BLUEPRINT FOR APPROVAL OF AFFORDABLE STATE-BASED EXCHANGES – FAQS

Below are the Frequently Asked Questions (FAQs) regarding key revisions to the 'Blueprint Application for Approval of State-based Health Insurance Exchanges on or after January 1, 2019.'

Note: The Blueprint Application for Approval of State-based Health Insurance Exchanges on or after January 1, 2019 updates the previous version of the Blueprint application and is effective for state elections to operate a State-based Exchange on or after the start of the 2019 coverage year.

Q1: What is the Exchange Blueprint application?

A1: States seeking to operate a State-based Exchange (SBE) or a State-based Exchange on the Federal Platform (SBE-FP) must receive approval or conditional approval from the U.S. Department of Health and Human Services (HHS). The Exchange Blueprint is the mechanism that the Centers for Medicare & Medicaid Services (CMS) uses to make the determination of approval or conditional approval and is comprised of two parts:

- An Exchange Model Declaration of Intent Letter from the state's Governor.
- Attestations that a state has met, or will meet, all legal and operational requirements associated with the Exchange model that the state intends to operate. States will also agree to demonstrate operational readiness to execute Exchange activities and functions.

Q2: Why is CMS releasing a new Exchange Blueprint application and why is this important?

A2: CMS published the first Exchange Blueprint application in 2012. The application was approved via the Paperwork Reduction Act (PRA). Since 2012, CMS has updated the Exchange Blueprint to reflect the evolution of Exchanges and Exchange models, and changes to Exchange program and Exchange model requirements, obtaining PRA review and approval as necessary. This revised Exchange Blueprint ensures that any states seeking to operate an SBE or SBE-FP for coverage years beginning on or after January 1, 2019 have the continued ability to apply through the Blueprint application. This revised Blueprint application began its first public comment period (60 days) on April 4, 2018. The second comment period (30 days) began on August 27, 2018. Final PRA approval for the revised Blueprint application was received November 2, 2018.

Additionally, the revised Blueprint is intended to reduce burdens on states wishing to apply to become an SBE or an SBE-FP. For example, states may find the revised Blueprint's attestation-based approach easier and more streamlined.

Finally, in furtherance of CMS's goal to give states more flexible options to craft solutions that address the unique circumstances of their markets, the revised Blueprint is designed to work in conjunction with the State Relief and Empowerment Waivers (also referred to as section 1332 waivers or State Innovation Waivers) to give states options. As stated in CMS guidance,[1] some waiver options may be easier to implement for states with SBEs. In addition, a state could seek waivers that would allow the functions and

[1] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/SRE-Waiver-Fact-Sheet.pdf

offerings of the Exchange in the state to be tailored to the state's waiver plan as many requirements applicable to Exchange functions and activities are waivable under section 1332.

Section 1332 of the Patient Protection and Affordable Care Act (PPACA) permits states to request waivers of certain requirements governing Exchanges under federal law to pursue innovative strategies for providing its residents with access to high quality, affordable health insurance. In addition, this Blueprint makes several improvements that will make the Blueprint application process less burdensome for states seeking to become SBEs or SBE-FPs.

Q3: What is new in the Exchange Blueprint application?

A3: The revised Blueprint application establishes two separate applications for coverage years beginning on or after January 1, 2019. There is one application for SBEs and one application for SBE-FPs. The revised Blueprint application incorporates the following updates to make the process easier for states:

- Reflects current State Exchange model options (SBE or SBE-FP) program requirements.
- Includes updates based on regulatory requirements promulgated through the 2017, 2018, and 2019 Payment Notices, as well as through the Marketplace Stabilization Rule.
- Replaces the requirement for document and evidence submissions with attestations across all sections to further reduce burden.
- Discontinues the Blueprint submission requirement for states that wish to work in partnership with the Federally-facilitated Exchange to conduct plan management activities in its state, formerly known as the State Partner Exchange (SPE) model.

CMS also updated the Blueprint to more closely align with the CMS Center for Consumer Information and Insurance Oversight (CCIIO) Exchange Establishment Review Process, which provides guidance and monitors a state's implementation and execution of the required Exchange activities described in the Blueprint.

Q4: Which states need to complete and submit the revised Blueprint application?[2]

A4: States seeking to operate an SBE or SBE-FP for coverage years beginning on or after January 1, 2019 and who do not already have a conditionally-approved or approved Blueprint must submit the revised Blueprint application to CCIIO. CMS will provide technical assistance to states that have previously submitted a Blueprint application and are seeking to transition to a SBE or SBE-FP model to understand which sections or attestations require updating. States are not required to submit a Blueprint application to have an FFE operate in the state.

States seeking to operate an SBE-FP will be required to sign CMS's SBE-FP Agreement (see Appendix B for the version of the SBE-FP Agreement that existed at the time this document was published). This is a mutual agreement that is executed between an SBE-FP and CMS when the SBE-FP elects to operate an SBE-FP. The SBE-FP will rely on the federal platform (FP) to carry out certain Exchange functions, including eligibility and enrollment and the maintenance of the related information technology, call center operations, and casework support. The SBE-FP will maintain and assume various obligations across

[2] Appendix A provides an illustrative representation of the Exchange models and associated Blueprint roadmap.

various operational areas to be detailed in the FP Agreement, including compliance with Exchange standards, a user fee collected by CMS from SBE-FP issuers, and various Federal standards otherwise applicable to participation in the FFEs. SBE-FPs must maintain applicable Exchange standards under 45 CFR §155.200.

States that previously received approval or conditional approval to operate as SPEs are not required to update their Blueprint application and should work closely with CCIIO's Marketplace Plan Management Group (MPMG) regarding participating in plan management activities in partnership with CMS. While the formal SPE model that required a Blueprint application is no longer offered, HHS continues to offer states the option to take part in plan management activities. States should also refer to the annual CMS Letter to Issuers in FFEs[3] for additional guidance on state engagement in FFE plan management activities.

Any FFE state that wishes to begin participating in plan management activities in partnership with CMS should contact CCIIO's MPMG at PlanManagementStateCoordination@cms.hhs.gov.

Q5: What is an SBE-FP Federal Platform User Fee and how does CMS collect this fee?

A5: While an SBE-FP is responsible for activities such as certifying qualified health plans (QHPs), providing oversight of issuers, managing assister programs, and providing stakeholder outreach and education, the SBE-FP relies on FFE information technology systems and its consumer call center to perform eligibility and enrollment functions. Accordingly, under 45 CFR §156.50(c)(2), CMS charges all issuers offering QHPs through SBE-FPs a user fee for the portion of federal platform services and benefits provided to the issuer, and is based upon effectuated enrollments at the issuer payee level. CMS can either collect user fees from the SBE-FP or directly from SBE-FP issuers, per SBE-FP preference. Please visit the following link for further guidance: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/SBE-FP-User-Fee-Technical-Guidance.pdf.

Q6: Do states that previously received HHS conditional-approval or approval to operate an SBE or SBE-FP and intend to continue to operate as an SBE or SBE-FP need to complete and submit the revised Blueprint application?

