

Frequently Asked Questions on Allowable Uses of Section 1311 Funding for States in a State Partnership Marketplace or in States with a Federally-Facilitated Marketplace

Below are a number of Frequently Asked Questions (FAQs) about grant funding available to states in which the federal government will operate a Federally-facilitated Marketplace (FFM), including a State Partnership Marketplace (SPM), under Affordable Care Act Section 1311(a). These FAQs are applicable to the amended Funding Opportunity Announcement (FOA) released on November 30, 2012, (“Cooperative Agreement to Support Establishment of Affordable Care Act’s Health Insurance Exchanges¹”), and related 1311 funding, which can be found at www.grants.gov, under Catalog of Federal Domestic Assistance number 93.525.

These FAQs are considered general guidance only and are in no way guaranteeing approval of funding requests. All requests for funding are reviewed for allowability, allocability, and reasonableness and other requirements set forth in the funding announcement.

Q1: In a state in which the federal government will operate an FFM, including an SPM, what types of activities are allowable uses of 1311 funding?

A1: The list in the table below outlines generally allowable activities for the use of 1311 funds. This list is not exhaustive, but provides examples of potential activities. States are encouraged to consult with HHS regarding the use of 1311 funds for these and other activities associated with enabling a successful FFM.

Operational Area	State Activities
Consumer and Stakeholder Engagement and Support	<ul style="list-style-type: none"> • Develop a Marketplace stakeholder list and participate in stakeholder consultations, including tribal consultations, with HHS. • Compile and share with HHS information on any state licensure requirements impacting Navigators • Perform analysis necessary to develop policy options and decisions on the role of agents, brokers, and web brokers • Gather and share with HHS state contact and certification/ licensure information on agents/brokers • Share with HHS relevant state consumer assistance resources information • Under defined limits, perform consumer outreach and education • Gather and share state-specific content for FFM web portal with HHS
Plan Management	<ul style="list-style-type: none"> • Perform analysis necessary to develop policy options and decisions about health insurance market regulation • Compile and share with HHS and the Office of Personnel Management information on state efforts related to plan quality, issuer monitoring and oversight, and performance data

	<ul style="list-style-type: none"> • Support process to review Consumer-Operated and Oriented Plans (CO-OPs) for state licensing • Perform analysis necessary to support policy options and decisions regarding state-based standard population for actuarial value calculations • Engage with HHS regarding formal information collection process around complaints and fraud referrals
Risk Adjustment and Reinsurance	<ul style="list-style-type: none"> • Analysis and decision-making for reinsurance program policies • For states with Department of Health and Human Services (HHS) administered reinsurance and risk adjustment programs: <ul style="list-style-type: none"> ◦ Engage with HHS around reinsurance and risk adjustment planning and operation • For states that operate reinsurance: <ul style="list-style-type: none"> ◦ Assess and confirm appropriate legal authority to operate reinsurance ◦ Issue payment notice ◦ Support reporting for oversight and monitoring of reinsurance • For states that opt to collect additional reinsurance or administrative contributions, and/or use more than one reinsurance entity: <ul style="list-style-type: none"> ◦ Publish the modifications in the state notice of benefit and payment parameters
Small Business Health Options Program (SHOP)	<ul style="list-style-type: none"> • Gather and share with HHS information related to the state's small group market, and a state's preferences for collaboration with the Federally-facilitated SHOP (e.g. state definition of small employer)
Oversight, Monitoring & Reporting	<ul style="list-style-type: none"> • Provide information on types and format of states' issuer compliance data, issuer performance data, and other performance data necessary for oversight and monitoring • Preview, test, and participate in training on complaint tracking
Market Issues	<ul style="list-style-type: none"> • Gather and share with HHS information related to collaborative enforcement, market environment, and other model-specific implementation issues

Q2: If a state has acknowledged interest in performing plan management activities, what types of activities are allowable uses of 1311 funds?

A2: For states that have acknowledged interest in performing plan management activities, the list in the table below outlines generally allowable activities for the use of 1311 funds. This list is not exhaustive, but provides examples of potential activities. States must consult with HHS regarding the use of 1311 funds for these and other activities.

