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Department of Health and Human Services

Centers for Medicare & Medicaid Services

Plan Management Blueprint – Exchange Business Architecture Supplement

Draft

Version 1.0

May 3, 2011

Foreword

The *Plan Management Blueprint – Exchange Business Architecture Supplement* provides the initial description of the business architecture for the Exchange Plan Management business area for use in discussions with states and federal partners. This document identifies and defines the major Plan Management business functions, processes, and services to be implemented by Exchanges. It is intended to provide preliminary information initially for grantees, does not constitute official guidance or policy, and is subject to change in the future.

The Centers for Medicare & Medicaid Services (CMS) has reviewed and accepted the *Plan Management Blueprint* as a foundational component of the Exchange Architecture in accordance with the CMS information technology (IT) governance process.

The CMS Deputy Chief Information Officer leads the development of this Architecture with the support of all components of the IT staff and contractors.

Any changes to the Exchange Architecture must be approved by the CMS Chief Information Officer.

Henry Chao Date
Deputy Chief Information Officer
Centers for Medicare and Medicaid Services

Record of Changes

Number	Date	Reference	A=Add, M=Modify, D=Delete	Description of Change	CR #
1	March 23, 2011	All	M/D	Draft v 0.6 for CMS/IRS review and comment	NA
2	May 3, 2011	All	M/D	Draft v 1.0 for State review	NA

CR: Change Request

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1. Introduction

The Patient Protection and Affordable Care Act of 2010[1] (hereafter simply the "Affordable Care Act") provides for each state to have a health insurance Exchange. An Exchange is an organized marketplace to help consumers and small businesses buy health insurance in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. Consumers seeking health care coverage will be able to go the health insurance Exchanges to obtain comprehensive information on coverage options currently available and make informed health insurance choices. By pooling consumers, reducing transaction costs, and increasing transparency, Exchanges create more efficient and competitive health insurance markets for individuals and small employers.

The Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) is responsible for providing guidance and oversight for the Exchanges. This responsibility includes defining business, information, and technical guidance that will create a common baseline and a set of standards for health insurance Exchange implementations. CMS will focus this guidance on the key tradeoffs and technology choices necessary to create interoperable and coordinated Exchange services between the federal government and the states. CMS has established the *Exchange Reference Architecture: Foundation Guidance*, Version 1.0, to provide the business architecture, information architecture, and technical architecture for the nationwide health insurance Exchange(s). The business architecture will be described in a series of business architecture blueprint supplements.

CMS is participating in a collaborative business analysis effort to generate business architecture blueprints for use in communicating Exchange operations to stakeholders and as the foundation for system design and development activities. A business architecture blueprint consists of detailed definitions of business processes, business services, and supporting data necessary to support the implementation of the services for each of the Exchange business areas. Blueprints provide a foundation for beginning detailed requirements as well as data and technical standards definition activities.

This *Plan Management Blueprint – Exchange Business Architecture Supplement* is the second business blueprint to provide states and federal agencies definitions of the major business functions, processes, and services to be implemented by Exchanges.

1.1 Purpose

This *Plan Management Blueprint – Exchange Business Architecture Supplement*, Version 1.0, describes the initial business architecture for the Plan Management business area. It identifies and defines the major Plan Management business functions, processes, and services for use in

[1] Public Law 111–148, Patient Protection and Affordable Care Act, March 23, 2010, 124 Stat. 119, http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html http://www.healthreform.gov/health_reform_and_hhs.html

discussions with the states and federal partners for implementing Exchanges. This blueprint is preliminary and is subject to change.

The business architecture blueprint is intended to facilitate discussions with states to establish a shared understanding of the major business functions, processes, and services to be implemented by Exchanges. This initial version is a work in progress that CMS will revise periodically to reflect improved understanding of the needs and functions, processes, and services to be implemented by Exchanges.

1.2 Scope

This document addresses the major business processes for the Plan Management business area, including the following:

- Establish Issuer and Plan Initial Certification and Agreement
- Monitor Issuer and Plan Certification Compliance
- Establish Issuer and Plan Renewal and Recertification
- Maintain Operational Data
- Process Change in Plan Enrollment Availability
- Review Rate Increase Justifications

This document does not address Plan Payment processes. Plan Payment processes will be addressed in the Financial Management Business Architecture supplement. In addition, the Plan Management blueprint represents a preliminary "point in time" analysis that may be superseded by future regulations and/or guidance.

This document also identifies and defines business services representing the Plan Management functionality to be performed by Exchanges and by stakeholders interacting with Exchanges. The Data Services Hub (hereafter simply the "Hub") provides supporting business services with federal agencies. CMS will document the Hub integration with other federal stakeholders in a separate Business Architecture supplement.

This document is limited to addressing Plan Management capabilities and services to be provided by the Exchange from the perspective of Exchanges. Subsequent versions of this document will capture results from discussions with states.

1.3 Intended Audience

This supplement is intended for use by state business and IT personnel who are developing Exchange implementations in the states, and for use by their federal counterparts who are developing federal capabilities to support state Exchange implementations.

The distribution of this document is available to all states; other federal agencies, including CMS, Internal Revenue Service (IRS), other stakeholders responsible for implementing state Exchanges or for interacting with Exchange Environments, and supporting contractors.

1.4 The Exchange Blueprints

The business blueprint communicates Exchange operations through process models illustrating the interactions and information exchanges among functional activities and stakeholders (e.g., states, federal agencies, insurers, and employers) performing those activities. These depictions provide the foundation for understanding Exchange business functions, capabilities, and information needs to support those functions and capabilities. These depictions also provide the foundation for understanding stakeholder relationships and information exchanges to facilitate coordination and agreement among stakeholders concerning their respective roles, responsibilities, and information exchange needs.

As part of the Exchange Business Blueprints, CMS has developed:

- Business process models[2] that comprise process flow illustrations and metadata for describing aspects of the models, including functional descriptions of the process flows, activities, and associated capabilities to enable IT development. These descriptions include high-level business needs that will form the basis of requirements.
- A Business Process Hierarchy derived through identification of higher-level Exchange business processes represented in the process models.
- Business Services derived through analysis of the stakeholder interactions and activities represented in the process models.

Blueprints are the primary vehicle for developing the business architecture viewpoints detailed in this Exchange Business Architecture supplement.

1.4.1 Overview of Business Process Model

CMS uses a business process model to organize Exchange business processes into categories (or tiers) of processes. The Exchange business process model provides a structured framework for grouping together business processes that have a common purpose and share data. Business processes within the business process model describe what the organization does and the results of those activities. The business process model identifies the hierarchical relationship among business areas and the underlying business processes comprising the business area.

Figure 1 illustrates the process model tiers adopted to identify the hierarchical relationship among Exchange business areas and related business processes. Business process categories at the top tier (Tier 1) are business areas. The lowest level of the hierarchy (Tier 3) simply identifies the business processes. Business processes are uniquely identified by a dark border surrounding the process box. The middle level of the hierarchy (Tier 2) identifies groupings or clusters of functionally aligned business processes. In some situations Tier 2 may include no groupings or clusters, in other situations Tier 2 may contain its own hierarchy of process

[2] Business Process Models do not include procedures, business rules, policy decisions, workflow, or performance standards.

groupings and clusters. For example, because of the relatively small number of business processes, the Plan Management business area has not defined any Tier 2 business groupings.

