U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight

The Health Insurance Enforcement and Consumer Protections Grant Program

Grants to States for Planning and Implementing the Insurance Market Reforms under Part A of Title XXVII of the Public Health Service Act,
Cycle I

Announcement
Invitation to Apply for 2016

Funding Opportunity Number: PR-PRP-17-001
CFDA: 93.881

Date: June 15, 2016

Cycle I Applicable Dates:

FOA Posting Date	June 15, 2016
Mandatory Letter of Intent to Apply Due Date	July 6, 2016
Electronic Application Due Date:	August 15, 2016 (3:00 p.m. Eastern – Baltimore MD – Time)
Anticipated Issuance Notices of Award:	October 19, 2016
Anticipated Period of Performance:	October 19, 2016 – October 18, 2018

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OVERVIEW INFORMATION

Agency Name: Department of Health and Human Services (HHS)
Centers for Medicare & Medicaid Services (CMS)
Center for Consumer Information and Insurance Oversight (CCIIO)

Funding Opportunity Title: Grants to States for Planning and Implementing the Insurance Market Reforms under Part A of Title XXVII of the Public Health Service Act, Cycle I

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Date of Posting: **June 15, 2016**

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Period of Performance: The period of performance will be 24 months.

I. PROGRAM DESCRIPTION

1. Background and Purpose

a. Statutory Provisions: Section 2794 of the Public Health Service Act, "Ensuring That Consumers Get Value for Their Dollars"

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act. On March 30, 2010, the Health Care and Education Reconciliation Act of 2010 was also signed into law. The two laws are collectively referred to as the Affordable Care Act (ACA). The ACA includes a wide variety of provisions designed to promote accountability, affordability, quality, and accessibility in the health care system. The ACA also includes significant grant funding for States to work with the Federal government to implement consumer protections.

The ACA includes, among other things, a number of provisions that reform the health insurance market and strengthen the Federal consumer protections through amendments to title XXVII of the Public Health Service Act (PHS Act) and corresponding amendments to the Employee

Retirement Income Security Act and the Internal Revenue Code. These reforms and protections work to put consumers back in charge of their health coverage and care, ensuring they receive value for their premium dollars and have access to affordable coverage options.

Section 1003 of the ACA adds a new section 2794 to the PHS Act entitled, "Ensuring That Consumers Get Value for Their Dollars." Specifically, section 2794(a) requires the Secretary of the Department of Health and Human Services (the Secretary) (HHS), in conjunction with the States, to establish a process for the annual review of health insurance premiums[1] to protect consumers from unreasonable rate increases. Section 2794(c) directs the Secretary to carry out a program to award grants to States.

Congress appropriated $250 million to be awarded in Federal fiscal years (FFYs) 2010 through 2014 for the Rate Review Grant Program. Through 2010-2014, there were four cycles of Rate Review Grants awarded. Section 2794(c)(2)(B)[2] specifies that if there are any appropriated Rate Review Grant funds that are not fully obligated by the end of FY14, such amounts shall remain available to the Secretary for grants to States for planning and implementing the insurance market reforms and consumer protections under Part A of title XXVII of the PHS Act.

Title XXVII of the PHS Act contemplates that States will exercise primary enforcement authority over health insurance issuers in the group and individual markets to ensure compliance with the Federal health insurance market reforms and consumer protections. In the event that a State notifies the Centers for Medicare & Medicaid Services (CMS) that it does not have statutory authority to enforce or that it is not otherwise enforcing one or more of the provisions of title XXVII, or if CMS determines that the State is not substantially enforcing the requirements, CMS has the responsibility to enforce these provisions in that State. States and CMS have worked closely to ensure compliance with the Federal health insurance reforms and consumer protections. The vast majority of States are enforcing the ACA health insurance market reforms and consumer protections. However, some States lack the authority to enforce these provisions, the ability to do so, or both. CMS has responsibility for enforcing these requirements in a State that notifies CMS that it does not have the authority to, or otherwise will not enforce the health insurance market

[1] The Affordable Care Act uses the term "premium"; however, the National Association of Insurance Commissioners uses the term, "rate" for purposes of industry review. To remain aligned with industry terminology, "rate" will be used in lieu of "premium" in this grant announcement.

[2] PHS Act section 2794(c)(2)(B) states in full: "If the amounts appropriated under subparagraph (A) are not fully obligated under grants under paragraph (1) by the end of fiscal year 2014, any remaining funds shall remain available to the Secretary for grants to States for planning and implementing the insurance reforms and consumer protections under part A."

reforms. Also, CMS has responsibility for enforcing these requirements in a State that it determines is not substantially enforcing the health insurance market reforms, and can exercise that authority either through a collaborative arrangement with the State or by direct enforcement[3].

The provisions in Part A of title XXVII of the PHS Act include market-wide reforms in the group and individual private health insurance markets intended to protect consumers, increase transparency, and regulate health insurance industry practices.

b. Market Reforms in Part A of title XXVII of the Public Health Service Act

Many of the market reforms and consumer protections in Part A of title XXVII of the PHS Act are new provisions that became effective for plan years beginning in 2014. The Health Insurance Enforcement and Consumer Protections grants will provide a funding source to assist States in implementing and planning for several of the Federal market reforms and consumer protections, which are listed below. The Health Insurance Enforcement and Consumer Protections grants will provide States with the opportunity to ensure their laws, regulations, and procedures are in line with Federal requirements and that States are able to effectively oversee and enforce these provisions under the PHS Act's title XXVII Part A market reform and consumer protection with respect to health insurance issuers.

Funding under the Health Insurance Enforcement and Consumer Protections Grant Program is available to States for activities related to planning and implementing the following provisions of Part A of title XXVII of the PHS Act:

I. Section 2707 –Non-discrimination under Comprehensive Health Insurance Coverage (Essential Health Benefits Package)
II. Section 2713 - Coverage of Preventive Health Services
III. Section 2718 - Bringing down the Cost of Health Care Coverage (MLR)
IV. Section 2719 - Appeals Process
V. Section 2726 - Parity in Mental Health and Substance Use Disorder Benefits

A summary of these provisions is found under Appendix E.

These pre-selected market reforms were chosen due to their relative complexity and the anticipated benefits that these reforms will have on consumers and the rates they pay.

[3] As of the date of this publication, the four States where CMS enforces the Affordable Care Act health insurance market reforms and consumer protections are: Missouri, Oklahoma, Texas and Wyoming.

c. Market Reforms - Regulations

Please visit the following link on the U.S. Government Publishing Office Website to view the full list of relevant regulations that the Department of Health and Human Services has published under Title 45 of the Code of Federal Regulations: http://www.ecfr.gov/cgi-bin/text-idx?SID=b5efa98fb81bbcea0badd134ad59efa9&mc=true&tpl=/ecfrbrowse/Title45/45CsubchapB.tpl.

d. Use of Funds

Applicants may use grant funds for a variety of planning and implementation objectives, including but not limited to implementing or enhancing policy form review, market conduct examinations, market analysis, financial examinations, and consumer complaint investigations with respect to the pre-selected market reforms and consumer protections under Part A of title XXVII of the PHS Act.

e. Recommended Areas of Focus for Market Reforms Activities

One of the goals of the Health Insurance Enforcement and Consumer Protections Grant Program is to enhance the States' ability to effectively enforce the pre-selected market reforms and consumer protections under Part A of Title XXVII of the PHS Act. Provided below are recommended areas of focus for State market reform activities that can be funded by these grants.

Section 2707 – Non-Discrimination under Comprehensive Health Insurance Coverage (Essential Health Benefits Package)

States may use grant funds to enhance existing policy filing review processes to ensure health insurance issuers do not include discriminatory benefit designs that discourage people with potentially high-cost medical conditions from enrolling in those plans.