A6: No. States that previously received HHS conditional approval to operate an SBE or SBE-FP and are continuing with existing operations are not required to complete the revised Blueprint application. However, SBEs or SBE-FPs that already have a conditionally-approved Blueprint and wish to transition to an SBE-FP or SBE, respectively, must submit an updated Declaration of Intent letter, and submit an update to their Blueprint application after consulting with CMS within the timelines in accordance with 45 CFR 155.105 and 45 CFR 155.106. Additionally, a conditionally-approved or approved SBE or SBE-FP that intends to make significant modifications to its operations for any subsequent plan years must, in accordance with 45 CFR 155.105, modify its Blueprint application and receive approval from HHS. For example; if a state changes the entity that had legal authority to operate the SBE or SBE-FP in the state, then the state must submit an updated:

- Exchange Model Declaration of Intent Letter from the state's Governor; and a
- Blueprint application to demonstrate that the new Exchange will meet the Exchange requirements.

Q7: When completing the revised Blueprint application to operate as an SBE or SBE-FP, can states leverage any previously completed sections from a prior Blueprint application?

[3] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Letter-to-Issuers.pdf

A7: Yes. While the requirements in the revised Blueprint application are similar to those in the initial Blueprint application, some requirements have changed to reflect current regulations and guidance. Since Exchanges are required to comply with current requirements, States should contact and work with their CCIIO State Officer (SO) to determine which elements of a previous Blueprint submission may be used in future Blueprint submissions.

States that previously received approval or conditional approval to operate as a SPE are not required to update their Blueprint application and should work closely with CCIIO's Marketplace Plan Management Group (MPMG) for all requirements associated with participating in plan management activities in partnership with CMS. Any FFE state that wishes to begin participating in plan management activities should contact CCIIO's MPMG at PlanManagementStateCoordination@cms.hhs.gov.

Q8: When is the Blueprint application submission deadline?

A8: As set forth in the HHS Notice of Benefit and Payment Parameters for 2019[4], CMS has set new Blueprint application deadlines for coverage years beginning on or after January 1, 2019.

1. A State electing to seek approval of its SBE must submit:
   - A completed SBE Blueprint application for HHS approval **at least 15 months prior** to the date on which the Exchange proposes to begin open enrollment as an SBE.
   - Have in effect an approved, or conditionally approved, Exchange Blueprint and operational readiness assessment **at least 14 months prior** to the date on which the Exchange proposes to begin open enrollment as an SBE.
2. A State electing to seek approval of its SBE-FP must submit:
   - A completed SBE-FP Blueprint application for HHS approval **at least three months prior** to the beginning of an SBE-FP's first open enrollment, or any significant changes to its conditionally-approved Blueprint application at least three months prior to the date on which the Exchange proposes to begin open enrollment as an SBE-FP.
   - Have in effect an approved, or conditionally-approved, Exchange Blueprint and operational readiness assessment **at least two months prior** to the date on which the Exchange proposes to begin open enrollment as an SBE-FP.

Prior to a state's Blueprint application submission, CCIIO will work closely with the state through a series of consultations.

Q9: Does the revised Blueprint application still require states to submit a Declaration of Intent Letter, as well as attest to the completion of Exchange activities?

A9: Yes. A state seeking to operate an SBE or SBE-FP for coverage years beginning on or after January 1, 2019, will be required to declare the type of Exchange model it intends to pursue through an Exchange Declaration of Intent Letter as part of its Exchange Blueprint application. States are encouraged to submit their Exchange Declaration of Intent Letters early, however CMS has generally recommended that states submit this letter no later than 21 months prior to the beginning of an SBE's proposed first open

[4] https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-07355.pdf

enrollment and no later than nine months prior to the beginning of an SBE-FP's proposed first open enrollment. States should consult with CCIIO for further guidance as needed.

In addition, individual(s) designated in the Declaration of Intent Letter (the Designee[s]) must attest, on behalf of the state, to either completion or expected completion of Exchange activities outlined in the Blueprint relevant to the Exchange model for which the state is applying. Applicants will attest to either completion or expected completion at the activity level, as well as the accuracy of the information submitted for the entire Blueprint submission.

Q10: When will the Blueprint application be available online?

A10: The Blueprint application is available online via SERVIS at https://portal.cms.gov.[5] States must complete and submit their Blueprint application online through SERVIS. SERVIS is the only mechanism through which HHS accepts the Blueprint application. CMS provides states a PDF version of the Blueprint application on an offline basis only as a planning tool to help SBE and SBE-FP states prepare their Blueprint submission.

Q11: What technical assistance does CCIIO provide to ensure states successfully meet the Blueprint application submission deadline?

A11: CCIIO works very closely with each state to ensure proper submission of their Blueprint application and all required documents. This includes regular state calls, topic-specific state user groups where CCIIO provides technical assistance, and implementation and/or operational readiness reviews to monitor and provide guidance to states. States should also look to the Health Insurance Marketplace Weekly Update newsletter published by CCIIO's SMIPG and on SERVIS for the most up-to-date information. SERVIS is a user-friendly, state-facing web portal that provides technical assistance resources related to all aspects of Exchange implementation.

Q12: Is there Section 1311 grant funding available to states electing to become an SBE or SBE-FP?

A12: No. Section 1311 grant funding is no longer available to states to establish an SBE or SBE-FP. HHS will continue to work closely with states that wish to transition to either model.

Q13: If a State has questions about the Exchange Blueprint, who is the appropriate contact person?

A13: The state's State Officer (SO) at CCIIO is the point of contact for all questions related to the Exchange Blueprint submission. General questions may be directed to SMIPG at SBMOversight@cms.hhs.gov for information about technical assistance consultations, and resources available to states on the Exchange Blueprint process.

Q14: If a State has questions about State Relief and Empowerment Waivers or Section 1332 waivers, who is the appropriate contact person and where can I find more information?

A14: State Relief and Empowerment Waivers under section 1332 of the PPACA represent an exciting opportunity for states, and we stand ready to help states pursue waivers. CMS encourages states that are interested in section 1332 waivers to contact CCIIO to discuss goals and to receive technical assistance if they are interested in submitting a waiver application and have questions. Interested parties may send an email to StateInnovationWaivers@cms.hhs.gov for more information.

[5] States must have an active Enterprise Identity Management (EIDM) Portal and SERVIS accounts to access the Blueprint application.