Operational Areas	State Activities
Legal Authority and	<ul style="list-style-type: none"> • Assess and confirm appropriate legal authority to operate a Plan

Governance	Management Partnership or perform plan management activities
Eligibility & Enrollment	<ul style="list-style-type: none"> • Develop Pre-existing Condition Insurance Program (PCIP) transition plan
Plan Management	<ul style="list-style-type: none"> • Coordinate the development of an agreement to support State-operated plan management functions with other state agencies as applicable • Determine and share with HHS information regarding the entity performing PM Partnership functions and governance structure • Develop and publish Qualified Health Plan (QHP) application, develop and implement a QHP certification process consistent with Federal requirements (including for stand-alone dental plans and CO-OPs), and collaborate with HHS throughout certification process • Develop an approach to ensure QHP issuers meet accreditation requirements • Collect and transmit issuer and plan data to HHS to support QHP certification and Marketplace operations • Collaborate with HHS during the plan preview period for issuers and develop a process for making necessary corrections to plan data • Develop day-to-day issuer account management activities, including serving as point of contact for issuer questions and issues related to QHP certification and responsibilities; managing communications with QHP issuers and the FFM related to Marketplace issues and monitoring; developing processes to resolve consumer complaints; and track and coordinate as necessary with FFM • Develop general approach to ensuring QHP compliance and monitoring QHP performance • Coordinate with the FFM on Marketplace operational oversight (i.e. compliance with Marketplace standards) and develop a process for taking compliance actions against QHP issuers when necessary • Develop notice of deficiency for QHP certification, and appeal notice for QHP recertification and decertification • Conduct other quality or performance monitoring at the discretion of the State. • Participate in consultations and other checkpoints with HHS • Develop a work plan for supporting issuers and providing TA • Create necessary plan management information technology (IT) systems and ensure connections are tested and operational
Oversight, Monitoring & Reporting	<ul style="list-style-type: none"> • Conduct routine oversight and monitoring of the state's PM activities • Track/report performance and outcomes metrics related to the state's PM activities

Q3: Does 1311 funding cover Marketplace costs for preparing to transition from a FFM model to an SPM or SBM?

A3: Yes, the November 30, 2012 FOA clarifies that §1311(a) grant funds allow states the flexibility to transition between Marketplace models over time. Per the FOA and the Blueprint for Approval of State-Based and State Partnership Insurance Exchanges² (<http://cciio.cms.gov/resources/factsheets/hie-blueprint-states.html>), published November 9, 2012, the state must develop a transition plan with HHS, comply with Marketplace Blueprint requirements, submit a Model Declaration Letter and Marketplace Blueprint Application on applicable timelines, and obtain approval or conditional approval from CCIIO 12 months before the start of the plan year.

Per guidance released October 5, 2012 (“Supplemental Guidance on Cost Allocation for Exchange and Medicaid IT Systems³” <http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/Key-Cost-Allocation-QAs-10-05-12.pdf>), as part of a transition from a FFM to a SBM model, states may apply for funding to invest in long-term creation of a modern eligibility system to be shared between a State-based Marketplace and the state Medicaid/ Children’s Health Insurance Program (CHIP). In this case, states must cost allocate funding appropriately between Medicaid, CHIP, and the Marketplace (see additional information in Q6 below). States may also have to allocate to human service programs if they have an integrated system. Please refer to 2 CFR Part 225, Cost Principles for State, Local, and Indian Tribal Governments (previously OMB Circular A-87) for additional guidance on cost allocation.

Q4: Can Section 1311 funding be used to support activities related to Medicaid/CHIP administrative, policy or systems activities involved in interfacing with an FFM?

A4: Per guidance released October 5, 2012 (“Supplemental Guidance on Cost Allocation for Exchange and Medicaid IT Systems⁴” <http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/Key-Cost-Allocation-QAs-10-05-12.pdf>), in a FFM or SPM state that has not declared its intent to transition to a SBM in 2015, SBM, Marketplace funds may not be used to improve systems or processes related to Medicaid/CHIP interfaces with the Federally-Facilitated Marketplace. This includes building systems designed to coordinate with the FFM, to manage applicant account, such as connecting with the hub and augmenting the federal call center.

Q5: What if a state, through modernizing their Medicaid/CHIP eligibility and enrollment system, is not ready to affirm its intent to build a State-Based Marketplace? If the State later opts to establish a State-based Marketplace and therefore request grant funds to make the transformation, does it allocate costs to the Marketplace grant in order to make that transformation?

A5: Yes, if a State opts to establish a State-based Marketplace later, Marketplace establishment funding would be available prospectively to transform systems, subject to approval from CMS, and assuming it is properly represented and characterized in the application for grant funding. However, please note that the availability of Marketplace establishment funding (and therefore ability to readjust cost allocation on a prospective basis taking that funding into account) is subject to certain timelines, and States will need to

make decisions about their intention to establish a State Marketplace along that timing in order to receive such funding.

¹This applies to what CMS refers to as the Affordable Care Act's Health Insurance Marketplaces

²This applies to what CMS refers to as the Affordable Care Act's Health Insurance Marketplaces

³This applies to what CMS refers to as the Affordable Care Act's Health Insurance Marketplaces

⁴This applies to what CMS refers to as the Affordable Care Act's Health Insurance Marketplaces