Section 2707(a) of the PHS Act requires issuers that offer non-grandfathered coverage in the individual and small group markets to ensure that such coverage includes the essential health benefits package required under section 1302(a) of the ACA. The accompanying non-discrimination provisions under Section 1302(b)(4) of the ACA and 45 CFR § 156.125 prohibit issuers from using or implementing benefit designs that have the effect of discriminating against individuals on the basis of, among other things, age, expected length of life, present or predicted disability, quality of life, or other health conditions. In addition, 45 CFR § 156.200(e), which applies to plans subject to the EHB requirements under 45 CFR §156.125(b), prohibits issuers from discriminating on the basis of race, color, national origin, disability, age, sex, gender identity

or sexual orientation. These protections under §§ 156.125 and 156.200 apply market-wide, to all non-grandfathered plans in the individual and small group markets.

Discriminatory benefit designs that discourage people with potentially high-cost medical conditions from enrolling in coverage could be contrary to the regulations discussed above. However, § 1563(d) of the ACA specifies that the Secretary may not prohibit a group health plan or health insurance issuer from carrying out utilization management techniques that were commonly used as of the date of enactment of the ACA (March 23, 2010).

- **Procedures and/or tools to identify discriminatory benefit design**

States may develop standard operating procedures and/or tools or use currently available tools to review plans to identify discriminatory benefit design. There are various CMS tools currently available that States could use, including the Non-Discrimination Formulary Clinical Appropriateness and Formulary Outlier Tools. The Qualified Health Plan (QHP) Application Review Tools for Plan Year 2016 can be found on the CCIIO website at: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html.

- **Use tools or hire staff to conduct formulary review**

Pursuant to 45 CFR 156.122, a health plan providing essential health benefits (EHB) must cover at least the greater of (1) one drug in every United States Pharmacopeia (USP) category and class, or (2) the same number of prescription drugs in each USP category and class as the State's EHB benchmark plan. States may not currently have clinicians on staff to conduct formulary review.

States could use tools currently available, including the Category Class Drug Count Tool on the CCIIO website at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html.

States could also hire or contract with a clinician to review formularies or create a standard operating procedure so that form filing reviewers can successfully review formularies and any related documentation. CCIIO suggests that the successful clinician would have the following:

- A clinical background in pharmacology including pharmacotherapeutics, pharmacokinetics, pharmacodynamics.

- A broad understanding of common disease conditions and the drugs used in their treatment, based on nationally recognized treatment guidelines and recommendations.
- An understanding of 45 CFR 156.122 and ACA policies in benefit plan design, including EHB benchmarks and non-discrimination requirements. Staff should also be able to keep track of developing drug policies and guidance.
- A working knowledge of prescription formulary plan design, development, and implementation.

Section 2713- Coverage of Preventive Health Services

States may use grant funds to facilitate coverage of specified preventive health services without cost sharing. States may also use the grant funds to enhance review of issuer form filings to ensure coverage of the required specified preventive health services without cost sharing.

- **Review of issuers policy forms**

  States with the most effective policy form review programs closely review issuers' policy forms to ensure coverage without cost sharing for all required preventive services. This is accomplished either by verifying that links are provided to the list of recommended preventive services specified in section 2713 and 45 C.F.R. § 147.130(a), or by verifying that the policy form individually specifies each required preventive service. The State also ensures that no-cost coverage is provided for at least one form of contraception in each of the methods identified for women by the Food and Drug Administration (FDA), and that there is an easily accessible, transparent, and sufficiently expedient exceptions process for a contraceptive item or service to be covered without cost sharing if an individual's attending provider recommends a particular item or service based on a determination of medical necessity with respect to that individual.

Section 2718 - Bringing down the Cost of Health Care Coverage (Medical Loss Ratios)

Effective 2011, the ACA requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement in order to calculate their Medical Loss Ratio (MLR). MLR requires insurance companies to spend at least 80% or 85% of premium dollars on medical care. If an issuer fails to meet the standards, it is required to provide a rebate to its policyholders and enrollees.

States may utilize grant funds to develop a Federal MLR audit and enforcement program at the State-level.[4] Such programs should extend beyond the limited-scope, controls-based review of an issuer's MLR or MLR reporting form that may be part of a State's regular financial examination. Pursuant to 45 CFR §158.403, HHS may accept the findings of a State's audit of an issuer's Federal MLR reporting and rebate obligations if certain conditions are met (e.g., State law permits the public release of the audit findings and the audit examines and reports on the validity of the issuer's reported data regarding expenses and premiums, as well as the accuracy and timeliness of rebates).

- **Perform substantive testing of an issuer's MLR Annual Report against each element of the MLR regulations**

  In conjunction with the NAIC, CCIIO developed a set of 22 agreed-upon-procedures (AUPs) that closely track each criterion of the Federal MLR requirements (statute and regulation (section 2718 of the PHS Act; 45 CFR Part 158). The AUPs are revised from time to time, as necessary, to reflect changes to the Federal reporting requirements. States may use grant funds to perform their own substantive testing of each element on an issuer's Federal MLR reporting form, including each State template for issuers with business in more than one State. A few of the recommended areas of such review are:

  - Comparing the issuer's Federal MLR reporting form against the Supplemental Health Care Exhibit (SHCE) that the issuer submitted to the State, and ensuring that reporting is consistent. Differences between the SHCE and the Federal MLR form (both the 12/31 and 3/31 columns) should be reconciled.
  - Verifying that the issuer correctly determined the number of employees an employer employed, as well as the accompanying group size and market classification (e.g., small group or large group) for such coverage.
  - Determining the basis of the issuer's allocation methodology and ensuring it was reasonable, including the allocation amongst different lines of business and different but affiliated legal entities, if any.
  - Reviewing the description of each of the issuer's quality improving activities (QIA) to confirm they meet the regulatory definition of 45 CFR §158.150-151 and testing that only allowable QIA expenses were included in the issuer's MLR calculation. States should also make sure that they understand the scope of QIA expenses included in each program or activity.

[4] The HHS Secretary is responsible for primary enforcement of the Federal MLR requirements under section 2718 of the PHS Act.

- If the issuer owed rebates for the MLR reporting year under review, testing a sample of rebates to ensure disbursement in accordance with the regulation, and reviewing the Rebate Notices.

- **Review additional processes as part of MLR oversight.**

Comparing an issuer's experience on specific MLR reporting categories to that of other issuers helps the regulator in determining the appropriateness of the items reported and helps identify trends within the market. States are encouraged to review the entirety of issuers' annual MLR reporting forms and perform some additional analyses. States may want to use funds to perform the following analyses:

- Review an issuer's entire annual MLR report against the reports of other issuers in the State as well as the nation.
- Review an issuer's raw MLR (claims/premiums) against its Federal, adjusted MLR.
- Review an issuer's reported experience for the MLR reporting year to that of prior years for any large variations.
- Review the amount and percentage of premium expended on QIA, community benefit expenditures, taxes, claims reserves against other issuers.

- **Items for a State to include in its final MLR Examination Report**

States that conduct MLR audits should publish the final MLR examination report on their websites. States may create a detailed report that delineates each MLR element that was tested and the results of such review.

Some key elements to include in State final MLR examination reports are:

- An explanation as to how the State tested the various regulatory elements.
- All of the State's detailed findings.
- A statement regarding the issuer's compliance, or lack thereof, with 45 CFR Part 158.
- The issuer's response to each finding, including any corrective action plan (CAP), the acceptability of the CAP to the State or the rejection of that response.