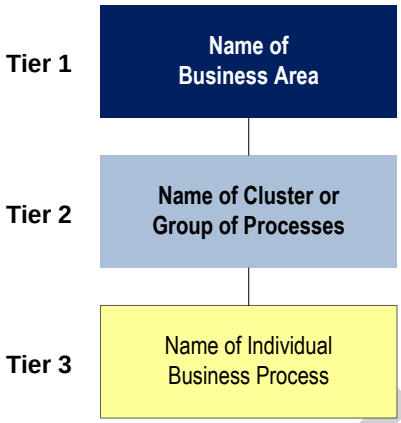

Figure 1. CMS Exchange Business Process Model

1.4.2 Overview of Business Services Model

Each business process identified in the business process model is further decomposed into a collection of business services. Figure 2 illustrates the two types of business services addressed in this supplement and relationships.

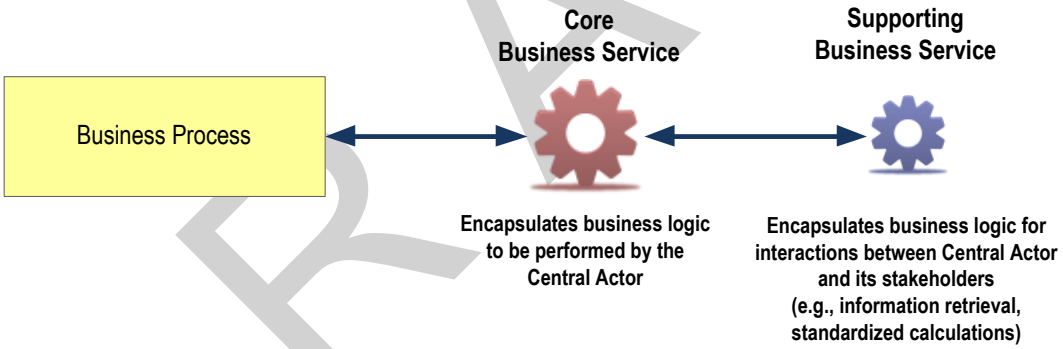

Figure 2. Business Services Model

Core business services (CBSs) encapsulate the business logic required by a business process that are performed by the Central Actor. The business logic needed by a business process may be provided in one or more core business services. Similarly, the business logic encapsulated in a core business service may be reused by multiple business processes. The collection of core business services associated with a business process is intended to represent the breadth of the business functionality and logic associated with the process. For instance, when the Exchange is the central actor, the collection of CBSs represents the breadth of business functionality performed by the Exchange. It is envisioned that Central Actors will implement core business services and leverage reuse opportunities to the maximum extent possible.

Supporting business services (SBSs) encapsulate the business logic for specific interactions between Central Actors and their stakeholders. Business logic performed by supporting business

services includes information retrievals, information transfers, and specific operations. Supporting business services perform the business logic needed by a business process through their association with core business services. Supporting business services may be utilized by multiple core business services. Similarly, the business logic encapsulated in a supporting business service may be reused by multiple core business services (and associated business processes). It is envisioned that Central Actors and stakeholders will agree on interoperability standards, and that stakeholders and Central Actors will work together to define, develop, and integrate supporting business services and leverage reuse opportunities to the maximum extent possible.

1.5 Additional Activities for Refinement of Plan Management Business Architecture

CMS invites feedback from states about the proposed Plan Management business architecture. In order to accomplish this, CMS and the states collaborating in the implementation of Exchanges will undertake the following activities:

- **Review** this document thoroughly
- **Engage** in discussions regarding approaches and integration points required to support the operation of a state Exchange (IRS, Issuers, State Departments of Insurance, etc.)
- **Identify** opportunities for business service reuse across state and federal health programs
- **Provide** feedback to CMS regarding proposed Exchange business architecture
- **Review and revise** business processes as follows:
    1. When comments from states and other stakeholders are available,
    2. When regulation development is complete, and
    3. When results from IT Innovator States are available.

CMS recognizes that effective guidance for service implementation will require more detailed business services specifications. Therefore, CMS invites feedback on the business processes and business services identified in this document. In particular, CMS seeks state feedback on the Data Services Hub functions and the supporting business services that the IRS will provide. This feedback will be valuable to CMS in the subsequent refinement of the concepts and capabilities described in this version.

1.6 Document Organization

This document is organized as follows:

Section		Purpose
Section 2:	Plan Management Business Area Overview	Presents an overview of the Plan Management business area and the envisioned stakeholder interactions supporting this business area.

Section		Purpose
Section 3:	Plan Management Business Process Model	Describes the Plan Management business processes.
Section 4:	Plan Management Information Model	Describes the Plan Management information needs.
Section 5:	Plan Management Business Services Model	Describes the business services enabling the Plan Management business processes and identifies services that are candidates for sharing within and across Exchanges.
Appendix A.	Representative Solicitation Data	Describes representative data for a qualified health plan solicitation.
Acronyms		Defines the acronyms used in this document.
List of References		Presents the references used in the preparation of this document.

2. Plan Management Business Area Overview

The Plan Management business area consists of business processes for acquiring, certifying, monitoring, renewing, and managing the withdrawal of qualified health plans and the issuers that offer these plans[3]. Plan Management consists of six major business processes (designated BP-PM:01, etc.) as shown in Figure 3.

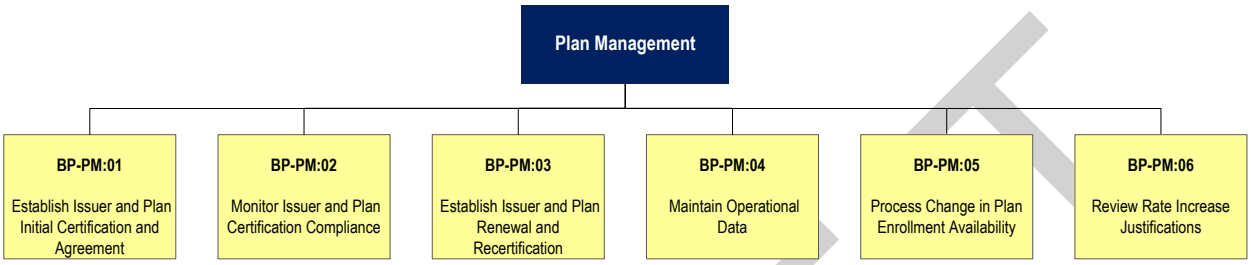

Figure 3. Plan Management Business Processes

The Plan Management business area encompasses the following activities performed by the Exchange:

- Certify/recertify/decertify plans offered by issuers as qualified health plans
- Establish agreements with the issuers to offer qualified health plans
- Assign and update plan quality ratings
- Collect rate information and review rate increase justifications
- Monitor agreements with issuers to ensure compliance
- Process changes in plan enrollment availability
- Maintain the operational data associated with issuers and plans.

Plan Management does not include plan payment flows, which will be addressed in the Financial Management business area. During the execution of these activities, the Exchange will both use information from and provide information to the issuers, the State Departments of Insurance (SDOI) and federal partners.