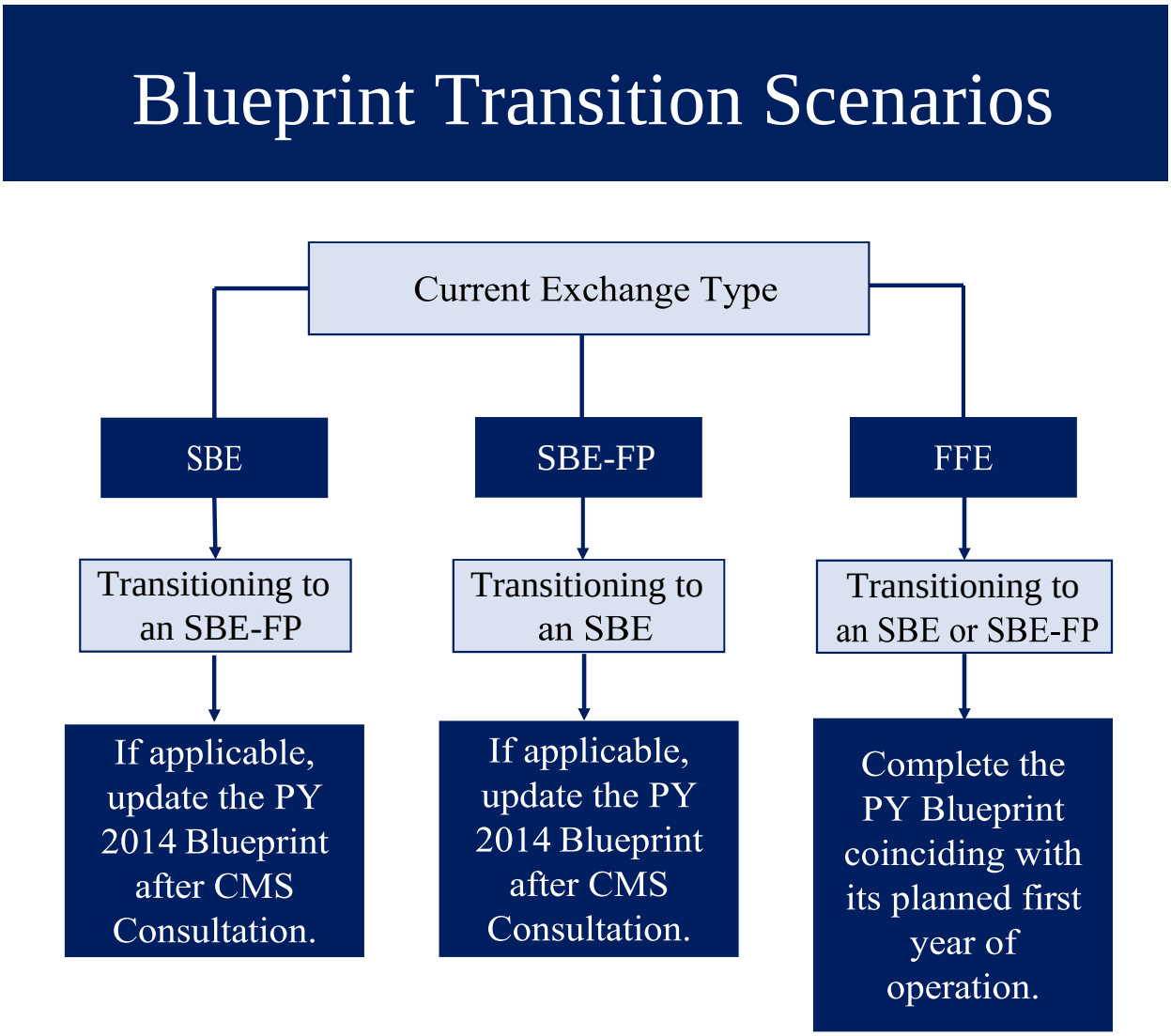
States can also find more information on the requirements for section 1332 waivers, regulations, and state applications on the CCIIO website: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html

Q15: What is a Section 1332 Waiver or State Relief and Empowerment Waiver?

A15: Under section 1332 of the PPACA, a State can apply for a State Innovation Waiver, allowing the state to implement innovative ways to provide access to quality health care so long as coverage under the waiver is at least as comprehensive and affordable as would be provided under the PPACA absent the waiver, coverage is provided to a comparable number of residents of the state as would be provided absent a waiver, and the waiver does not increase the Federal deficit.

APPENDIX A: BLUEPRINT TRANSITION SCENARIOS

The figure below is an illustrative representation of the Exchange models and associated Blueprint roadmap.



APPENDIX B:

EXAMPLE FEDERAL PLATFORM AGREEMENT[6]

FEDERAL PLATFORM AGREEMENT

No. 2016-01 BETWEEN

DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE & MEDICAID SERVICES
AND
STATE-BASED EXCHANGES ON THE FEDERAL PLATFORM

I. PURPOSE, LEGAL AUTHORITIES, DEFINITIONS, EXCHANGE BLUEPRINT

A. Purpose

THIS FEDERAL PLATFORM ("FP") **AGREEMENT** ("Agreement") is entered into by and between an entity operating a State Exchange on the Federal platform (SBE-FP) and THE CENTERS FOR MEDICARE & MEDICAID SERVICES ("CMS"), as the
entity responsible for management and oversight of the Federally-facilitated Exchanges ("FFEs"), including the Federally-facilitated Small Business Health Options Programs ("FF-SHOPs") and the Federal eligibility and enrollment platform upon which certain State-based Exchanges ("SBEs") rely to carry out various Exchange functions. CMS and the SBE-FP each are hereinafter referred to as a "Party" or, collectively, the "Parties."

This Agreement establishes the mutual obligations of the SBE-FP and CMS when the SBE-FP elects to operate a State-based Exchange on the Federal Platform ("SBE-FP"). The SBE-FP will rely on the Federal eligibility and enrollment platform to carry out certain Exchange functions, including eligibility and enrollment, and the maintenance of the related information technology, call center operations, and casework support. SBE-FP will maintain and assume various obligations across various operational areas to be detailed in this Agreement, including compliance with Exchange standards, a user fee collected by CMS from SBE-FP issuers, and various Federal standards otherwise applicable to participation in the FFEs. SBE-FP must maintain applicable Exchange standards under 45 CFR §155.200.

B. Legal Authorities

This Agreement is executed to implement certain health care reform provisions of the Patient

[6] This version of the SBE-FP Agreement was the one in use at the time these FAQs were published. Terms are subject to change.

Protection and Affordable Care Act (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and referred to collectively as the Affordable Care Act (ACA) and the regulations and guidance promulgated thereunder, including 42 CFR Parts 431, 435, 457, and 45 CFR Parts 155, 156, and 157.

1. Section 1311 of the ACA establishes the requirement that each State shall establish an Exchange that meets certain minimum functions.

2. 45 C.F.R. § 155.106 establishes relevant processes and timelines for States, especially States operating SBE-FPs, to submit or update Exchange Blueprints, submit declaration letters.

3. 45 C.F.R. § 155.200 establishes that an eligible SBE may rely on Federal services that the Federal government agrees to provide under a Federal platform agreement to meet its obligations under 45 C.F.R. §155.200(a).

4. 45 C.F.R. § 155.220(l) extends the FFE agent and broker standards established under 45 C.F.R. § 155.220 to agents and brokers who assist with enrollments through SBE-FPs.

5. 45 C.F.R. § 155.260 establishes privacy and security requirements for Exchanges and for "Non-Exchange Entities," as defined at 45 C.F.R. 155.260(b)(1), and to which SBE-FPs must adhere.

6. 45 C.F.R. § 155.1200 establishes standards for Exchange program integrity and oversight, including various accounting, reporting, and external auditing requirements.

7. 45 C.F.R. § 155.1210 establishes standards for the maintenance of various Exchange documents, records, and other evidence of accounting procedures and practices, namely that an Exchange, its contractor, subcontractors, and agents maintain the same for a period of 10 years.

8. 45 C.F.R. § 156.50(c)(2) establishes that HHS will charge issuers participating in the SBE-FP market in the State a user fee for the services and benefits provided by the FFE.

9. 45 C.F.R. § 156.122(d)(2) establishes the requirement for a QHP to make available published, up-to-date, accurate, and complete formulary drug list on its website in a format and at times determined by HHS.

10. 45 C.F.R. § 156.230 establishes the minimum criteria for network adequacy that health and dental plan issuers must meet to be certified as QHPs, including SADPs, in accordance with the Secretary's authority in section 1311(c)(1)(B) of the Affordable Care Act.

11. 45 C.F.R. § 156.235 – establishes various general requirements and alternative standards applicable to essential community providers. SBE-FPs have an obligation to ensure oversight and enforcement of this provision against their issuers.