Section 2719- Appeals Process

Non-grandfathered group health plans and health insurance issuers are required to have both internal and external review processes to review claims denials. Health insurance issuers can utilize a State external review process if the State process includes, at a minimum, the consumer

protections in the NAIC Uniform Model Act or if the State process meets minimum standards established by HHS and is considered to be similar to the NAIC process (an NAIC-similar process). If a State does not have an external review process that includes the minimum consumer protections in the NAIC Uniform Model Act or is an NAIC-similar process (also known as States that are failing), non-grandfathered plans and issuers in that State must use a Federal external review process.

- **Bringing external review process up to the NAIC standard**

States that currently do not have an external review process that includes the minimum protections of the NAIC Uniform Model Act, but have an NAIC-similar process or are failing, have until December 31, 2017 to bring their process up to the NAIC standard in order for plans and issuers in their State to be able to use the State external review process beyond that date. These States can utilize grant funds to assist with bringing their external review process up to the NAIC standard provided that they can demonstrate that there is a reasonable chance that they can meet the standard by December 31, 2017. The minimum consumer protections that must be included in an external review process to meet the NAIC standard are specified in HHS regulations at 45 CFR 147.136(c)(2). Some of the protections are as follows:

- The process must provide for external review of adverse benefit determinations (and final internal adverse benefit determinations) based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

- Issuers (or plans) must be required to provide effective written notice to claimants of their rights to external review. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary if – (a) the issuer (or plan) waives the exhaustion requirement; (b) the issuer (or plan) is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process except those failures that are based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant and meet certain other requirements; or (c) the claimant simultaneously requests an expedited internal appeal and an expedited external review.

- The cost of an independent review organization (IRO) to conduct an external review must be borne by the issuer (or plan), although the process may require a nominal filing fee from the claimant requesting external review if the fee was in place as of November 18, 2015 and certain requirements related to the filing fee are met.

- There cannot be any restriction on the minimum dollar amount of a claim in order to be eligible for external review.

- The process must allow at least four months to file a request for external review after the receipt of the notice of adverse benefit determination or final internal adverse benefit determination.

- The IRO must be assigned by the State or an independent entity, on a random basis or another method of assignment that ensures the independence and impartiality of the assignment process (such as rotational assignment), and in no event assigned by the issuer, the plan, or the individual.

- The process must provide for the maintenance of a list of approved IROs (only those that are accredited by a nationally recognized private accrediting organization) qualified to conduct the external review based on the nature of the health care service that is the subject of the review.

- Approved IROs must have no conflicts of interest that will influence their independence.

Section 2726- Parity in Mental Health and Substance Use Disorder Benefits

The Mental Health Parity and Addiction Equity Act (MHPAEA) generally prevents group health plans and health insurance issuers, other than grandfathered or self-funded small employer group health plans and grandfathered small employer group health insurance coverage, that provide mental health and substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical coverage. States may use funds to expand their review for parity in mental health and substance use disorder benefits.

- **Review of forms, plan descriptions, and other plan documents**

  States with the most effective programs for enforcing MHPAEA conduct a thorough review of issuer policy forms, summary plan descriptions, certificates of coverage, and other plan documents to assess the plan's compliance with MHPAEA. The summary of benefits and coverage is also reviewed to assist in identifying potential disparities between medical/surgical benefits and mental health or substance use disorder benefits within a classification in terms of financial requirements (such as copays and coinsurance) and quantitative treatment limitations (such as day or visit limits). For any disparities identified – for example, charging the medical/surgical specialist cost sharing level for a mental health/substance use disorder (MH/SUD) office visit instead of the primary care cost sharing

level for medical/surgical office visit -- the State requests and reviews the issuer's quantitative parity analysis.

The State also thoroughly reviews any non-quantitative treatment limitations (such as prior authorization and other medical management techniques) on MH/SUD benefits, and requests written documentation from the issuer of the processes, strategies, evidentiary standards, and other factors used to develop non-quantitative treatment limitations (NQTLs) for medical/surgical and MH/SUD benefits to assure that the factors used in applying the limitation to MH/SUD benefits in the classification are comparable to, and applied no more stringently than, those used in applying the limitation to medical/surgical benefits in the classification.

The State also assures that the MHPAEA transparency standards are met. MHPAEA and the final regulations implementing MHPAEA provide express disclosure requirements. Specifically, the criteria for medical necessity determinations with respect to MH/SUD benefits must be made available by the plan administrator or the health insurance issuer to any current or potential participant, beneficiary, or contracting provider upon request. In addition, under MHPAEA, the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits must be made available to participants and beneficiaries. The Departments also explained in the preamble to the final regulations that, in addition to these specific disclosure obligations under MHPAEA, the Employee Retirement Income Security Act's (ERISA) general disclosure obligation in section 104(b) and the accompanying disclosure regulation at 29 CFR 2520.104b-1 provide that, for plans subject to ERISA, instruments under which the plan is established or operated must generally be furnished to plan participants within 30 days of request. Instruments under which the plan is established or operated include documents with information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and MH/SUD benefits under the plan. In addition, 29 CFR 2560.503-1, 29 CFR 2590.715-2719 and 45 CFR 147.136 set forth rules regarding claims and appeals, including the right of claimants (or their authorized representative) upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits. This includes documents with information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and MH/SUD benefits under the plan.

2. Authority

The Health Insurance Enforcement and Consumer Protections Grant Program is being administered by HHS under the authority of section 1003 of the ACA which adds a new section, 2794, to the PHS Act entitled, "Ensuring That Consumers Get Value for Their Dollars." Specifically, section 2794(c) directs the Secretary to carry out a program to award grants to States.

Section 2794 of the PHS Act appropriates $250 million to the Secretary to award grants to States to assist them with the health insurance rate review process, from fiscal year (FY) 2010 through FY 2014. Section 2794(c)(2)(B)[5] specifies that any appropriated Rate Review Grant funds that are not fully obligated by the end of FY 2014 shall remain available to the Secretary for grants to States for planning and implementing the insurance market reforms and consumer protections under Part A of title XXVII of the PHS Act.

3. Program Requirements

a. Overview

States may only apply for a Health Insurance Enforcement and Consumer Protections grant for the following purposes:

(1) Planning and/or implementing one or more of the below insurance market reforms or consumer protections under Part A of title XXVII of the PHS Act:

i. Section 2707 – Non-discrimination under Comprehensive Health Insurance Coverage (Essential Health Benefits Package)
ii. Section 2713 - Coverage of Preventive Health Services
iii. Section 2718 - Bringing down the Cost of Health Care Coverage (MLR)
iv. Section 2719 - Appeals Process
v. Section 2726 - Parity in Mental Health and Substance Use Disorder Benefits

[5] PHS Act section 2794(c)(2)(B) states in full: "If the amounts appropriated under subparagraph (A) are not fully obligated under grants under paragraph (1) by the end of fiscal year 2014, any remaining funds shall remain available to the Secretary for grants to States for planning and implementing the insurance reforms and consumer protections under part A."

A summary of these provisions is found under Appendix E. States may not use grant funding for any other provision under Part A of Title XXVII of the PHS Act that is not specifically listed above.

The Health Insurance Enforcement and Consumer Protections grant is open to all States that are currently enforcing the ACA market reforms, and also for those States who are not currently enforcing the ACA market reforms to assist with their respective transition to an active enforcement role for all the market reforms and consumer protections under Part A of Title XXVII of the PHS Act.

Applicants may only apply for funding for those reforms that the State is not currently receiving Federal grant funding to plan and implement the ACA market reform provision(s). Detailed eligibility criteria are described in Section III, *Eligibility*.