2.1 Roles & Responsibilities

Table 1 presents the preliminary primary roles and responsibilities of the Exchange and its major stakeholders.

[3] This document reflects reporting by Issuers to the Exchanges in connection with Plan Management and does not reflect the full scope of reporting that Issuers may be required to provide to other state and federal agencies.

Table 1. Preliminary Plan Management Roles and Responsibilities

Stakeholder	Primary Roles and Responsibilities
Exchange	• Establish and execute processes to certify, recertify, and decertify qualified health plans • Establish and execute processes to establish, monitor, and renew QHP agreements with issuers • Assign and update plan quality ratings • Receive and analyze QHP agreement-related data, information, and communications from issuers and take appropriate action • Review justifications for rate increases • Maintain issuer and plan operational data • Transact issuer and plan data with the State Department of Insurance and with CMS
Issuer	• Prepare proposals • Negotiate and accept QHP agreements • Operate qualified health plans • Provide data, information, and communications as required
CMS	• Define essential health benefits • Establish minimum certification criteria • Develop plan quality rating methodology • Collect and aggregate issuer and plan data from Exchanges • When requested, provide information on issuers and plans to Exchanges • At least annually, provide to IRS data on plans offered, premiums and level of coverage
State Department of Insurance	• Provide information on issuers and plans to Exchanges • Receive information on issuers and plans from Exchanges • Perform rate reviews as determined by each state

2.2 Exchange Interactions

Table 2 provides a summary of current understanding of the major interactions between the Exchange and key stakeholders in support of the Plan Management operations. The interactions noted in Table 1 are a work in progress and will continue to be revised through stakeholder engagement and feedback.

Table 2. Plan Management Stakeholder-Exchange Interaction

Interaction Number	Stakeholder Interacting with the Exchange	Description of Stakeholder-Exchange Interaction
1	Issuer	• The Exchange publishes a qualified health plan solicitation and the issuer submits a proposal. Based on the Exchange's proposal evaluation, proposal revisions may be required. • The Exchange certifies an offering as a qualified health plan and notifies the issuer. • The Exchange generates (or updates) the qualified health plan agreement and provides it to the issuer. The issuer accepts the agreement, and provides the accepted agreement to the Exchange. • The issuer provides quality rating data to the Exchange. • If continuing participation, the issuer provides recertification process information as required by the Exchange. • The Exchange notifies the issuer of recertification. • The issuer updates (either periodically or as changes occur) issuer and plan information in accordance with QHP agreement requirements. This information may include, for example, provider network updates, changes to issuer general information, transparency and quality information, complaint information, and marketing materials. • The issuer provides a justification for proposed rate increases.
2	CMS	• The Exchange provides issuer and plan information. CMS may collect this information from all Exchanges, geographically aggregates it, and makes it available for use by the Exchanges. In addition, CMS provides information on plans offered, premiums and level of coverage to IRS. • The Exchange notifies CMS when plans are not renewed or when the availability of plan enrollment changes. CMS notifies IRS of plan non-renewals. • CMS provides the plan quality rating methodology.
3	State Department of Insurance	• The State Department of Insurance may make available information on issuers and plans (e.g., licensure, solvency, market conduct information, complaints). • The State Department of Insurance may conduct and provide the results of rate and actuarial reviews. • The Exchange provides issuer and plan information to the State Department of Insurance.
4	State Agencies	• State Agencies may provide issuer and plan complaint information to the Exchange. States may opt to have the State Department of Insurance aggregate this information prior to providing it to the Exchange.

3. Plan Management Business Process Model

The Plan Management Business Process Model, which consists of six business processes, as depicted in Figure 3, describes the business processes and information needs for the Plan Management business area. This section presents a Business Process Overview (including assumptions) and Business Process Definitions for this business area. The business process flows and the supporting metadata capture the potential major activities, sequence of activities (flow), the information used by the individual business processes, and the stakeholders participating in the processes.

3.1 Business Process Overview

As shown in Figure 3, the six business processes for Plan Management are:

- **BP-PM:01 – Establish Issuer and Plan Initial Certification and Agreement.** This process may be performed in order to accomplish the initial (first-time) certification and agreement for a qualified health plan provided by an issuer.
- **BP-PM:02 – Monitor Issuer and Plan Certification Compliance.** This process may consist of administrative activities performed in order to monitor plan performance and certification compliance.
- **BP-PM:03 – Establish Issuer and Plan Renewal and Recertification.** This process may be performed after the initial certification process for qualified health plans. The process may include activities associated with the recertification of qualified health plan participation, including potential decertification of the qualified health plan.
- **BP-PM:04 – Maintain Operational Data.** This process may be performed to maintain the currency of the operational data received from issuers, to analyze changes in the data, and to take appropriate actions based on the changes in the data. The data may include: provider network data, issuer general information, transparency data, quality information, complaint data (from multiple sources), and marketing materials and notifications to members.
- **BP-PM:05 – Process Change in Plan Enrollment Availability.** This process may be performed when an issuer either closes or re-opens enrollment for a QHP during a plan year. The issuer may close enrollment of a QHP under certain conditions specified in section 2702 of the Public Health Service Act (i.e., service capacity limits).
- **BP-PM:06– Review Rate Increase Justifications.** This process may be performed to receive rate information and review justifications for rate increases.

3.2 Assumptions for Description of the Plan Management Business Area

The preparation of the Plan Management business processes required some assumptions, partly because regulation development is still underway. Additional assumptions were required to reflect state flexibility in the Plan Management business area. Therefore, CMS made the following assumptions in developing the Plan Management business processes:

- Exchanges may establish a QHP agreement with issuers, even if a full contracting process is not utilized
- Exchanges may engage in annual or multi-year agreements, and the Exchange may choose to fully recertify plans less than annually (although Exchanges must review rate/benefit information on a more frequent basis)
- Exchanges will populate the plan quality rating tool in accordance with the CMS plan quality rating methodology
- A plan selection tool (or rules engine) may connect the provider directory, the electronic calculator, and quality ratings capabilities to distinguish the potential plans based on consumer input
- The electronic calculator will provide and estimate of the consumer's cost of coverage after deducting the advance premium tax credit amount, and any cost sharing reduction. Portions of this calculator may be supported by modules provided by federal partners (e.g., premium tax credit computation).
- CMS may aggregate issuer and plan data from all Exchanges and provide the aggregated information to the Exchanges for comparative purposes
- Plans may have the ability to close and re-open enrollment
- Exchanges may provide a consolidated provider directory. If not, the Exchanges may link to the directory provided on the plan's website
- The review of premium rate justifications, and other rate related activities, may be performed by the SDOI instead of the Exchange
- Exchanges may decide to review plan marketing materials and notifications
- Exchanges may have an automated Plan Management System (PMS) of some type to store issuer and plan information, including plan history (7–10 years' worth) and updates over time. The PMS would load, store, and manage issuer and plan information (e.g., general issuer information, rates, and benefits) and generate notices/reports. Information on complaints, performance, and quality may be in the PMS or in a separate database. The Exchange's complaint tracking system may provide an automated upload of complaints to the PMS or separate database

Finally, in preparing the Plan Management business processes, CMS notes that this business area:

- Is information intensive
  - Exchanges may collect information from different sources in different formats
  - Standardizing certain information will be essential (see Section 4, *Plan Management Information Model* for more detail)
- Plan management activities often involve non-routine, case-by-case review and decision-making activities. The Plan Management transactions are fewer, less structured, and more complex than those in the Eligibility & Enrollment business area. It is likely the Plan Management transactions and supporting activities may involve a much higher degree of manual processing.