12. 45 C.F.R. § 156.298 – establishes standards for ensuring that QHPs are meaningfully different from one another. SBE-FPs have an obligation to ensure oversight and enforcement of this provision against their issuers.

13. 45 C.F.R. § 156.330 – establishes that issuers must communicate to HHS any changes of ownership along with their agreement to adhere to all applicable statutes and regulations. SBE-FPs have an obligation to ensure oversight and enforcement of this provision against their issuers.

14. 45 C.F.R. § 156.340(a)(4) establishes standards related to QHP issuer compliance and compliance of delegated and downstream entities. SBE-FPs have an obligation to ensure oversight and enforcement of this provision against their issuers.

15. 45 C.F.R. § 156.1010 – establishes FFE case work standards, which SBE-FPs have an obligation for overseeing and enforcing against their issuers.

16. 45 C.F.R. § 155.200(f)(3) – establishes that HHS will work collaboratively with the SBE-FP to ensure that FFE issuer standards are enforced directly against the issuers or plans that do not meet them, and provides that HHS has the authority to suppress a plan from displaying under 45 C.F.R. § 156.815 in that event.

17. 45 C.F.R. § 156.350 – establishes that QHP issuers that participate in SBE-FPs must comply with certain HHS regulations and guidance pertaining to issuer eligibility and enrollment functions as if the issuer were offering QHPs through an FFE.

C. Definitions

1. "ACA" means Patient Protection and Affordable Care Act (Public Law No. 111- 148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152) (collectively, the ACA).

2. "Agent" or "broker" has the meaning set forth at 45 CFR 155.20.

3. "APTC" means advance payments of the premium tax credit allowable in Section 36B of the Internal Revenue Code (as added by Section 1401 of the Affordable Care Act) which are provided on behalf of an eligible individual enrolled in a Qualified Health Plan through an Exchange in accordance with Section 1402 of the Affordable Care Act.

4. "Assister" means an individual or organization acting as a Navigator, non- Navigator assistance personnel, certified application counselor designated organization, or certified application counselor.

5. "Certified application counselor" or "CAC" means a staff member or volunteer of a certified application counselor designated organization who is certified by either an Exchange or the certified application counselor designated organization to perform the duties and meet the standards and requirements for CACs in 45 C.F.R. § 155.225.

6. "Certified application counselor designated organization" or "CDO" means an organization designated by an Exchange to certify its staff members or volunteers to act as CACs.

7. "CMS" means the Centers for Medicare & Medicaid Services.

8. "CSR" means cost-sharing reductions for an eligible individual enrolled in a silver level plan through an Exchange or for an individual who is an Indian enrolled in a QHP through an Exchange.

9. "Eligibility Determination" means the determination of eligibility for enrollment in a Qualified Health Plan through an Exchange (without APTC or CSR), for an Insurance Affordability Program, or for certifications of exemption from the requirement to maintain minimum essential coverage or the individual shared responsibility payment. The term "Eligibility Determination" includes initial assessments and determinations for Medicaid, mid-year and annual Redeterminations, and Renewals, and any appeal process related to an Eligibility Determination. In a SHOP, the term "Eligibility Determination" means a determination of employer eligibility to purchase coverage through the SHOP.

10. "Eligibility Verification" means any verification completed or information obtained in order to determine that an applicant is eligible for enrollment in a QHP through an Exchange as described in 45 CFR 155.315.

11. "Enrollee" has the meaning set forth at 45 CFR 155.20.

12. "Exchange" means an American Health Benefit Exchange established under Sections 1311(b), 1311(d), or 1321(c)(1) of the ACA, including both State-based Exchanges (SBEs) and FFEs.

13. "Exchange Blueprint" has the meaning set forth at 45 CFR 155.20.

14. "Federal eligibility and enrollment platform," "Federal platform," and "FP" mean the Federal eligibility and enrollment functionality and related information technology infrastructure to complete eligibility and enrollment related functions,

including but not limited to the HealthCare.gov Web site, the Federal call center, the Health Insurance Casework System (HICS), and direct enrollment functionality.

15. "Federal platform agreement" has the meaning set forth at 45 CFR 155.20.

16. "Federally-facilitated Exchange" or "FFE" has the meaning set forth at 45 CFR 155.20.

17. "Federally-facilitated SHOP" or "FF-SHOP" has the meaning set forth at 45 CFR 155.20.

18. "Hub" or "Federal Data Services Hub" is the CMS Federally-managed service to transmit data between Federal and State-based Entities carrying out functions in relation to Eligibility Determinations and reporting related to enrollment in QHPs or in Insurance Affordability Programs, and to interface with Federal agency partners and data sources.

19. "Insurance Affordability Programs" means (1) the program under title I of the ACA that makes available coverage in a Qualified Health Plan through an Exchange with or without APTCs or CSRs; (2) a Medicaid program under title XIX of the Social Security Act; (3) a Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act; and (4) a program under Section 1331 of the ACA establishing qualified basic health plans.

20. "Medicaid" means the health insurance program established under Title XIX of the Social Security Act and is one of the Insurance Affordability Programs.

21. "Navigator" has the meaning set forth at 45 CFR 155.20.

22. "Non-Navigator assistance personnel" means an entity or individual that is not a Navigator and that has been authorized by an Exchange to carry out consumer assistance functions under 45 CFR §155.205(d) and (e).

23. "PII" or "personally identifiable information" is defined by OMB Memorandum M-07-16 (May 22, 2007) and refers to information which can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

24. "Qualified Health Plan" or "QHP" means an insurance plan that is certified by an Exchange in each State in which it is sold as meeting the applicable standards, including, providing essential health benefits, following established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and satisfying other requirements.

25. "Redetermination" means the process by which an Exchange or a Basic Health Program makes an Eligibility Determination for an Enrollee in one of the following circumstances: (1) on an annual basis prior to an Exchange open enrollment period; (2) on a periodic cycle (e.g., 12 months) tied to the date of the application; and/or (3) when an individual communicates an update to an Exchange that indicates a change to the individual's circumstances affecting their eligibility.

26. "Renewal" means the annual process for an Enrollee to be considered for continued coverage in a QHP.

27. "SHOP" has the meaning set forth at 45 CFR 155.20.

28. "SBE" or "State-based Exchange," means an Exchange established and operated by a State under Section 1311(b)(1) of the ACA.

29. "Web-broker" means an agent or broker who uses its own website, or that of another agent or broker, to facilitate enrollment through an FFE or SBE-FP.

D. Exchange Blueprint ("Blueprint")

The SBE-FP will receive approval or conditional approval to operate an SBE-FP through the Blueprint process set out at 45 CFR §155.106(c), and meet its obligations under §155.200(a) by entering into this Agreement. This Agreement must be executed to receive CMS approval of the SBE-FP's Blueprint.

The SBE-FP's election to rely on the Federal platform to operate an individual market Exchange, SHOP, or both as an SBE-FP will be documented in its Blueprint submission, and this Agreement shall be executed as part of the Blueprint approval process in order for the SBE-FP to operate as an SBE-FP for a given coverage year. This must occur in accordance with applicable timelines under §155.106(c).

This Agreement incorporates by reference relevant Blueprint sections and Exchange policies applicable to the various operational areas herein, including eligibility and enrollment, consumer assistance, plan management, program integrity and oversight and monitoring, SHOP, technology, and privacy and security.