B. Eligibility Requirements and Limitations on Scope

Eligibility requirements applying to States seeking to pursue Market Reform Activities with Cycle I funds

To be eligible for an award under the Health Insurance Enforcement and Consumer Protections grant, a State must be able to demonstrate at the time of the application either that it is already enforcing the ACA market reforms and consumer protections, or that, with the funding resources under this grant, it can transition to an active enforcement role with respect to all of the ACA market reforms and consumer protections established under Part A of title XXVII of the PHS Act.

States that are not currently enforcing the ACA market reforms and consumer protections under Part A of Title XXVII of the PHS Act at the time of application may select which of the pre-selected specific market reforms they wish to apply funding towards. However, these States must transition to an active enforcement role for **all** of the ACA market reforms and consumer protections under Part A of Title XXVII of the PHS Act ***within the first year and a half of their Cycle I grant award***. HHS may restrict future grant funds for certain grant activities if milestones are not met.

Applicants must ensure that they are only seeking funding to plan and implement those provisions that they are not currently receiving Federal grant funding to plan and implement.

Each State seeking to plan and implement the pre-selected ACA market reforms and consumer protections under Part A of title XXVII of the PHS Act must include in its Project Narrative and Work Plan a proposal for program activities that enhance its current enforcement status or how it

would lead to the transition to an active enforcement role with respect to all the market reforms and consumer protections under Part A of Title XXVII of the PHS Act within the first year and a half of their Cycle I grant award.

e. Work Plan

Each State will be required to develop and submit a Work Plan that outlines specific milestones for successful planning and/or implementation of activities related to the Federal market reforms and consumer protections established under Part A of title XXVII of the PHS Act that the State seeks grant funding for. These milestones must be articulated clearly, be measureable, and be appropriate for the award time period. Each State will also provide Progress Metrics towards each of their objectives as described in Section IV, Application and Submission Information, (E), Work Plan. Section IV.E provides additional information and examples of milestones. Section II, *Award Information*, provides additional information regarding the process that will be used to inform States of the funding availability.

f. Demonstrating Progress toward Milestones

Progress toward the milestones outlined in the Work Plan will be reported during the quarterly programmatic progress reports and in the required programmatic annual reports. States will have the opportunity to update and amend their Work Plans on a quarterly basis throughout the Cycle I Grant Program. HHS will work closely with a State in the event that a State updates its Work Plan as its plans evolve, and HHS will make technical assistance available to facilitate and support State progress throughout the Grant Program.

States will be required to describe the current State of their implementation or enforcement program, identify the goal(s) to be met through use of the grant funding, specify how the grant funds would be used to achieve the identified goal, and provide a description of how the State would measure success of the outcome. To establish quantitative measurement of the goals, the grant will require States to provide updates on the completion of each activity on a quarterly basis, based on the Reporting Metrics described in Section IV, Application and Submission Information, (E), Work Plan, which will provide metrics for CMS to monitor the progress of each proposed activity.

State progress will be evaluated based on the submission of quarterly and annual reports, and advancement toward the described milestones. Additional technical assistance will be available to States that are not showing progress toward the required milestones; however, HHS may restrict future grant funds for certain grant activities if milestones are not met. More detailed information

will be provided on the quarterly and annual reports as well as the reporting structure in the Notice of Award.

g. Commitment to Mentor States (Optional)

States that are currently enforcing the pre-selected ACA market reforms and consumer protections under Part A of Title XXVII of the PHS Act may agree to mentor and collaborate with other States on the planning and/or implementation, of market reform activities and best practices. Interested States must provide additional information per the Mentor section in the application.

II. FEDERAL AWARD INFORMATION

1. Total Funding

Under section 2794 of the PHS Act, funds are available to support grants as necessary to fulfill the purpose of this funding opportunity to all eligible States, including the District of Columbia, that are currently enforcing, as well as those that with the additional funding resources can transition to an active enforcement role with respect to all of the ACA market reforms and consumer protections under Part A of title XXVII of the PHS Act. CMS is anticipating approximately $22 million will be available for the Health Insurance Enforcement and Consumer Protections grants, pending availability of funds.

The amount of funds awarded to each recipient will be conditional upon funding availability and the specifically selected reforms. As a result, all applicants must submit the mandatory Letter of Intent by the deadline given, July 6, 2016. HHS will use this information to determine the amount of funding available to each recipient. The project period is expected to be 24 months (see Section II. 2. *Award Amount* for more information). HHS will provide applicants with information on funding allocation prior to July 15, 2016.

Baseline funding for the Health Insurance Enforcement and Consumer Protections grants consists of a minimum of approximately $250,000 for the length of the award. Provided sufficient funds are available after providing each State with baseline funding for a two-year project period, States may also receive additional "Selected Market Reforms" funding, which will be a flat dollar amount for each selected market reform that will be the same for all States and determined based on the anticipated impact the selected market reform will have on consumers and their premiums, as further described under Section 2 below. If there are sufficient funds available after providing baseline funding and "Selected Market Reforms" funding, States may also receive supplemental awards called "Workload" funds. Workload funds are determined based on the population and number of health insurance issuers in the State, as further described in Appendix D. Following submission of the mandatory Letters of Intent, HHS will inform States of funding allocations, including whether baseline award amounts have increased and if there are sufficient funds

available for the "Selected Market Reforms" and "Workload" supplemental awards. The baseline funding formula will be consistent, regardless of the activities for which a State applies for funds.

2. Award Amount

Award amounts will consist of Baseline, Selected Market Reforms and Workload awards, as follows:

- Baseline Award Amount: Each eligible State will be awarded a minimum of $250,000 baseline award for 24 months.

- Additional Funding for Selected Market Reforms: States will have the opportunity to receive additional funding based on their selection of each applicable market reform provision for this grant listed below, provided sufficient funds are available after providing for baseline funding for a two-year project period for all eligible applicants. HHS has designated and ordered the additional funding for planning and implementation of the selected market reforms based on the anticipated impact the selected market reform will have on consumers and their premiums. States may select of their choice any subset of combinations of the applicable market reform provisions listed below.

  The below list of market reforms is ordered from (1)-(5), with (1) receiving the highest amount of additional funding, and (5) receiving the lowest. The exact amounts will be provided to the applicant after HHS has received the Mandatory Letters of Intent and is able to determine the amount of funds available for this purpose. Each selected market reform listed below will be given a specific flat dollar amount.

  1) Section 2726 - Parity in Mental Health and Substance Use Disorder Benefits (MHPAEA)

  2) Section 2713 - Coverage of Preventive Health Services

  3) Section 2707 - Non-discrimination under Comprehensive Health Insurance Coverage (Essential Health Benefits Package)

  4) Section 2718 - Bringing down the Cost of Health Care Coverage (MLR)

  5) Section 2719 – Appeals Process

  If additional funding is available for selected market reforms, these funds will be awarded automatically along with the Baseline Award in the Notice of Award for eligible applicants.

- Workload Awards: Workload funds will only be available if there are sufficient funds available after providing baseline awards and providing additional funds for the selected market reforms listed under section II.2(b), for all eligible applicants.

  Funding Formula for Workload Awards: States will be eligible to receive additional grant funds based on the State population size and the number of issuers with five percent or more market share (combined individual and small group market) within the State, as further described in Appendix D.

  If funding is available for Workload awards, the Workload funds will be awarded along with the Baseline Award and the additional funding for the selected market reforms in the Notice of Award for eligible States. HHS will inform States whether sufficient funds are available for Workload funds following submission of the mandatory Letters of Intent.

  See Appendix D (Workload Funds Allocation and Example) for additional information.

3. Anticipated Award Date

The Health Insurance Enforcement and Consumer Protections grant awards will be issued October 19, 2016.

4. The Period of Performance

The grant will have a project and budget period of 24 months from the award date.