3.3 Business Process Definitions

Table 3 provides a description for each of the six Plan Management business processes.

Table 3. Plan Management Business Process Definitions

Business Process	Business Process Description	Services Cross-References
BP-PM:01 – Establish Issuer and Plan Initial Certification and Agreement	• The Exchange develops and issues a qualified health plan solicitation. If the state is requiring services beyond the essential health benefits, the solicitation may specify these services. After the solicitation is issued, the Exchange may elect to hold a vendor conference to answer respondent questions, and issue a data book. • The Exchange evaluates the proposals submitted by the issuers. In evaluating the proposals, the Exchange may need to access information from the following sources: (1) information contained in the issuer's response, (2) information about the issuer from the State Department of Insurance, and (3) may include information about the issuer from CMS. Some of the required information in the proposal may be standardized and evaluated using electronic tools in such areas as network adequacy and benefit design. The Exchange may elect to request oral presentations or conduct site visits. • The Exchange may need or want to conduct negotiations with those issuers whose proposed qualified health plans meet the certification criteria. Based on the negotiations, the Exchange may accept the issuer's proposal or request revisions to the proposal. • If the Exchange accepts the issuer's proposal, the Exchange certifies the offering as a qualified health plan and notifies the issuer. The Exchange then may generate and send the qualified health plan agreement.	Subsection 5.2.1

Business Process	Business Process Description	Services Cross-References
BP-PM:01 – Establish Issuer and Plan Initial Certification and Agreement (continued)	• If an Exchange uses an agreement, the Exchange sets up QHP agreement information regarding the issuer and the qualified health plan(s) in an automated system (e.g., a database), once the agreement has been accepted by the issuer. The Exchange may direct the Issuer to upload the information into the system (either at the time of application or at agreement signing). The Exchange may also work with the issuer(s) during this period to ensure a successful transition to operations. • The Exchange assigns an initial plan quality rating. In assigning the rating, the Exchange uses the Plan Quality Rating Methodology provided by CMS which establishes common quality rating elements.	Subsection 5.2.1
BP-PM:02 – Monitor Issuer and Plan Certification Compliance	• The Exchange reviews certification compliance data received from the issuers and monitors plan performance. The Exchange may establish a Performance Indicator Dashboard for tracking performance data. The Exchange also monitors issuer operations and financial reporting in accordance with the QHP agreement, if applicable. • The Exchange provides issuer and plan data to CMS. • The Exchange may update the plan quality rating. In assigning the rating, the Exchange uses the Plan Quality Rating Methodology provided by CMS which establishes common quality rating elements.	Subsection 5.2.2
BP-PM:03 – Establish Issuer and Plan Renewal and Recertification	• The Exchange may request that issuers of qualified health plans notify them of their intent to continue (renewal) or discontinue (non-renewal) offering qualified health plans through the Exchange. • The Exchange evaluates information provided by the issuer seeking renewal in the recertification process. This process may mirror many of activities in the initial certification process. • The Exchange updates the issuer and plan information in its automated system.	Subsection 5.2.3
BP-PM:04 – Maintain Operational Data	• The issuer submits updates to plan and issuer information. This information may include changes to the plan's provider network, issuer general information, transparency and quality information, complaint information, and marketing materials/member notifications.	Subsection 5.2.4
BP-PM:05 – Process Change in Plan Enrollment Availability	• The Exchange receives a notification of change in plan enrollment availability (close/re-open enrollment) from the issuer. The issuer also provides the notification to the SDOI. • The Exchange updates the issuer and plan information in its automated system, updates the Exchange website, updates plan selection tools, and issues communications to stakeholders. • The Exchange notifies CMS of the plan change in availability.	Subsection 5.2.5
BP-PM:06– Review Rate Increase Justifications	• For rate/benefit data, the Exchange receives and analyzes justifications associated with rate increases.	Subsection 5.2.6

4. Plan Management Business Information Model

Table 4 provides a summary of the information used or created by Plan Management business processes. The table describes the major entities and the considerations for data standardization.

Table 4. Plan Management Entities

Major Entities	Entity Description	Data Standardization Considerations
Complaint	One type of data that could be collected by the Exchange to assess and monitor issuer/plan performance. Complaint data can be received from numerous sources. Depending on the source, the Exchange may receive actual complaints or a summary of complaint data such as number of complaints per time period per 1,000 enrollees. Complaint rates can serve as a plan performance measure.	Exchanges may choose to assign standard categories to complaints to facilitate analysis.
Issuer	An issuer is an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to state law that regulates insurance [within the meaning of Section 514(b)(2) of the Employment Retirement Insurance Security Act (ERISA)]. General information about an issuer needed by an Exchange may include such items as issuer name (legal name, trade name, doing business as); physical address; mailing address; points of contact; and tax ID number. Other information about an issuer may be requested during the solicitation process such as parent/subsidiary relationships, experience, key management staff, licensure, and solvency.	
Notification	The Plan Management business area involves a number of different notifications between the Exchange and the issuers, and in some cases, other stakeholders.	
Plan Benefit	A benefit provided by a qualified health plan. Benefit information also includes such items as limits and co-payments.	The means by which benefit information is represented may assist consumers in plan selection.
Plan Performance Measure	A measure used by the Exchange to assess plan performance (e.g., complaint rates, claims payment timeliness, call center metrics).	May use standard performance measures for all plans participating in an Exchange that could facilitate plan performance comparisons.
Plan Quality Measure	A measure used by the Exchange to assess plan quality. Possibilities may include measures from the Healthcare Effectiveness Data and Information Set **(**HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program. A measure used by the Exchange to assess plan quality. These may	May use standard quality measures for all plans participating in an Exchange that would facilitate plan quality comparisons.

Major Entities	Entity Description	Data Standardization Considerations
	include the Plan Performance Measures above.	
Proposal	An issuer's response to an Exchange solicitation for Qualified Health Plan submissions. The content of the proposal will depend on the solicitation request. See Appendix A, Representative Solicitation Data, for the types of information a proposal might contain.	
Provider	A provider in the context of plan management is a supplier of health care services. A provider network is a term used to describe the set of providers that have an agreement to participate in the plan. Provider network information that may used by the Exchange may include provider name, location, type, specialties, preferred/non-preferred status, and whether or not the provider is accepting new enrollees. Additional data for institutional providers like hospitals may include capacity data, specialized services (e.g., trauma care, transplants) and lab services.	Provider network data received by the Exchange may be standardized to the degree necessary for the Exchange to perform provider network analysis and as needed for the operation of the plan selection tool.
Qualified Health Plan	Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Exchange in which it is sold.	
Solicitation	A request prepared by the Exchange to solicit proposals from issuers for offering qualified health plans through the Exchange. The solicitation may consist of multiple parts. See Appendix A, Representative Solicitation Data, for representative types of information that might be included in a solicitation.	This information is expected to vary by state, but may be standardized by the Exchange for all issuers within the state.
Transparency Information	Information provided by issuers to the Exchange such as payment policies and practices, financial disclosures, enrollment/disenrollment data, claims denials, and rating practices.	