II. FEDERAL SERVICES AND MUTUAL OBLIGATIONS

A. Customization

At this time, the Federal services and resources listed below, which are made available to the SBE-FP through the Federal platform, come as a bundled package. That is, CMS does not offer a "menu" of Federal services from which the SBE-FP may select certain services, but not

others, in order to customize to meet particular State needs. The SBE-FP may specify, however, that it will rely on the Federal platform for individual market Exchange functions, SHOP functions, or both.

B. Eligibility & Enrollment (*Blueprint Section 3.0*) and Consumer Assistance (*Blueprint Section 2.0*). The following provisions apply regardless of whether the SBE-FP relies on the federal platform for individual market functions, SHOP functions, or both:

1. The SBE-FP will rely on the Federal platform to provide for Eligibility Determinations and to facilitate enrollment in QHPs.

2. Issuers

For an SBE-FP that transitioned from an SBE that did not rely on the Federal platform, the SBE-FP is responsible for ensuring issuers offering plans through the SBE-FP are prepared to transition to the Federal platform for the coverage year in which the SBE-FP will begin operations as an SBE-FP, and communicating to these issuers the requirements for onboarding to the Federal platform for the purposes of exchanging enrollment data with CMS.

This includes communicating to issuers the requirements around issuer electronic data interchange (EDI) registration and testing with the Federal platform, as well as communicating associated CMS training opportunities for issuers. These requirements can be found at the CMSzONE Issuer Community at: https://zone.cms.gov/document/edi-onboarding-form-and-instructions- connectivity-testing. SBE-FPs and issuers can establish registration for this community via the CMS Enterprise Identity Management System (EIDM) at: https://portal.cms.gov/. CMS training opportunities for issuers can be found at: www.RegTap.info. SBE-FPs and issuers are able register at this site via: https://www.regtap.info/register.php. Lastly, SBE-FPs should also direct their issuers to e-mail the CMS Issuer Communications distribution list (CMS_Issuer_Communications@cms.hhs.gov) to receive regular CMS communications to issuers.

3. Federal Call Center

As part of the SBE-FP's reliance on the Federal platform, the SBE-FP will rely on the Federal call center to provide telephonic consumer support to consumers applying for, and enrolling in, coverage through the SBE-FP.

4. Toll-Free Hotline

By leveraging the Federal call center, the SBE-FP satisfies the requirement to operate a toll-free call center, if it, at a minimum, operates a toll-free telephone hotline to respond to requests for assistance to consumers in the SBE-FP, in accordance with §1311(d)(4)(B) of the ACA. This includes having the capability to provide information to consumers and appropriately direct them to the Federal call center or HealthCare.gov to apply for, and enroll in, QHP

coverage.

5. Internet Web Site

As part of the SBE-FP's reliance on the Federal platform, the SBE-FP will rely on HealthCare.gov, the Federally-provided consumer-facing Web site, to provide the information technology infrastructure to enable consumers to receive eligibility determinations and enroll in QHPs. While the SBE-FP will rely on HealthCare.gov, it must at a minimum operate an informational Internet Web site in accordance with §1311(d)(4)(C) of the ACA. This includes having the capability to provide information to consumers and direct them to HealthCare.gov to apply for, and enroll in, QHP coverage.

6. Casework

Due to the nature of cases that involve the Federal platform, CMS will handle consumer casework that is not the responsibility of the issuer and will also ensure that issuers are resolving cases according to Federal laws, regulations and guidance. Cases will be entered in the Federally-operated Health Insurance Casework System (HICS) and will be routed to appropriate entities, including issuers. Thus, CMS will enter cases into HICS and assign cases to the relevant issuer, as appropriate. The SBE-FP's role will be to enforce the Federal casework standards in 156.1010 (further guidance is provided at https://www.cms.gov/CCIIO/Resources/Regulations-and- Guidance/Downloads/casework-guidance-03132014.pdf) with respect to issuers participating in the SBE-FP. SBE-FPs may accomplish this through coordination with the state regulatory authority. As with all other Exchange models, State regulatory authorities will continue to handle appropriate consumer complaints related to issuers in their States.

7. Assisters

The SBE-FP will maintain responsibility for working with Assisters in the SBE- FP, as set forth below:

a. Navigators

The SBE-FP maintains full responsibility for establishing, funding, and operating its Navigator grant program in accordance with §1311(d)(4)(K) and §1311(i) of the ACA. Specifically, the SBE-FP must ensure that Navigators complete any required SBE training(s) and comply with all applicable statutory and regulatory requirements, including §1311(i) of the ACA, 45 C.F.R. §155.205(d)-(e), 45 C.F.R. §155.210, and 45 C.F.R. §155.260(b).

b. Non-Navigator Assistance Personnel

If the SBE-FP opts to have a Non-Navigator Assistance Personnel program, the SBE-FP maintains full responsibility for program operations, as well as for selecting and ensuring the proper training of all Non- Navigator Assistance Personnel in the SBE-FP. Specifically, the SBE-FP must ensure that Non-Navigator Assistance Personnel complete any required SBE

training(s) and comply with all applicable regulatory requirements, including 45 C.F.R. §155.205(d)-(e), 45 C.F.R. §155.215 (if applicable), and 45 C.F.R. §155.260(b).

c. CACs and CDOs

The SBE-FP maintains full responsibility for its CAC program, including for designating CDOs and for ensuring that all CACs in the SBE-FP are certified, either by certifying staff and volunteers of CDOs directly, or by designating CDOs to certify their staff and volunteers, or by a combination of both approaches. Specifically, the SBE-FP must ensure, either directly or through CDOs, that CACs complete required SBE-approved training(s) and comply with all applicable regulatory requirements, including 45 C.F.R. §155.225.

Navigators and other Assisters in SBE-FPs are encouraged to use FFE resources for Assisters, such as FFE Assister training content, webinars, newsletters, and other resources on Marketplace.cms.gov. Navigators, Non-Navigator assistance personnel, CDOs, and CACs in SBE-FPs may sign up for the CMS Assister listserv by emailing assisterlistserv@cms.hhs.gov and writing "add to listserv" in the subject line.

As part of the SBE-FP's responsibility to operate an informational Internet Web site and to maintain responsibility (as described above) for its Assister programs, the SBE-FP will maintain a tool on its website for consumers to use to find local Assisters for help applying for and enrolling in coverage. HealthCare.gov's Find Local Help tool will direct consumers to this SBE-FP-developed and operated tool.

8. Agents and Brokers

The SBE-FP maintains responsibility for ensuring that agents and brokers in the SBE-FP complete the applicable FFE training and registration requirements under 45 C.F.R. § 155.220 and any required State-specific training(s), requirements under 45 C.F.R. §155.260(b), as well as comply with State licensure requirements.

Once the agent or broker completes those requirements, they will be provided the option to display their information on HealthCare.gov's Find Local Help tool for consumer assistance applying for and enrolling in coverage.

Additionally, CMS provides public access to the Agent and Broker Registration Completion List which may be used only for the following purposes:

a. To confirm that an agent or broker has successfully completed registration requirements for the FFE or SBE-FP for the individual market and/or the SHOP; and

b. To allow States and other stakeholders to conduct oversight, monitoring and enforcement activities related to agents and brokers, and to educate consumers about agents and brokers who may provide assistance to consumer who are

interested in obtaining health care coverage through the FFE or SBE-FP in their States.