24-month project and budget period: October 19, 2016 to October 18, 2018

5. Milestones and Funding

The drawdown of funds will be dependent on HHS acceptance of the required quarterly reports and the grantee's performance toward specified milestones according to the set due dates as outlined in this FOA, program requirements, and in the terms and conditions provided with the Notice of Award.

6. Number of Awards

There will be no more than fifty-one initial Baseline Amounts awarded, for each of the fifty States and the District of Columbia. Only one State is currently eligible for its Baseline Amount award to be issued as two separate awards.[6] All awards are subject to funding availability.

7. Type of Award

These awards will be issued and structured as grants. HHS will work closely with each State to evaluate its progress against its Work Plan and may condition the availability of funding on a State's demonstrated progress toward the proposed grant Work Plan. HHS Project Officers will track each State's progress and provide technical assistance when needed.

III. ELIGIBILITY INFORMATION

1. Eligible Applicants

This FOA is open to all fifty States and the District of Columbia for planning and/or implementing one or more of the five pre-selected market reforms and consumer protections in Part A of title XXVII of the PHS Act. Please refer to Section I.1.(b) for the PHS Act provisions applicable to this funding opportunity.

Only one application per State is permitted, except in a State in which there is more than one regulating entity, each with a primary responsibility over the regulation of a portion of the private health insurance market.

Applicants must submit the following letters (or other permissible document as outlined):

- If the applicant/State is currently enforcing the ACA market reforms in Part A of title XXVII of the PHS Act, a letter signed by the head of the applicable State regulatory agency attesting that the State is enforcing the ACA Federal market reforms in Part A of title XXVII of the PHS Act at the time of application and will continue enforcing the Federal market reforms for the duration of the grant project period.
- If the applicant/State is not enforcing the ACA market reforms under Part A of Title XXVII of the PHS Act at the time of application, a letter indicating that they plan to transition to an active enforcement role with respect to all of the ACA market reforms and

[6] This provision currently applies to the State of California, which has two regulatory agencies that are each primarily responsible for regulating a portion of the private health insurance market. A State eligible to submit multiple applications will be required to split the total grant award allocated for that State and therefore the regulatory agencies involved must collaborate with each other regarding a proposed budget. However, each State regulatory agency will be viewed as a distinct grantee responsible for submitting separate programmatic and financial reports.

consumer protections under Part A of title XXVII of the PHS Act within the first year and a half of their Cycle I grant award.

- A letter attesting that the State is not receiving other Federal grant dollars for the same activity for which it will receive the Health Insurance Enforcement and Consumer Protections grant funding.
- A State certification of Maintenance of Effort verifying that the grant funds will not supplant existing State expenditures for Market Reforms activities.

Additional eligibility criteria:

(a) All applicants must be currently enforcing, or within one and a half years of receiving grant funding will be able to transition to an active enforcement role relating to all of, the ACA market reforms and consumer protections under Part A of title XXVII of the PHS Act. (b) States may request funding only for activities not already funded/supported by another Federal grant award. Each award made under this funding opportunity should support different activities and should not be used for activities funded by other grant awards. In the budget request, States should distinguish between activities that will be funded under this application and activities funded with other sources.

2. Continued Eligibility

A State must meet the milestones proposed in the grant application and outlined in the Work Plan to continue to be eligible throughout the project period. A State must continue to meet the eligibility criteria described in Subsection 1, *Eligible Applicants,* of Section III, *Eligibility Information*, throughout the project period.

3. Legal Status

All applicants must have a valid Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN) assigned by the Internal Revenue Service.

4. Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS number)

All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number in order to apply. The DUNS number is a nine-digit identification number that uniquely identifies business entities. To obtain a DUNS number, access the following website: www.dunandbradstreet.com or call 1-866-705-5711. See Section IV, *Application and Submission Information*, for more information on obtaining a DUNS number.

5. System for Award Management (SAM)

System for Award Management (SAM) Requirement: All applicants must provide their Data Universal Numbering System (DUNS) and Employee Identification Number/Tax Identification Number (EIN/TIN) numbers in order to be able to register in the System for Award Management (SAM)* https://www.sam.gov/portal/public/SAM/. Please see Appendix H for further information on SAM.

6. Cost Sharing/Matching

Awardees are not required to provide matching contributions.

7. Foreign and International Organizations

Foreign and international organizations are not eligible to apply.

8. Faith Based Organizations

Faith-based organizations are not eligible to apply.

9. Maintenance of Effort

The State share of funds expended for Market Reforms activities under the State's proposed plan for Market Reforms activities shall not be less than the State (non-grant) funds expended for Market Reforms activities in the fiscal year preceding the fiscal year for which the grant is awarded. All applicants that are currently enforcing the ACA market reforms must ensure that grant funds will only be used for the planning and/or implementation, of the State's existing Market Reforms efforts, and not as a substitute for existing funding for such efforts.

10. One Application Requirement, with Certain Exceptions

Only one application may be submitted by a single eligible State for funding in Cycle I, except in a State in which there is more than one regulating agency, each with a primary responsibility over the regulation of a portion of the private health insurance market. A State with more than one application will be required to split the total grant award allocated for that State and therefore must collaborate with the other applicable State agencies regarding a proposed budget. However, each State regulatory agency will be viewed as a distinct grantee responsible for submitting separate programmatic and financial reports.

11. Pre-Application Conference Call

HHS will hold pre-application conference calls for potential applicants. During the call, HHS staff will provide an overview of the Grant Program, offer budget guidance, review the guidance provided by this FOA and other available materials, and provide an opportunity for States to ask

questions. Details on the date, time, and call-in information will be provided prior to the conference call.

IV. APPLICATION AND SUBMISSION INFORMATION

1. Required Information and Material for Application Package

This FOA contains instructions to apply for the Cycle I Health Insurance Enforcement and Consumer Protections Grant Program. The application should be written primarily as a narrative with the addition of standard forms required by the Federal government for all grants. Please refer to Appendix H for the full description of all the information and material required to apply under this Funding Opportunity Announcement.

A Letter of Intent is required for Cycle I funding. A Letter of Intent should include a brief explanation of a State's intent to apply and should clearly list exactly which provision(s) that it seeks funding for under the Cycle I Health Insurance Enforcement and Consumer Protections Grant Program. The purpose of the Letter of Intent is to determine the number of applications and total funding for award planning purposes. Following review of the Letters of Intent, eligible applicants will be notified of their potential funding eligibility. Please note that submitting a Letter of Intent to apply is not binding on an applicant. The Letter of Intent must be submitted electronically in PDF format to James.Taing@cms.hhs.gov by the deadline stated in the Overview Section.

1. Application Materials

For additional application materials and guidance, refer to Appendix H. *Application and Submission Information*. For content and form requirements of the application material, refer to Section IV.2. *Content and Form of Application Submission.*

Applications must be submitted in the required electronic-format at http://www.grants.gov no later than the established deadline date and time as listed in the Executive Summary.

Please refer to the Executive Summary for deadline date. If an applicant fails to submit all of the required documents or does not address each of the topics, the applicant risks not being awarded a grant. See Section V. *Application Review Information*.

All applications will receive an automatic time stamp upon submission and applicants will receive an email reply acknowledging the application's receipt. Applications not received by the application deadline through www.grants.gov will not be reviewed.

2. Content and Form of Application Submission

Each application must include all contents described below and in conformity with the following specifications:

The application Project Narrative must not exceed 20 pages in length; the Budget Narrative must not exceed 10 pages; the Work Plan must not exceed 15 pages for all Work Plans combined; and the Business Assessment of Applicant Organization must not exceed 10 pages.