The information needs listed here may change and will be further addressed in the *Conceptual Data Model and Data Sources – Exchange Reference Architecture Supplement* (in development) and may change as a result of the Conceptual Data Model.

5. Plan Management Business Services Model

As described in Section 3, CMS has defined Core Business Services and Supporting Business Services for the Plan Management business area. The Core Business Services for the Plan Management business area capture the business logic required by a business process that are performed by the central actor. In the case of Plan Management, the central actor is always the Exchange. The Supporting Business Services encapsulate the business logic for interactions between Exchanges and its stakeholders involving data retrievals and transfers, verifications, and other operations. It is envisioned that Exchanges will gain operational efficiencies by reusing Core Business Services and Supporting Business Services where appropriate.

Section 5 describes the business services defined for Plan Management (subsection 5.1), and provides mappings between business processes, core business services, and supporting business services (subsection 5.2). In addition, two specialized views are provided. Subsection 5.3 lists the supporting business services provided by each stakeholder, and subsection 5.4 provides tables showing the reuse of each business service.

5.1 Business Service Definition

CMS analyzed the Plan Management business flows to identify the business services that comprise the breadth of the Plan Management business functionality for the Exchange. This subsection describes the business services elements for each Plan Management business area. Supporting business services identify the interactions with stakeholders participating in the business process.

Table 5 provides a brief description of information captured about the Plan Management business services. Subsections 5.1.1 and 5.1.2, respectively, provide the definitions of the Core Business Services and Supporting Business Services for this business area.

Table 5. Business Service Elements Description

Element	Description	Business Services Definition Table
Business Service Name	Name of the Exchange or supporting business service.	**Both**
Description	Brief description of the business service purpose and operation.	**Both**
Service Owner	Stakeholder identified as responsible for providing the business service.	**Supporting**
Input Entities	Major information provided as input to the business service.	**Both**
Outcome	Outcome or information produced as a result of the business service operation.	**Both**

Element	Description	Business Services Definition Table
Authoritative Sources	Identifies the authoritative source of data used or provided by the service and identifies the authoritative source of derived data resulting from the service.	**Supporting**
Automation Indicator	Indicates whether service is anticipated to be automated, performed manually, or a combination of the two.	**Both**

5.1.1 Core Business Services

Core Business Services identify the functionality performed by the central actor (i.e., the Exchange) in carrying out Plan Management business processes. Core Business Services may include partially automated business process workflows involving interactions with Exchange operations staff and stakeholders as well as fully automated business rules processing.

Table 6 describes the Core Business Services identified for the Plan Management business area. Note that the specific approaches for many of the Core Business Services described below are still under development. Additional guidance and information will be released as it becomes available.

Table 6. Plan Management Core Business Services

Core Business Service Name	Description	Input Entities	Outcomes	Automation Indicator
CBS-EXCH-PM:01 – Manage Plan Submission Process	Develop and publish solicitation, and evaluate proposal. Conduct negotiations with issuer if required.	CMS Plan Certification Criteria, Essential Health Benefits, Issuer Proposal, Issuer Information	Solicitation, proposal revision request	Mixed
CBS-EXCH-PM:02 – Certify / Recertify/ Decertify Plan	Certify/ recertify/ decertify plans as qualified health plans. Notify issuer.	Certification – Issuer proposal and negotiation results Recertification – Updates to issuer proposal / information and negotiation results Decertification – Exchange may decertify qualified health plan if necessary	Notice of certification to issuer Notice of recertification to issuer Notice of decertification to issuer Notice of decertification to enrollees	Mixed
CBS-EXCH-PM:03 – Form QHP Agreement with Issuer	Develop, update, and send qualified health plan agreement	Certification or recertification of the plan as a qualified health plan	QHP Agreement	Mixed
CBS-EXCH-PM:04 – Monitor Plan Compliance	Evaluate certification compliance information from multiple sources. Notify issuer of certification compliance information.	Issuer certification compliance information, SDOI and CMS Issuer and Plan information, customer feedback, and complaints	Issuer and Plan performance and quality information, notification of certification compliance information	Mixed

Core Business Service Name	Description	Input Entities	Outcomes	Automation Indicator
CBS-EXCH-PM:05 – Manage Issuer and Plan Information	Create, update, and/or analyze Issuer and Plan information. Applies to initial creation and subsequent updates to information.	Issuer and Plan Information	Updated Issuer and Plan Information	Mixed
CBS-EXCH-PM:06 – Report Issuer and Plan Information	Report Issuer and Plan information to external stakeholders	Issuer and Plan Information	Issuer and Plan Information	Automated
CBS-EXCH-PM:07 – Assign Plan Quality Rating	Assign plan quality rating. For initial rating, may be based on commercial market information from issuer.	CMS Plan Quality Rating Methodology, Issuer Commercial Market information (for initial rating), Issuer performance and quality information	Plan Quality Rating	Mixed
CBS-EXCH-PM:08 – Process Change in Plan Enrollment Availability	Process plan availability when a plan either closes or re-opens enrollment during a plan year.	Issuer notice of change enrollment availability (close/re-open enrollment)	Plan change in availability notice	Mixed
CBS-EXCH-PM:09 - Review Rate Increase Justifications	Review justifications for rate increases	Issuer rate and benefit data, rate increase justification State rate review results	Plan Rate and Benefit Data	Mixed

5.1.2 Supporting Business Services

Supporting Business Services identify the interactions with stakeholders participating in the business process. Supporting Business Services enable stakeholders to share information with the central actor (Exchanges) and provide other services in support of Exchange operations.

Table 7 describes the Supporting Business Services identified for the Plan Management business area. Note that a number of Supporting Business Services identified in this table are listed with information sources that are still not fully defined. CMS continues to investigate authoritative sources of data and will collaborate with states in this effort. Also note that this table does not contain an exhaustive list of interactions between Exchanges and other stakeholders. Future guidance will detail additional interactions..