The SBE-FP is responsible for operating an informational Internet Web site and to maintain certain responsibilities (as described above) and direct consumers to HealthCare.gov's Find Local Help tool. A redirect to the SBE- FP may be available if the SBE-FP has developed supplemental consumer support tools that list only those agents and brokers who appear on the CMS Registration Completion List.

9. Coordinated Outreach

The SBE-FP will coordinate closely with CMS to develop an outreach strategy to identify what – if any – outreach the SBE-FP will conduct for current enrollees, as well as new consumers looking to gain new coverage. These activities will include identifying all stakeholders. (e.g., current Exchange enrollees, general population, tribes), potential outreach and education campaigns (e.g., paid media, digital, grassroots), and other activities. CMS may also conduct Federal outreach campaigns, including geo-targeted messaging on FFE social media channels throughout open enrollment.

C. Additional Eligibility & Enrollment (*Blueprint Section 3.0*) and Consumer Assistance (*Blueprint Section 2.0*) for an Individual Market SBE-FP

1. An Individual Market SBE-FP will also rely on the Federal platform for the following:

a. Processing applications for consumers to apply for coverage in a QHP, an Insurance Affordability Program, or for certifications of exemption from the requirement to maintain minimum essential coverage or the individual shared responsibility payment.

For an SBE-FP that transitioned from an SBE that did not rely on the Federal platform, all existing QHP enrollees must re-apply and re-enroll for coverage through HealthCare.gov, the Federal call center, or by mail to continue their QHP coverage in the coverage year within which the SBE begins operations as an SBE-FP. Applicants also may apply with in- person assistance or, in an individual-market SBE-FP, through a QHP issuer or web-broker using the direct enrollment pathway;

b. Annual Renewals and Redeterminations beginning from the end of the coverage year within which the SBE begins operations as an SBE-FP;

c. Notices and data matching, including Form 1095-A generation and corrections for only those coverage years for which the SBE operates as an SBE-FP (will not include any 1095-A corrections for SBE years);

d. Eligibility Verifications beginning from the coverage year within which the SBE begins operations as an SBE-FP (the SBE is responsible resolving/expiring open inconsistencies for all prior years when the SBE did not rely on the federal platform);

e. Eligibility Determinations for enrollment in a QHP through the SBE-FP;

f. Eligibility for Special Enrollment Periods from the coverage year within which the SBE begins operations as an SBE-FP (the SBE is responsible for processing any Special Enrollment Periods for all prior years when the SBE did not rely on the federal platform)

g. Eligibility Determinations for APTC and CSR from the coverage year within which the SBE begins operations as an SBE-FP (the SBE is responsible for eligibility determinations for all prior years when the SBE did not rely on the federal platform);

h. Eligibility assessment or determination of eligibility for Medicaid and CHIP from the coverage year within which the SBE begins operations as an SBE-FP (the SBE is responsible for eligibility determinations for all prior years when the SBE did not rely on the federal platform);

i. Employer notifications;

j. Enrollment in QHP coverage; and

k. Eligibility appeals beginning in the coverage year within which the SBE begins operations as an SBE-FP.

2. Connect to the Non-Employer Sponsored Insurance (Non-ESI) Minimum Essential Coverage (MEC) HUB service via the State Medicaid Agency.

The SBE-FP understands that the Medicaid agency in its State must have sufficient technology to ensure that the Medicaid agency can connect to the non- ESI MEC Hub service for the FFE to check Medicaid/CHIP enrollment as appropriate.

3. Federal Data Services Hub (Hub)

The SBE-FP must ensure it has all appropriate connectivity to the Hub to meet its obligations under paragraph 5(a) of this section II.C., as applicable, and meets all privacy and other related contractual agreements referenced in this Agreement.

4. Special Enrollment Periods

While the SBE-FP maintains legal authority to administer special enrollment periods (SEPs) in the SBE-FP, due to operational limitations of leveraging the Federal platform, SBE-FPs agrees to set SEPs in a manner consistent with those set by the FFEs at 45 CFR 155.420. Further information about the SEPs that are currently available in the FFEs under 45 CFR 155.420 can be found at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html. This list is subject to change.

5. Reporting

An SBE-FP that transitioned from an SBE that did not rely on the Federal platform must maintain responsibility for, or designate its issuers to fulfill, the following reporting requirements:

a. IRS Reporting

The SBE-FP must ensure proper reporting to the IRS for all coverage years prior to the transition, which may include retrospective monthly or annual reporting to the IRS.

b. CMS Monthly Enrollment & Payment Data Workbook Reporting

The SBE-FP must ensure that it (or its issuers) submit any outstanding CMS monthly enrollment and payment data workbook reporting to CMS for all coverage years) prior to the transition, to support CMS payments of APTCs to the issuers that provided coverage to APTC-eligible consumers. The SBE-FP may either submit the reporting itself or designate its QHP issuers to submit this reporting.

c. CMS Policy Level Enrollment Reporting

The SBE-FP must ensure proper and timely reporting to CMS for all coverage years prior to the transition.

6. Data Sharing

CMS will disclose data to the SBE-FP that is necessary for the SBE-FP to fulfill its responsibilities described under its Blueprint Application, including consumer outreach and support, as described at 45 CFR Parts 155-157. This is currently described under the Information Disclosure Agreement (IDA), which establishes the terms, conditions, safeguards, and procedures under which CMS will disclose information to the SBE-FP.

The current IDA provides for Qualified Health Plan Selection Enrollment Data to be disclosed by CMS to the SBE-FP by zip code and other breakdowns. Should any indicator have less than twenty (20) individuals reported within a data cell, no number will be provided rather, a blank cell or other indicator will be used to safeguard against the identification of individuals, and to maintain compliance with all relevant provisions of the Privacy Act of 1974 (Title 5 U.S.C. § 552a) and its implementing regulations and guidance. CMS will disclose this data to the SBE-FP through a secure electronic process. Cumulative data for the 2016 coverage year will be

provided based on the most recent data available. The QHP Selection Enrollment Data will be provided on a monthly basis, beginning with QHP Selection Enrollment Data for coverage year 2016 and will continue for each coverage year as long as this Agreement is in effect.

CMS may provide the SBE-FP with additional data for the purposes of the SBE- FP fulfilling its responsibilities in the area of consumer assistance and outreach. Should such additional data be provided, the specific data elements, along with the uses of such data, would be specified through a new data-sharing agreement, or through an amendment to existing data-sharing agreements, between CMS and the SBE-FP.

D. Additional Eligibility & Enrollment (*Blueprint Section 3.0*) and Consumer Assistance (*Blueprint Section 2.0*) for an SBE-FP utilizing the Federal platform for SHOP Functions(*Blueprint Section 6.0*)

1. An SBE-FP utilizing the Federal platform for SHOP functions will also rely on the Federal platform for the following:

    1. SHOP Single Employer and Employee Applications;

For an SBE-FP that transitioned from an SBE that did not rely on the Federal platform for its SHOP, all existing employers participating in the SBE-FP must re-apply and re-enroll for group coverage through the enrollment and application processes applicable to Federally-facilitated SHOPs.