Formatting Requirement for the Project Narrative, Budget Narrative[7], and Work Plan:

Paragraph: Single space
Font Size: 12pt font size
Typeface: Times New Roman or Arial
Margin: 1 inch (2.54 cm) all around
Paper Size: 8.5" x 11"
All pages of the project narrative must be paginated in a single sequence.
The project narrative must be double-spaced.
The budget narrative may be single-spaced.
Numbers of Copies: One
Sequence or Assembly Requirement: None
Charts/Graph: Any. Charts and tables may be single-spaced. However, charts and tables should not be used to avoid the double-spaced narrative requirement.

The Standard Forms and additional supporting documentation listed below are excluded from the page limitation and are excluded from the formatting requirements listed above.

The following documents are required for a complete application:

A. Standard Forms (excluded from page limitations)

The following forms must be completed with an original signature and enclosed as part of the application:

- SF 424: Official Application for Federal Assistance (see note below)
- SF 424A: Budget Information Non-Construction
- SF 424B: Assurances-Non-Construction Programs
- SF LLL: Disclosure of Lobbying Activities *All applicants must submit this document. If your entity does not engage in lobbying, please insert "Non-Applicable" on the document and include the required Authorized Organizational Representative (AOR) name, contact information, and signature.*
- Project Site Location Form(s)

[7] When creating the budget narrative, applicants should follow the example provided in Section VIII., Appendix C., *Guidance for Preparing a Budget Request and Narrative in Response to SF-424A.*

Note: On SF 424 "Application for Federal Assistance:"

- Item 15 "Descriptive Title of Applicant's Project." Please indicate in this section the name of this grant: "Grants to States for Planning and Implementing the Insurance Market Reforms under Part A of Title XXVII of the Public Health Service Act, Cycle I."

- Check box "C" to item 19, as Review by State Executive Order 12372 does not apply to these grants.

- Assure that the total Federal funding requested is for the entire period of the grant.

B. Applicant's Application Cover Letter or Cover Page (required)

A letter from the applicant must identify the:

- Project Title
- Applicant Name
- Project Director Name (with email and phone number)
- Authorized Official (person with authority to sign off on all decisions for the award)

C. Project Abstract Form (required)

Applicants will be able to use a blank form in GrantSolutions in which they will be able to provide a one-page abstract to serve as a succinct description of the proposed project and must include the goals of the project, the total budget, and a description of how the grant will be used to plan, implement, and/or enhance the pre-selected market reforms under Part A of title XXVII of the PHS Act.

Place the following at the top of the abstract for the application:

A. Application title
B. Applicant organization name
C. Program applying under, including funding opportunity number
D. Project Director
E. Project Director address
F. Project Director contact phone numbers (phone and fax)
G. Project Director email address
H. Organizational Website address, if applicable
I. Projected date(s) for project(s) completion

D. Project Narrative (required) – 20 page maximum

For each proposed grant activity, the applicant must provide a Project Narrative that articulates in detail, the goals, measurable objectives, and milestones. Progress in completing these goals, objectives, and milestones will be monitored closely throughout the grant reporting process. **At the beginning of the Project Narrative, please include the title "Project Narrative."**

Both the required and optional sections of the Project Narrative are described below.

For each selected market reform that the State plans on pursuing with the Cycle I grant funds, the applicant must address the following sections based on each of the selected reforms that it seeks grant funding for:

- Section (b), "Description of Current [selected market reform] Processes"; and
- Section (c), "Proposed Activities for Planning and/or Implementing Market Reforms"

All States must provide the following sections:

- Section (a), "Eligibility"; and
- Section (d), "Evaluation Plan."
- Section (e), "Commitment to Mentor States," is optional; however, States interested in mentoring other States must address this section.

Section (a), Eligibility
Mandatory: This section is mandatory for all applicants.

Each applicant must identify the criteria under which they are eligible for Cycle I, and describe how the applicant meets the relevant eligibility criteria. An applicant must meet one of the eligibility requirements described below.

All States applying to fund Market Reform Activities must select one below:

☐ Currently enforcing the ACA market reforms and consumer protections under Part A of title XXVII of the PHS Act; and not receiving other Federal grant dollars for the same market reform activities for which the applicant is pursuing funding under the Health Insurance Enforcement and Consumer Protections grant.

☐ Will transition to an active enforcement role with respect to all of the ACA market reforms and consumer protections under Part A of title XXVII of the PHS act within one and half years of receiving grant funds; and is not receiving other Federal grant dollars for the same market reform activities for which the applicant is pursuing funding under the Health Insurance Enforcement and Consumer Protections grant.

Section (b), Description of Current Market Reform Processes
Mandatory: This section is required for all applicants.

As part of the Project Narrative, applicants must provide a detailed description of their current market reforms enforcement and oversight process. States must include in the Project Narrative a comprehensive description of the State's current authority and/or process for each of the market reform activities that they plan on pursing with the Cycle I grant. States that are not currently enforcing the ACA market reforms under Part A of title XXVII of the PHS Act must note that they are not currently enforcing the market reforms and what steps will be taken to transition to an active enforcement role with respect to all of the ACA market reforms within the first year and half of receiving grant funds.

Applicants must also provide information regarding their existing statutory and regulatory authority to implement and enforce the Federal market reforms and consumer protections established under Part A of title XXVII of the PHS Act.

Section (c), Proposed Activities for Planning and/or Implementing Market Reforms and Consumer Protections
Mandatory: This section is required for all applicants.

The Health Insurance Enforcement and Consumer Protections grant provides States a funding source to assist them in the areas of the five selected provisions that they deem most necessary after spending time and resources on implementing those five Federal market reforms. The Cycle I grant will provide States with the opportunity to ensure their laws, regulations, and procedures are in line with Federal law and that they are able to effectively enforce the pre-selected market reform provisions under Part A of title XXVII of the PHS Act.

Applicants may use grant funds for a variety of planning and implementation objectives, including but not limited to implementing or enhancing policy form review, market conduct examinations, market analysis, financial examinations, and consumer complaint investigations. Grant funds can be used for, but are not limited to being used for the following activities:

- Hiring staff and/or consultants to ensure issuer compliance;
- Providing staff training;
- Developing internal manuals, checklists, and training materials;
- Implementing recommended areas of focus for market reform activities identified in the Funding Opportunity Announcement;
- Hiring consultants to develop best practices, market analysis, and/or process improvement;
- Developing IT infrastructure or databases;

- Purchasing or using software or other technological services, including staff training on using the technology. Software examples include TeamMate to assist with policy form review and market conduct examinations, and ACL Analytics to assist with data sampling and analysis.
- Creating external checklists or materials to assist issuers with compliance with the pre-selected Part A provisions;
- Developing consumer-friendly outreach information on the pre-selected Part A provisions, such as fact sheets or FAQs, which could lead to more consumer complaints on issuer non-compliance;
- Enhancing or reconciling State requirements with Federal standards; and/or,
- Enhancing State websites to: (1) provide information on the pre-selected Part A provisions to the public and/or issuers; (2) develop or enhance the ability to receive comments/questions/complaints from consumers about the market reforms or issuer compliance; and/or (3) develop or enhance the ability of issuers to provide compliance information to the State electronically through its website.

Section (d), Evaluation Plan
Mandatory: This section is required for all applicants.

To ensure accountability, States are required as part of the grant application to describe the current state of their program, identify the goal of the grant funding, specify how the grant funds would be used to achieve the identified goal, and provide a description of how the State would measure success of the outcome. Throughout the course of the grant period, States will be required to provide quarterly and annual reports that specify the milestones being met to achieve the goal or outcome.