Table 7. Plan Management Supporting Business Services

Supporting Business Service Name	Description	Service Owner	Input Entities	Outcomes	Authoritative Sources	Automation Indicator
SBS-CMS:19 – Publish Issuer and Plan Information	Publish Issuer and Plan information. Information may be geographically aggregated. CMS may collect the information from all Exchanges and make it available to individual Exchanges on request. Examples of types of information include performance and quality information	CMS	Exchange Issuer and Plan Information	Issuer and Plan Information	Exchange	Automated
SBS-CMS:20 – Provide Plan Quality Rating Methodology	Provide Plan Quality Rating Methodology	CMS	Regulation requirements	Quality Rating Methodology Instructions and Datasheets	CMS	Mixed
SBS-CMS:21 – Receive Issuer and Plan Information	Receive Issuer and Plan information and store in an CMS repository. This may include such information as issuers and plans offered in each exchange, rates/benefits information for each plan, plan performance and quality information, and data that might be needed for Healthcare.gov or for IRS.	CMS	Exchange Issuer and Plan Information	Aggregated Exchange Issuer and Plan Information	Exchange	Automated

Table 7. Plan Management Supporting Business Services, continued

Supporting Business Service Name	Description	Service Owner	Input Entities	Outcomes	Authoritative Sources	Automation Indicator
SBS-CMS:22 – Receive Plan Non-Renewal, Decertification, and Change in Availability Notices	Receive Plan Non-Renewal, Decertification, and Change in Availability Notices and store in an CMS repository.	CMS	Exchange Plan Non-Renewal, Decertification, and Change in Availability Notices	Stored Exchange Plan Non-Renewal, Decertification and Change in Availability Notices	Exchange	Automated
SBS-CMS:28 – Receive Rate and Benefit Data	Receive Plan Rate and Benefit Data and store in an CMS repository.	CMS	Plan Rate and Benefit Data	Transmission of selected information to IRS	Exchange	Automated
SBS-ISS:05 – Provide Response to Solicitation	Provide solicitation materials, including the proposal (original and revisions) or updated issuer information for recertification.	Issuer	Solicitation	Proposal, updated issuer information for recertification	Issuer	Mixed
SBS-ISS:06 – Provide QHP Agreement Materials	Provide QHP agreement materials, including the [accepted] qualified health plan agreement.	Issuer	[unsigned] Qualified Health Plan Agreement	[accepted] Qualified Health Plan Agreement	Issuer	Mixed
SBS-ISS:07 – Provide Required Issuer and Plan Information	Provide required Issuer and Plan information, including reports, plans, communications, and data.	Issuer	Qualified Health Plan Agreement, Compliance Problem Description, Agreement communications from Exchange	Agreement Communications and Reports, Plans, issuer and plan data	Issuer	Mixed

Table 7. Plan Management Supporting Business Services, concluded

Supporting Business Service Name	Description	Service Owner	Input Entities	Outcomes	Authoritative Sources	Automation Indicator
SBS-ISS:09 – Provide Plan Non-Renewal and Change in Availability Notices	Provide Plan Non-Renewal and Change in Availability Notices as required by the QHP agreement.	Issuer	QHP Agreement	Notice of intent to non-renew, change in plan availability notice	Issuer	Mixed
SBS-SDOI:01 – Provide Issuer and Plan Information	May provide Issuer and Plan information. Information may be geographically aggregated. This information may include complaints information, licensure changes, solvency status and other financial information, market conduct analysis results.	State Department of Insurance	Issuer and Plan Information	Issuer and Plan Information	Issuer	Automated
SBS-SDOI:02 – Receive Issuer and Plan Information	May receive Issuer and Plan information. This information may include plan performance and quality information, rates/benefits information, and other information required by the SDOI.	State Department of Insurance	Exchange's Issuer and Plan Information	Aggregated Exchange Issuer and Plan Information	Exchange	Automated
SBS-SDOI:03 – Receive Plan Non-Renewal, Decertification, and Change in Availability Notices	Receive Plan Non-Renewal, Decertification, and Change in Availability Notices.	State Department of Insurance	Plan Non-Renewal, Decertification, and Availability Notices	Stored Exchange Plan Non-Renewal, Decertification, and Availability Notices	Exchange	Automated
SBS-SDOI:04 – Provide Rate Information	Conduct rate reviews of plan rates and benefits and provide review results information to the Exchange.	State Department of Insurance	Rates and Benefits data	Rate Review Results	SDOI	Mixed

5.2 Business Process-Services Mapping

This section provides a summary of the Core Business Services and supporting business services used by the business processes identified for Plan Management in Section 2. As discussed earlier, the collection of business services represents the breadth of functionality required by the business process. Furthermore, each of the supporting business services identifies the specific interaction between the Exchange and its stakeholders needed to complete the business process. The following subsections present the supporting business services for each Exchange business process.

5.2.1 BP-PM:01 – Establish Issuer and Plan Initial Certification and Agreement

Table 8 provides a listing of the Supporting Business Services that enable the Core Business Services that support the BP-PM:01 – Establish Issuer and Plan Initial Certification and Agreement business process.

Table 8. BP-PM:01 – Establish Issuer and Plan Initial Certification and Agreement Business Services

Core Business Services	Supporting Business Services
CBS-EXCH-PM:01 – Manage Plan Submission Process	SBS-CMS:19 – Publish Issuer and Plan Information SBS-ISS:05 – Provide Response to Solicitation SBS-SDOI:01 – Provide Issuer and Plan Information
CBS-EXCH-PM:02 – Certify/ Recertify/ Decertify Plan	SBS-ISS:07 – Provide Required Issuer and Plan Information
CBS-EXCH-PM:03 – Form QHP Agreement with Issuer	SBS-ISS:06 – Provide QHP Agreement Materials
CBS-EXCH-PM:05 – Manage Issuer and Plan Information	SBS-ISS:07 – Provide Required Issuer and Plan Information
CBS-EXCH-PM:06 – Report Issuer and Plan Information	SBS-CMS:21 – Receive Issuer and Plan Information SBS-SDOI:02 – Receive Issuer and Plan Information
CBS-EXCH-PM:07 – Assign Plan Quality Rating	SBS-CMS:20 – Provide Plan Quality Rating Methodology SBS-ISS:07 – Provide Required Issuer and Plan Information

5.2.2 BP-PM:02 – Monitor Issuer and Plan Certification Compliance

Table 9 provides a listing of the Supporting Business Services that enable the Core Business Services that support the BP-PM:02 – Monitor Issuer and Plan Certification Compliance business process.

Table 9. BP-PM:02 – Monitor Issuer and Plan Certification Compliance Business Services

Core Business Service	Supporting Business Service
CBS-EXCH-PM:04 – Monitor Plan Compliance	SBS-CMS:19 – Publish Issuer and Plan Information SBS-ISS:07 – Provide Required Issuer and Plan Information SBS-SDOI:01 – Provide Issuer and Plan Information
CBS-EXCH-PM:05 – Manage Issuer and Plan Information	SBS-ISS:07 – Provide Required Issuer and Plan Information
CBS-EXCH-PM:06 – Report Issuer and Plan Information	SBS-CMS:21 – Receive Issuer and Plan Information SBS-SDOI:02 – Receive Issuer and Plan Information
CBS-EXCH-PM:07 – Assign Plan Quality Rating	SBS-CMS:20 – Provide Plan Quality Rating Methodology SBS-ISS:07 – Provide Required Issuer and Plan Information

5.2.3 BP-PM:03 – Establish Issuer and Plan Renewal and Recertification

Table 10 provides a listing of the Supporting Business Services that enable the Core Business Services that support the BP-PM:03 – Establish Issuer and Plan Renewal and Recertification business process.

