accounting, reporting, auditing, cooperation with investigations, and application of the False Claims Act.						Indicate the financial or accounting standards with which the Exchange is in compliance (e.g., Government Accounting Standards Board, Government Accountability Office (GAO) Government Auditing Standards (Yellow Book), OMB Circular A-123 "Management's Responsibility for Internal Control").	
12.0 Contracting, Outsourcing, and Agreements								
12.1	The Exchange has executed appropriate contractual, outsourcing, and partnership agreements with vendors and/or State and Federal agencies for all Exchange activities and functionality as needed, including data and privacy agreements. Exchange contracting entities meet the requirements for eligible contracting entities outlined in 45 CFR 155.110.						List of all contractor(s) with which Exchange has contracted and a notation of the services that the contractor(s) will support.	
13.0 State Partnership Exchange Activities								
13.1	The State has appropriate agreements in place to operate the Plan Management activities for a State Partnership Exchange.							
13.1a	The State and applicable entities have agreed to a process for timely plan management data submission in the specified format to the Federally-facilitated Exchange.							
13.1b	The State and applicable entities have signed and agreed to adhere to the terms and conditions of all necessary agreement(s) required to carry out required Exchange activities.							
13.1c	The State and applicable entities have agreed on a process for coordination with Federally-facilitated Exchange account managers and oversight.							

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13.2	The State has the capacity to interface with the Federally-facilitated Exchange, as necessary, to ensure a seamless consumer experience.							
13.2a	The State and the applicable State agencies have the capacity to conduct necessary coordination with the Exchange regarding customer service, outreach, and education.							
13.2b	The applicable State agencies have the capacity to share data with the Exchange that is needed to support the eligibility process for Insurance Affordability Programs.							
13.3	The appropriate State entity has appropriate agreements in place and capacity to manage and operate a Navigator program and to establish and operate an in-person assistance program for a State Partnership Exchange.							
13.3a	The appropriate State entity has established or has a process in place to support, administer, and oversee (as applicable) aspects of the Federally-facilitated Exchange Navigator program consistent with the applicable requirements of 45 CFR 155.210, including ensuring that Navigators are adhering to the training and conflict of interest standards established by the Federally-facilitated Exchange and to the privacy and security standards developed by the Federally-facilitated Exchange pursuant to 45 CFR 155.260.						Brief description of the appropriate State entity's plan to operate a Navigator program, including how it will ensure Navigators are appropriately trained and meet the Federally-facilitated Exchange's conflict of interest, privacy and security standards.	
13.3b	The appropriate State entity has established an in-person assistance program distinct from the Navigator program, and has a process in place to operate the program consistent with Federally-facilitated Exchange guidance, policies, and procedures.						Brief description of the appropriate State entity's plan to operate an in-person assistance program including documentation outlining how it will meet the requirements set out in Federally-facilitated Exchange guidance, policies, and procedures.	

Relevant File Uploads

The following files should be uploaded as applicable. Files should be clearly labeled with the appropriate activity(ies). Depending on the Exchange activity being tested, a given document or file may encompass multiple activities. In such cases, please note any file cross-referencing and clearly label the activities within the attachments. States do not need to upload the same file multiple times.

Testing Files	Browse
Supporting Documentation	Browse
Letter(s) from HHS allowing an applicant to waive out of any supporting documentation and/or testing file requirements given successful completion of an activity through Establishment Review(s)	Browse
Expected Completion Work Plan and Timeframes	Browse
Please provide any additional comments related to completion of this Application	