The Project Narrative must include specific measures on how the grantee will evaluate its progress and measure success within its market reforms program. Please provide baseline information or data for each measurable objective to be evaluated. The grantee will be expected to update information and data for each measure as part of the quarterly report and provide an evaluation plan that will assess the program on the overarching goals of the project. The grantee will also be expected to comply with Federal evaluation requirements. Specifically, applicants should include:

- Discussion of chosen key indicators to be measured;
- A description of baseline data for each indicator;
- Methods to monitor progress and evaluate the achievement of program goals both on an ongoing basis and at the conclusion of the program; and
- Inclusion of plans for timely interventions when targets are not met or obstacles delay progress.

Section (e), Commitment to Mentor States
This section is optional for all grant applicants.

States may agree to mentor and collaborate with other States on the planning and/or implementation, of market reform activities and best practices.

E. Work Plan (required) – 15 page maximum (all work plans combined)

The Work Plan must provide a comprehensive and thorough description of proposed activities, including milestones with specified timeframes for completion. The Work Plan should be as detailed as possible, and reflect the processes and activities specific to each State for achievement of the required milestones for the entire project period. For example, if the State procurement procedure requires six months to develop a request for proposal, review applications and award a contract, these steps and the associated time it takes to complete them should be taken into account in the lead time to achieving each milestone affected by procurement. All such processes should be described in detail throughout the Work Plan.

Additionally, States will need to provide Progress Metrics, as described below in section (E2), Progress Metrics, for each of the grant's activity.

The reasonableness and completeness of the specific tasks to be conducted throughout the project period will be reviewed as well as the adequacy of the projected timeframes. The Work Plan must indicate which milestones the Program plans to meet within the associated timeframes. The incremental steps to achieving these milestones should also be identified by the months and years in which they start, are carried out, and completed. States are permitted to do a separate Work Plan for different aspects of their grant application. There is not a specified template for the Work Plan. **At the beginning of the Work Plan, please include a title that includes the words "Work Plan" in it.**

E2. Progress Metrics:

In order to provide metrics for CMS to monitor the progress of each activity, each State will be required to report quantitative measurements (quarterly and annually) on each of their activity objectives, as described below:

Stage 0- No work has begun on stated goal.
Stage 1- Project Plan has been created and staff has been assigned to task. The work on achieving the goal has initially begun.

Stage 2- Goal of the Project Plan is underway, and any refinements or adjustments to original Project Plan were made.
Stage 3- Goal of the Project Plan is half way complete and continuously being worked on.
Stage 4- Deliverables are beginning to finalize and proposed goals are nearly completed.
Stage 5- 100% of stated goal has been completely achieved.

F. Budget and Budget Narrative (required)

i. SF-424A

All applicants must submit an SF 424A. To fill out the budget information requested on form SF 424A, review the general instructions provided for the SF 424A and follow the instructions outlined below.

Section A – Budget Summary

- *Grant Program Function or Activity* (column a) = Enter "Grants to States for Planning and Implementing the Insurance Market Reforms under Part A of Title XXVII of the Public Health Service Act, Cycle I" in row 1.

- *New or Revised Budget, Federal* (column e) = Enter the Total Federal Budget Requested for the project period in rows 1 and 5.

- *New or Revised Budget, Non-Federal* (column f) = Enter Total Amount of any Non-Federal Funds Contributed (if applicable) in rows 1 and 5.

- *New or Revised Budget, Total* (column g) = Enter Total Budget Proposed in rows 1 and 5, reflecting the sum of the amount for the Federal and Non-Federal Totals.

Section B – Budget Categories

- Enter the total costs requested for each Object Class Category (Section B, number 6) for each year of the project period. Under Section B, there are 5 columns (immediately below Grant Program, Function, or Activity). Cycle I applicants should complete columns (1), (2), and (5).
- Column (1) = Enter Year 1 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total

for direct and indirect charges for all year 1 line items should be entered in column 1, row k (sum of row i and j).

- Column (2) = Enter Year 2 costs (if applicable) for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all year 2 line items should be entered in column 2, row k (sum of row i and j).
- Column 5 = Enter total costs for the project period for each line item (rows a-h), direct total costs (row i), and indirect costs (row j). The total costs for all line items for the two years should be entered in row k (sum of row i and j). The total in column 5, row k should match the total provided in Section A – Budget Summary, New or Revised Budget, column g, row 5.

ii. Budget Narrative – maximum 10 pages

Applicants must supplement Form SF-424A with a Budget Narrative. The Budget Narrative must include a yearly breakdown of costs according to a 24-month project period (based upon information provided by HHS to States which submit the mandatory letter of intent). See Section II. *Award Information* for more information on the performance period. Applicants must include a clear description of the proposed set of services that will be covered with grant funds. The Budget Narrative should provide a detailed cost breakdown for each line item outlined in the SF-424A by grant year, including a breakdown of costs for each activity/cost within the line item. The proportion of the requested funding designated for each activity should be clearly defined and should justify the applicant's readiness to receive funding. The budget must separate out funding that is administered directly by the lead agency from funding that will be subcontracted to other partners.

The following information and budget categories should be addressed (as applicable) and match the budget shown in Section B of the SF-424A.

- Estimated Budget Total.
- Current State funding for market reforms efforts, if the State currently devotes funding to such activities. The amount that was spent in the preceding fiscal year on market reforms activities for the Maintenance of Effort requirement (MOE).
- Total estimated funding requirements for each of the following line items, and a break down for each line item by grant year:
    - Personnel
    - Fringe benefits
    - Contractual costs, including subcontract contracts
    - Equipment

- Supplies
- Travel
- Indirect charges, in compliance with the cost principles included in HHS regulation 45 CFR Part 75 (implementing OMB regulation 2 CFR Part 200).
- Other costs
- Completion of the Budget Form 424A remains a requirement for consideration of your application. This Estimated Budget Presentation is an important part of your proposal and will be reviewed carefully by HHS staff.
- Provide budget notes for major expenditures and notes on personnel costs and major contractual costs.

Please refer to the budget narrative example included in Section VIII., Appendix C, *Guidance for Preparing a Budget Request and Narrative in Response to SF424A*.

G. Required Business Assessment of Applicant Organization (maximum of 10 pages)

As required by 45 CFR §75.205 for competitive grants and cooperative agreements, CMS will evaluate the risk posed by applicants before they receive an award. This analysis of risk includes items such as financial stability, quality of management systems, and the ability to meet the management standards prescribed in 45 CFR Part 75.

All applicants must review and answer the business assessment questions outlined below. There are ten (10) topic areas labeled A-J, with a varying number of questions within each topic area. Applicants MUST provide an answer to each question. Moreover, applicants should refrain from solely answering yes or no to each question – i.e., a brief, substantive answer should be given for almost all questions (referring to sections of official agency policy is acceptable). If the answer to any question is non-applicable, please provide an explanation. Please note, if CMS cannot complete its review without contacting an applicant for additional clarification, the applicant may not be selected for award.

A. General Information

1. Does the organization have a Board of Directors with specific functions and responsibilities (by-laws)?
2. Are minutes of the Board of Directors' meetings maintained?
3. Is there an organizational chart or similar document establishing clear lines of responsibility and authority?
4. Are duties for key employees of the organization defined?
5. Does the organization have grants or cost-reimbursement contracts with other U.S.

Department of Health and Human Services components or other Federal agencies?

6. Have any aspects of the organization's activities been audited recently by a Government agency or independent public accountant?
7. Has the organization obtained fidelity bond coverage for responsible officials and employees of the organization?
8. Has the organization obtained fidelity bond insurance in amounts required by statute or organization policy?