Table 10. BP-PM:03 – Establish Issuer and Plan Renewal and Recertification Business Services

Core Business Service	Supporting Business Service
CBS-EXCH-PM:01 – Manage Plan Submission Process	SBS-ISS:05 – Provide Response to Solicitation SBS-CMS:19 – Publish Issuer and Plan Information SBS-SDOI:01 – Provide Issuer and Plan Information
CBS-EXCH-PM:02 – Certify/ Recertify/ Decertify Plan	SBS-ISS:07 – Provide Required Issuer and Plan Information
CBS-EXCH-PM:03 – Form QHP Agreement with Issuer	SBS-ISS:06 – Provide QHP Agreement Materials
CBS-EXCH-PM:05 – Manage Issuer and Plan Information	SBS-ISS:07 – Provide Required Issuer and Plan Information
CBS-EXCH-PM:06 – Report Issuer and Plan Information	SBS-CMS:21 – Receive Issuer and Plan Information SBS-SDOI:02 – Receive Issuer and Plan Information

5.2.4 BP-PM:04 – Maintain Operational Data

Table 11 provides a listing of the Supporting Business Services that enable the Core Business Services that support the BP-PM:04 – Maintain Operational Data business process.

Table 11. BP-PM:04 – Maintain Operational Data Business Services

Core Business Service	Supporting Business Service
CBS-EXCH-PM:05 – Manage Issuer and Plan Information	SBS-ISS:07 – Provide Required Issuer and Plan Information
CBS-EXCH-PM:06 – Report Issuer and Plan Information	SBS-CMS:21 – Receive Issuer and Plan Information SBS-SDOI:02 – Receive Issuer and Plan Information

5.2.5 BP-PM:05 – Process Change in Plan Enrollment Availability

Table 12 provides a listing of the Supporting Business Services that enable the Core Business Services that support the BP-PM:05 – Process Change in Plan Enrollment Availability business process.

Table 12. BP-PM:05 – Process Change in Plan Enrollment Availability Business Services

Core Business Service	Supporting Business Service
CBS-EXCH-PM:08 – Process Change in Plan Enrollment Availability	SBS-CMS:22 – Receive Plan Non-Renewal and Availability Notices SBS-ISS:09 – Provide Plan Non-Renewal and Change in Availability Notices SBS-SDOI:03 – Receive Plan Non-Renewal and Change in Availability Notices

5.2.6 BP-PM:06– Review Rate Increase Justifications

Table 13 provides a listing of the Supporting Business Services that enable the Core Business Services that support the BP-PM:06 – Review Rate Increase Justifications business process.

Table 13. BP-PM:06 – Review Rate Increase Justifications Business Services

Core Business Service	Supporting Business Service
CBS-EXCH-PM:09 – Manage Rates and Benefits	SBS-CMS:28 – Receive Rate and Benefit Data SBS-ISS:07 – Provide Required Issuer and Plan Information SBS-SDOI:04 – Provide Rate and Actuarial Information

5.3 Stakeholder-Provided Business Services

Table 14 summarizes the stakeholder interactions with Exchanges. This mapping will assist in identifying by stakeholder each of the major interactions that Exchanges must address.

Table 14. Supporting Business Services by Stakeholder

Stakeholder	Supporting Business Service
CMS	SBS-CMS:19 – Publish Issuer and Plan Information SBS-CMS:20 – Provide Plan Quality Rating Methodology SBS-CMS:21 – Receive Issuer and Plan Information SBS-CMS:22 – Receive Plan Non-Renewal and Change in Availability Notices SBS-CMS:28 – Receive Rate and Benefit Data
State Department of Insurance	SBS-SDOI:01 – Provide Issuer and Plan Information SBS-SDOI:02 – Receive Issuer and Plan Information SBS-SDOI:03 – Receive Plan Non-Renewal and Change in Availability Notices SBS-SDOI:04 – Conduct Rate and Actuarial Reviews
Issuer	SBS-ISS:05 – Provide Response to Solicitation SBS-ISS:06 – Provide QHP Agreement Materials SBS-ISS:07 – Provide Required Issuer and Plan Information SBS-ISS:09 – Provide Plan Non-Renewal and Change in Availability Notices

5.4 Business Service Reuse

Understanding business service reuse helps to prioritize service specification, implementation activities, and the breadth of business areas that business service reuse needs to support.

Tables 15 and 16 identify how the business services are reused. Table 15 lists the business processes in which each Exchange Business Service is used. Core Business Services with the largest amount of total reuse should be considered for early analysis and implementation.

Table 15. Reused Core Business Services

Core Business Services	Business Processes
CBS-EXCH-PM:01 – Manage Plan Submission Process	BP-PM:01 – Establish Issuer and Plan Initial Certification and Agreement BP-PM:03 – Establish Issuer and Plan Renewal and Recertification
CBS-EXCH-PM:02 – Certify / Recertify / Decertify Plan	BP-PM:01 – Establish Issuer and Plan Initial Certification and Agreement BP-PM:03 – Establish Issuer and Plan Renewal and Recertification
CBS-EXCH-PM:03 – Form QHP Agreement with Issuer	BP-PM:01 – Establish Issuer and Plan Initial Certification and Agreement BP-PM:03 – Establish Issuer and Plan Renewal and Recertification
CBS-EXCH-PM:04 – Monitor Plan Compliance	BP-PM:02 – Monitor Issuer and Plan Certification Compliance

Core Business Services	Business Processes
CBS-EXCH-PM:05 Manage Issuer and Plan Information	BP-PM:01 – Establish Issuer and Plan Initial Certification and Agreement BP-PM:02 – Monitor Issuer and Plan Certification Compliance BP-PM:03 – Establish Issuer and Plan Renewal and Recertification BP-PM:04 – Maintain Operational Data
CBS-EXCH-PM:06 Report Issuer and Plan Information	BP-PM:01 – Establish Issuer and Plan Initial Certification and Agreement BP-PM:02 – Monitor Issuer and Plan Certification Compliance BP-PM:03 – Establish Issuer and Plan Renewal and Recertification BP-PM:04 – Maintain Operational Data
CBS-EXCH-PM:07 – Assign Plan Quality Rating	BP-PM:01 – Establish Issuer and Plan Initial Certification and Agreement BP-PM:02 – Monitor Issuer and Plan Certification Compliance
CBS-EXCH-PM:08 – Process Change in Plan Enrollment Availability	BP-PM:06 – Process Change in Plan Enrollment Availability
CBS-EXCH-PM:09 – Manage Rates and Benefits	BP-PM:07 – Conduct Benefit Package and Rate Increase Justification Review

Table 16 lists the Core Business Service in which each Supporting Business Service is used. Supporting Business Services with the largest amount of reuse should be considered for early analysis and implementation.