2. Employer and Employee Eligibility Determinations for enrollment in a QHP through the SBE-FP;

3. All employer and employee notices related to eligibility and enrollment for only those coverage years for which the SBE operates as an SBE-FP;

4. Eligibility Verifications beginning for the coverage year within which the SBE begins operations as an SBE-FP;

5. Employer participation in the SBE-FP, including implementation of employee choice, as applicable;

6. Employee enrollment in QHP coverage;

7. Employee Renewals beginning at the end of the coverage year within which the SBE-FP begins operations as an SBE-FP;

8. Setting Employer Annual Enrollment Periods;

9. Employee eligibility for Special Enrollment Periods;

10. Eligibility appeals beginning in the coverage year within which the SBE begins operations as an SBE-FP; and

11. Premium payment administration, as applicable

2. SBE-FPs utilizing the Federal platform for SHOP eligibility and enrollment functions must ensure that issuers of QHPs offered through the SBE-FP comply with CMS regulations and guidance pertaining to issuer eligibility and enrollment functions as if the issuer were an issuer of a QHP on an FF-SHOP, as described at 45 CFR 156.350(a).

3. SBE-FPs that elect to leverage the Federal platform for SHOP eligibility and enrollment system functions will implement SEPs for SHOP according to generally-applicable FF-SHOP regulations, guidance, and procedures.

4. Vertical Choice

For coverage years beginning on or after January 1, 2017, unless the SBE-FP decides under 45 CFR 155.705(b)(3)(x) against offering these options, employers participating in an SBE-FP utilizing the Federal platform for SHOP functions may elect to offer qualified employees a choice of all QHPs and/or stand-alone dental plans offered through the SBE-FP utilizing the Federal platform for SHOP functions by a single issuer across all available levels of coverage, as described at 45 CFR 155.705(b)(3)(viii)(C) and (ix)(C).

5. Reporting

For an SBE-FP that transitioned from previously operating as an SBE that did not rely on the FP, the SBE-FP must ensure proper SHOP reporting for all prior years when the SBE did not rely on the Federal platform. This includes IRS reporting so that the SBE-FP ensures proper reporting to the IRS for all coverage years prior to the transition, which may include retrospective monthly or annual reporting to the IRS.

6. Federal Data Services Hub (Hub)

The SBE-FP must ensure it has all appropriate connectivity to the Hub to meet its obligations under paragraph 5 above of this section II.D., as applicable, and meets all privacy and other related contractual agreements referenced in this Agreement.

E. Plan Management (*Blueprint Section 4.0*)

1. QHP Certification

The SBE-FP maintains primary responsibility for QHP certification, and must review and transmit data to CMS in accordance with applicable requirements, as detailed in the current

final Letter to Issuers in the Federally-facilitated Exchanges.

2. Issuer Standards

Although the SBE-FP maintains primary responsibility for certifying QHPs and overseeing QHPs and issuers, it has an obligation under §155.200(f)(2) to establish and oversee certain requirements for its QHPs and QHP issuers that are no less strict than the requirements that apply to QHPs and QHP issuers on an FFE. The SBE-FP has the flexibility to exceed the standards listed in 155.200(f)(2) to the extent that doing so does not create data display problems on HealthCare.gov.

3. Enforcement

Under §155.200(f)(3), CMS will work closely and collaboratively with the SBE- FP to ensure that the issuer standards in paragraph II.C.2 above are enforced directly against issuer or plans who do not meet them. In that circumstance, CMS has the authority to suppress a plan, which means temporarily making a QHP certified to be offered through the Federally-facilitated Exchange unavailable for enrollment through the Federally-facilitated Exchange. Because plan suppression relates to plan display on HealthCare.gov and the availability of plans for enrollment, the ability to suppress a plan is a fundamental element of the Federal eligibility and enrollment infrastructure and CMS also has the authority under this Agreement to suppress plans on the SBE-FP under any of the grounds provided for under 45 CFR §156.815, as applied to issuers in the SBE-FP.

F. Program Integrity and Oversight (*Blueprint Section 11.0*)

1. All SBE-FPs remain responsible for compliance with key Exchange oversight and program integrity activities under 45 CFR §§155.1200 and 155.1210. These regulatory requirements and other guidance mandate a defined set of oversight activities, including independent external financial and programmatic audits, to track and monitor how Exchanges, including SBE-FPs, are meeting applicable standards.

2. To meet these standards, the SBE-FP, like all SBEs, must submit an annual State- based Marketplace Annual Reporting Tool (SMART), and must participate in ongoing oversight activities and readiness reviews as required by CMS. The SBE-FP remains responsible for submitting a SMART for any coverage years

during which it operated as an SBE and did not rely on the Federal platform for its eligibility and enrollment activities. Submission of the SMART ensures sufficient documentation is provided to demonstrate that the SBE-FP has complied with these and other applicable regulatory requirements, and helps identify observations and potential action items. In its SMART submission, the SBE-FP must demonstrate that it completes various oversight and program integrity activities relevant to activities for which the SBE-FP does not rely on the federal platform, including but not limited to:

a. Attesting to the establishment of policies and procedures on discrimination safeguards, accessibility of information, and identification, adjudication and reporting of incidences of fraud and abuse, in addition to compliance with applicable State and Federal privacy and requirements;

b. Submitting an annual financial statement and independent external financial audit report identifying any material weaknesses or significant deficiencies and the corrective actions taken by the Exchange to address the auditor's findings;

c. Submitting an external programmatic audit that addresses relevant subparts of 45 CFR, Part 155, including at a minimum, 45 CFR, Part 155, Subparts C, D, E and K, for any coverage years during which it operated as an SBE and did not rely on the Federal platform. The external programmatic audit should also include any material weaknesses or significant deficiencies, and the corrective actions taken by the Exchange to address the auditor's findings;

d. Submitting an external programmatic audit that addresses relevant subparts of 45 CFR, Part 155 that are consistent with the SBE-FP's obligations under this agreement, including at a minimum, 45 CFR, Part 155, Subparts C and K. The external programmatic audit should also include any material weaknesses or significant deficiencies and the corrective actions taken by the Exchange to address the auditor's findings; and

e. Additional SMART requirements include completing an executive summary to highlight accomplishments and updating the oversight and monitoring plan.

3. As the SBE-FP relies on the Federal eligibility and enrollment services and information technology infrastructure, CMS does not expect the SBE-FP to report on or maintain data related to QHP and APTC/CSR eligibility determinations, enrollment and dis-enrollments.

G. User Fee

1. Under 45 CFR §156.50(c)(2), CMS will charge all issuers offering QHPs through the SBE-FP a user fee for the services and benefits provided by the FFE. The SBE-FP acknowledges that the proposed user fee rate has been calculated based on the proportion of FFE costs that are associated with services and benefits provided to the SBE-FP issuers, which include the Federal Exchange information technology and call center infrastructure used in connection with eligibility determinations for enrollment.

2. For the 2017 coverage year, issuers offering plans through an SBE-FP will be charged an amount equal to 1.5 percent of monthly premium charged by the issuer for each policy under a plan offered through an SBE-FP. Under the HHS Notice of Benefit and Payment Parameters for 2017, this user fee rate was calculated at 3.0 percent of premiums for issuers offering plans through an SBE-FP. However, HHS received a waiver from OMB of the requirement that this user fee cover HHS' full costs for 2017 and will charge one-half the user fee rate calculated for the 2017 coverage year to issuers offering QHPs through the SBE-FP for coverage year 2017.

3. HHS will charge the user fee to SBE-FP issuers by market. HHS recognizes the benefits of SBE-FPs operating their own plan management and customer support functions, and do not intend to limit the SBE-FPs' ability to generate revenue to support these functions.