Table 16. Reused Supporting Business Services

Reused Supporting Business Services	Core Business Service
SBS-CMS:19 – Publish Issuer and Plan Information	CBS-EXCH-PM:01 – Manage Plan Submission Process CBS-EXCH-PM:04 – Monitor Plan Compliance
SBS-CMS:20 – Provide Plan Quality Rating Methodology	CBS-EXCH-PM:07 – Assign Plan Quality Rating
SBS-CMS:21 – Receive Issuer and Plan Information	CBS-EXCH-PM:06 – Report Issuer and Plan Information
SBS-CMS:22 – Receive Plan Non-Renewal and Availability Notices	CBS-EXCH-PM:02 – Certify / Recertify / Decertify Plan CBS-EXCH-PM:08 – Process Change in Plan Enrollment Availability
SBS-CMS:28 – Receive Rate and Benefit Data	CBS-EXCH-PM:09 – Manage Rates and Benefits
SBS-ISS:05 – Provide Response to Solicitation	CBS-EXCH-PM:01 – Manage Plan Submission Process
SBS-ISS:06 – Provide QHP Agreement Materials	CBS-EXCH-PM:03 – Form QHP Agreement with Issuer
SBS-ISS:07 – Provide Required Issuer and Plan Information	CBS-EXCH-PM:02 – Certify / Recertify / Decertify Plan

Reused Supporting Business Services	Core Business Service
	CBS-EXCH-PM:04 – Monitor Plan Compliance CBS-EXCH-PM:05 – Manage Issuer and Plan Information CBS-EXCH-PM:07 – Assign Plan Quality Rating CBS-EXCH-PM:09 – Manage Rates and Benefits
SBS-ISS:09 – Provide Plan Non-Renewal and Change in Availability Notices	CBS-EXCH-PM:02 – Certify / Recertify / Decertify Plan CBS-EXCH-PM:08 – Process Change in Plan Enrollment Availability
SBS-SDOI:01 – Provide Issuer and Plan Information	CBS-EXCH-PM:01 – Manage Plan Submission Process CBS-EXCH-PM:04 – Monitor Plan Compliance
SBS-SDOI:02 – Receive Issuer and Plan Information	CBS-EXCH-PM:06 – Report Issuer and Plan Information
SBS-SDOI:03 – Receive Plan Non-Renewal and Change in Availability Notices	CBS-EXCH-PM:02 – Certify / Recertify / Decertify Plan CBS-EXCH-PM:08 – Process Change in Plan Enrollment Availability
SBS-SDOI:04 – Provide Rate and Actuarial Information	CBS-EXCH-PM:09 – Manage Rates and Benefits

Appendix A. Representative Solicitation Data

Table 17 presents the following major categories and the representative data that Exchanges might request as part of a solicitation for participation as Qualified Health Plan Issuers in the Exchange.

Table 17. Representative Solicitation Data

Category	Representative Data
Issuer General Information	Issuer name (legal name, trade name, doing business as), physical address, mailing address, points of contact, tax id number.
Issuer Organizational Information	Summary and charts showing the history and structure of ownership, subsidiaries and business affiliations.
Certification and other Program Requirements	Describe how the organization meets the certification requirements as well as any other programmatic requirements of the Exchange.
Issuer Key Management Staff	Position descriptions for key management staff and an organizational chart showing the relationships of the various departments.
Issuer Experience	Information with regard to issuer's experience with participation in other exchanges. Information about any regulatory actions, sanctions, and/or fines imposed by any Federal or State regulatory entity, or a regulatory entity in another state (specify applicable time period). Descriptions of any letters of deficiencies, corrective actions, findings of non-compliance, and/or sanctions. Indication which of these actions were related to Medicaid, Medicare, CHIP programs, or the State Department of Insurance.
Administrative Management	• Description of the issuer's administrative management demonstrating that the Issuer has sufficient appropriate resources and structures available to effectively and efficiently manage administrative issues.
Licensure and Financial Condition	Could include the following: • Issuer is in good standing (in each state if regional exchange) • Issuer has a license (in each state if regional exchange) • Solvency data (level of reserves) • Issuer's audited financial statements
Plan Benefit Design	Could include the following: • Covered plan benefits – Essential health benefits (standard set) – Additional state required benefits (state specific) – Plan additional benefits (above essential benefits) • Cost sharing (limits, co-pays, etc.) • Plan level, e.g., gold and silver (actuarial value) • For silver plans—cost-sharing reduction information ***Note:*** *Data may need to be standardized for the calculator and for other functions*
Rates	**Rate Increase Justification** (some states may ask for this in year one from issuers with plans already in their state)

Category	Representative Data
Quality Information (Quality Reporting)	Plan- and provider-level reporting. In the first years, reporting may be performed on the commercial population instead of the exchange population. **Quality reporting categories** could include: • **Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) program CAHPS measures** • **Provider measures:** Examples could include patient safety metrics and hospital acquired conditions.
Quality Information (Quality Strategy)	**Quality Strategy (i.e., Quality Improvement Plan). Could include the plan's quality improvement plan, which describes** goals and implementation plan for the plan's quality improvement program. It may also include additional information on topics such as: • **Activities that Improve Health Outcomes:** – **Quality Reporting** – health plan quality performance measures. – **Case management and care coordination** – activities related to care management and coordination across providers or sites of care. – **Medical homes model** – qualitative (primary care management of a patient (e.g., by the primary care physician). Incentive payments to PCP for a patient so that care is coordinated. – **Chronic Disease Management** – activities to manage enrollees with chronic diseases such as diabetes, heart failure, and asthma. – **Medication and Care Compliance Initiatives –** medication adherence activities; measures to assess drug-to-drug interactions, gaps in medication therapy. • **Hospital Readmissions** • **Patient Safety** • **Health and Wellness Preventive care** • **Health Disparities**
Quality Information (Accreditation)	Information on whether the plan is accredited by an accreditation entity recognized by the Secretary of HHS. This information should be provided in response to the initial solicitation and upon renewals.
Quality Information (Pharmacy Utilization/Management Program)	May include Information on the plan's pharmacy utilization management program [e.g., use of pharmaceuticals, medication adherence, use of generic drugs, poly-pharmacy management (managing drug interactions)].
Quality Information (Quality Rating Data)	Would include information needed to populate the plan quality rating system.
Performance Information	This could consist of such items as claims payment timeliness, call wait times, complaint rates by type of complaint, and timeliness measures on responses to complaints.
Service Area	Could include a list of areas to be served by the plan.

Category	Representative Data
Provider Data	Data about the plan's provider network which could include: • Geo-access mapping showing time and distance (map providers to enrolled population for travel time) • Preferred/non-preferred status • Providers open to new enrollees • Provider type/specialties • Institutional provider details – Capacity (possibly by type of service) – Specialized services (e.g., transplants, trauma care) – Lab services • Essential community providers • Contracted Pharmacies ***Note:*** It may be beneficial to standardize all or portions of this data. There may be existing standards that can be utilized from other programs.
Attestations	The initial and renewal solicitations may include items that the issuer attests are correct, or that the issuer will perform. These could cover such areas as the following: • Marketing requirements • Health plan forms and notices • Enrollment periods • Enrollment process • Contracting requirements • Recertification process • Decertification/termination process • Agreement to follow decertification process • Fraud, waste, and abuse (attests procedures to address) • Transparency data • Quality information is made available to consumers • Business Integrity: Attestation of no prior integrity issues such as legal actions, administrative actions, or pending investigations. • Communications between Issuer and Exchange: Attestation to ensure effective and timely communications between the Issuer and Exchange.

Acronyms

BA	Business Architecture
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CIO	Chief Information Officer
CMS	Centers for Medicare & Medicaid Services
DCIO	Deputy Chief Information Officer
ERA	Exchange Reference Architecture
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
IRS	Internal Revenue Service
IT	Information Technology
LOA	Letter of Agreement
PCP	Primary Care Physician
PMS	Plan Management System
SDOI	State Department of Insurance
SME	Subject Matter Expert

List of References

1. *Exchange Reference Architecture: Foundation Guidance,* Draft, Version 0.99, Centers for Medicare & Medicaid Services (CMS), March 2011.