4. Upon request by the SBE-FP, HHS will collect the user fees charged to SBE-FP issuers directly from the SBE-FP. HHS will invoice the SBE-FP an amount equal to the total user fee that would have otherwise been collected directly from SBE- FP issuers, on a monthly basis. If an SBE-FP makes such a request by December 1, 2016, HHS will implement a monthly process by which HHS will calculate the monthly user fee amount that would have otherwise been collected directly from SBE-FP issuers at the rate specified for each user-fee eligible issuer offering plans through the SBE-FP, based on the monthly premium and enrollments effectuated as of the end of the prior month, and will then invoice the SBE-FP for that total user fee charge.

In order to effectuate this arrangement, the SBE-FP will need to work with HHS to ensure that it (or a designated entity) completes CMS's Vendor Management onboarding process. In order to receive invoices and make payments for the 2017 coverage year, the SBE-FP (or a designated entity) must be established as a paying entity in HHS's payment systems, which include Healthcare Integrated General Ledger Account System (HIGLAS) and Pay.gov with a Taxpayer Identification Number (TIN) and Bank Verification Letter from the banking institution by December 15, 2016. To complete this process, please contact CMS at vendor_management@cms.hhs.gov. The SBE-FP will be held to the Federal government standards for timely invoice payments, as established by the Office of Financial Management of the Centers for Medicare and Medicaid Services (CMS) in HHS.

H. Technology (*Blueprint Section 9.0*)

As applicable, if an SBE-FP has not already decommissioned an existing eligibility and enrollment system and information technology infrastructure, it must develop and execute an Exchange Information Technology (IT Decommission Plan and IT Systems and Data Migration) strategy and accompanying plans to do so.

I. Privacy and Security (*Blueprint Section 10.0*)

CMS will oversee and monitor the SBE-FPs to comply with the applicable privacy and security standards pursuant to §155.260, including the applicable documentation that is required to be maintained to comply with the Minimum Acceptable Risk Standards for Exchanges (MARS-E).

The SBE-FP remains responsible for ensuring that all legal agreements are fully-updated, to include the Computer Matching Agreement (CMA), Information Exchange Agreement (IEA), and Interconnection Security Agreement (ISA).

III. SEVERABILITY

If any term or other provision of this Agreement is determined to be invalid, illegal or incapable of being enforced by any rule or law, or public policy, all other terms, conditions, or provisions of this Agreement shall nevertheless remain in full force and effect, provided that the operation of the SBE-FP and its reliance on the Federal platform contemplated under this Agreement hereby is not affected in any manner materially adverse to any Party. Upon such determination that any term or other provision is invalid, illegal or incapable of being enforced, the Parties hereto shall negotiate in good faith to modify this Agreement so as to effect the original intent of the Parties as closely as possible in an acceptable manner to the end that the transactions contemplated hereby are satisfied to the fullest extent possible.

IV. PERSONS TO CONTACT

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V. EFFECTIVE DATE, TERM, MODIFICATION, TERMINATION, SIGNATURES

A. Effective Date and Term

This Agreement becomes effective on November 1, 2016 and terminates on December 31, 2017.

B. Renewal

This Agreement may be renewed upon the mutual written consent of both parties for subsequent and consecutive one (1) year periods.

C. Modification

The Parties may modify this Agreement at any time by a written modification, mutually agreed to by both Parties.

D. Signatures

Date	[CCIIO POC]
Date	[SBE-FP CEO/Director]

FEDERAL PLATFORM AGREEMENT No. 2016-01 ADDENDUM

Updated: December 12, 2017

This ADDENDUM modifies in part and supplements the existing Federal Platform (FP) Agreement whether or not the Parties have previously entered into an FP Agreement.

A. Casework (*Section II. B. 6.*)

CMS encourages SBE-FPs to coordinate with applicable state regulatory authorities to tailor a casework oversight and enforcement process that best suits the state's needs.

B. Coordinated Outreach (*Section II. B. 9.)*

CMS and the SBE-FP will coordinate closely to develop an outreach strategy to identify what – if any – outreach the SBE-FP will conduct for current enrollees, as well as new consumers looking to gain new coverage. These activities will include identifying all stakeholders, (e.g., current Exchange enrollees, general population, tribes), potential outreach and education campaigns (e.g., paid media, digital, grassroots), and other activities. CMS may also conduct Federal outreach campaigns, including geo-targeted messaging on FFE social media channels throughout open enrollment. However, the SBE-FP will still be primarily responsible for developing and implementing a localized consumer outreach strategy.

C. Data Sharing (*Section II. C. 6.*)

The Information Disclosure Agreement (IDA) will serve as the final authority cataloguing the data to be shared with the SBE-FP to allow it to fulfill its responsibilities under the Blueprint Application, including consumer outreach and support, as described at 45 CFR 155-157. Such data may include personally identifiable information subject to relevant safeguards and procedures.

D. Small Business Health Options Program (SHOP) (*Section II. D.*)

On October 27, 2017, CMS published the proposed 2019 HHS Notice of Benefit and Payment Parameters,[7] that proposed additional flexibilities for states to meet Affordable Care Act SHOP eligibility and enrollment requirements, which SHOPs utilizing the Federal Platform for SHOP functions (i.e. Federally-facilitated SHOPs and states operating SBE-FPs for SHOP) would follow. Accordingly, the annual HHS Notice of Benefit and Payment Parameters will serve as the final authority detailing SHOP requirements and options for SBE-FPs.

E. User Fee (*Section II. G. 2.*)

The annual HHS Notice of Benefit and Payment Parameters will serve as the final authority detailing the annual user fee rate applicable to SBE-FP issuers from year to year. For additional guidance regarding the various user fee payment options and mechanisms, please see our *SBE-FP User Fee Collection Process – Technical Guidance for States.*[8]

[7] https://www.gpo.gov/fdsys/pkg/FR-2017-11-02/pdf/2017-23599.pdf

[8] Available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/SBE-FP-User-Fee-Technical-Guidance.pdf

F. State-Based Marketplace Annual Reporting Tool (*Section II. F. 2.*)

As specified in this section the FP Agreement, and in fulfillment of program integrity requirements at 45 CFR 155.1200 and 1210, the SBE-FP remains obligated to submit a State-based Marketplace Annual Reporting Tool (SMART) for each year that the state uses the Federal platform, and participate in ongoing oversight activities and readiness reviews as required by CMS.

G. Term and Renewal (*Sections V. A., B.*)

As applicable, pursuant to section V. A. & B. of the FP Agreement, the Parties hereby mutually consent to renew their Agreement for a five (5) year period, effective January 1, 2018, and terminating on January 1, 2023, subject to further addendums per changes in future regulation impacting the responsibilities of the Parties as detailed herein. In the absence of renewal, when a newly-transitioning SBE-FP and CMS enter into the FP Agreement for the first time, this modified term governs. This Agreement may be terminated upon the SBE-FP's transition to another Exchange model, in accordance with 45 CFR 155.106.
Neither this Agreement nor the activities of the SBE-FP contemplated by and under this Agreement shall be deemed or construed to create in any way any joint venture or agency relationship between CMS and the SBE-FP. Neither the SBE-FP, nor CMS is, nor shall either the SBE-FP or CMS hold itself out to be, vested with any power or right to bind the other Party contractually or to act on behalf of the other Party, except to the extent expressly set forth in PPACA and the regulations codified thereunder, including as codified at 45 CFR 155.

H. Modification (*Section V. C.*)

Pursuant to section V.C. of the FP Agreement, the SBE-FP and CMS hereby mutually consent to the modifications of the FP Agreement herein, including any supplementary information provided.