B. Accounting System

1. Is there a chart of accounts?
2. Is a double-entry accounting system used?
3. Does the organization maintain the basic books of account as applicable?
    a. General ledger
    b. Operating ledger
    c. Project (Job) cost ledger
    d. Cash receipts journal
    e. Cash disbursement journal
    f. Payroll journal
    g. Income (sales) journal
    h. Purchase journal
    i. General journal
4. Does the accounting system adequately identify receipt and disbursement for each grant (or contract)?
5. Does the accounting system provide for the recording of expenditures for each program by required budget cost categories?
6. Does the accounting system provide for recording the non-Federal share and in-kind contributions (if applicable for a grant program)?
7. Does the organization prepare financial statements at least annually? If not, how often?
8. Have the financial statements been audited within the past 2 years by an independent public accountant?
9. Does the organization have a bookkeeper or accountant? If no, who is in charge of the accounting section?
10. Is there an accounting instruction manual?

C. Budgetary Controls

1. Does the organization use an operating budget to control project funds?

2. Are persons in the organization who approve budget amendments authorized to do so by the Board of Directors or top management?
3. Are there budgetary controls in effect to preclude incurring obligations in excess of:
    a. Total funds available for an award?
    b. Total funds available for a budget cost category?
4. Are cash requirements and/or drawdowns limited to immediate need?

D. Personnel

1. Are personnel policies established in writing or in the process of preparation which detail at a minimum:
    a. Duties and responsibilities of each employee's position?
    b. Qualifications for each position?
    c. Salary ranges associated with each job?
    d. Promotion Plan?
    e. Equal Employment Opportunity?
    f. Annual performance appraisals?
    g. Types and levels of fringe benefits paid to professionals, nonprofessionals, officers, or governing board members?
2. Is employee compensation reasonable and comparable to that paid for similar work in the competitive labor market?
3. Are salary comparability surveys conducted? How often?
4. Are salaries of personnel assigned to Government projects about the same as before assignment? Identify reasons for significant increases.
5. Does the organization maintain a payroll distribution system which meets the required standards as contained in the applicable cost principles for that organization?
6. Does the organization maintain daily attendance records for hourly employees? Does this show actual time employees sign in and out?
7. Does the payroll distribution system account for the total effort (100%) for which the employee is compensated by the organization?
8. Who signs and certifies work performed in items 5, 6, and 7 above?
9. Where duties require employees to spend considerable time away from their offices, are reports prepared for their supervisors disclosing their outside activities?

E. Payroll

1. Does preparation of the payroll require more than one employee?
2. Are the duties of those individuals preparing the payroll related?

3. Are the names of employees hired reported in writing by the personnel office to the payroll department?
4. Are the names of employees terminated reported in writing by the personnel office to the payroll department?
5. Is the payroll verified at regular intervals against the personnel records?
6. Are all salaries and wage rates authorized and approved in writing by a designated official or supervisor?
7. Are vacation and sick leave payments similarly authorized and approved?
8. Is there verification against payments for vacation, sick leave, etc., in excess of amounts approved and/or authorized?
9. Is the payroll double-checked as to:
    a. Hours?
    b. Rates?
    c. Deductions?
    d. Extensions, etc.?
10. Are signed authorizations on file for all deductions being made from employees' salaries and wages?
11. Is the payroll signed prior to payment by the employee preparing the payroll? The employee checking the payroll?
12. Are salary payrolls approved by an authorized official prior to payment?
13. Are employees paid by check or direct deposit? If no, how are they paid?
14. If paid by check, are the checks pre-numbered?
15. Are checks drawn and signed by employees who do not:
    a. Prepare the payroll?
    b. Have custody of cash funds?
    c. Maintain accounting records?
16. Are payroll checks distributed to employees by someone other than the supervisor?
17. Is there a payroll bank account? If no, will one be opened if recipient is selected for award?
18. Is the payroll bank account reconciled by someone other than payroll staff or personnel who sign and distribute the pay checks?

F. Consultants

1. Are there written policies or consistently followed procedures regarding the use of consultants which detail at a minimum:
    a. Circumstances under which consultants may be used?
    b. Consideration of in-house capabilities to accomplish services before contracting

for them?

c. Requirement for solicitation or bids from several contract sources to establish reasonableness of cost and quality of services to be provided?
d. Consulting rates, per diem, etc.?

2. Are consultants required to sign consulting agreements outlining services to be rendered, duration of engagement, reporting requirements, and pay rates?

G. Property Management

1. Are records maintained which provide a description of the items purchased, the acquisition cost, and the location?
2. Are detailed property and equipment records periodically balanced to the general ledger?
3. Are detailed property and equipment records periodically checked by physical inventory?
4. Are there written procedures governing the disposition of property and equipment?
5. Are periodic reports prepared showing obsolete equipment, equipment needing repair, or equipment no longer useful to the organization?
6. Does the organization have adequate insurance to protect the Federal interest in equipment and real property?

H. Purchases

1. Does the organization have written purchasing procedures? If not, briefly describe how purchasing activities are handled.
2. Does the policy/procedure consider such matters as quality, cost, delivery, competition, source selection, etc.?
3. Has the responsibility for purchasing been assigned to one department, section, or individual within the organization? If not, explain.
4. Is the purchasing function separate from accounting and receiving?
5. Are competitive bids obtained for items such as rentals or service agreements over certain amounts?
6. Are purchase orders required for purchasing all equipment and services?
7. Is control maintained over items or dollar amounts requiring the contracting or grants management officer's advance approval? Describe controlling factors.
8. Is the accounting department notified promptly of purchased goods returned to vendors?

9. Is there an adequate system for the recording and checking of partial deliveries and checking deliveries against purchase orders?
10. When only a partial order is received, is the project account credited for the undelivered portion of the purchase order?
11. Are the vendor invoices checked for:
    a. Prices and credit terms?
    b. Extensions?
    c. Errors and omissions?
    d. Freight charges and disallowances?
12. Are vouchers, supporting documents, expenses, or other distributions reviewed and cleared by designated staff before payment is authorized?

I. Travel

1. Does the organization have formal travel policies or consistently followed procedures which, at a minimum, state that:
    a. Travel charges are reimbursed based on actual costs incurred or by use of per diem and/or mileage rates?
    b. Receipts for lodging and meals are required when reimbursement is based on actual cost incurred?
    c. Per Diem rates include reasonable dollar limitations? Subsistence and lodging rates are comparable to current Federal per diem and mileage rates?
    d. Commercial transportation costs are incurred at coach fares unless adequately justified? Travel requests are approved prior to actual travel?
    e. Travel expense reports show purpose of trip?

J. Internal Controls

1. Is there a separation of responsibility in the receipt, payment, and recording of cash?
    a. For example: Are the duties of the record keeper or bookkeeper separated from any cash functions such as the receipt or payment of cash?
    b. Or, is the signing of checks limited to those designated officials whose duties exclude posting and/or recording cash received, approving vouchers for payment, and payroll preparation?
2. Are all checks approved by an authorized official before they are signed?
3. Are all accounting entries supported by appropriate documentation (e.g., purchase orders, vouchers, vendor payments)?
4. Does the organization have an internal auditor or internal audit staff?
5. Is there a petty cash fund where responsibility is vested in one individual; limited to a

reasonable amount; restricted as to purchase; and counted, verified, and balanced by an independent employee at time of reimbursement?

6. Are all checks pre-numbered and accounted for when general purpose bank account is reconciled?
7. If a mechanical or facsimile signature is used for cash disbursements, is the signature plate, die, key, electronic card, etc., under strict control?
8. Are bank accounts reconciled by persons not handling cash in the organization?
9. Are all employees who handle funds required to be bonded against loss by reason of fraud or dishonesty?

H. Required Supporting Documentation

The following supporting documentation should accompany the application. This information is excluded from the page limit for applications.

a) Applicants must submit the following letters:
   - Each applicant must submit a letter signed by the head of the applicable State regulatory agency attesting that the State is enforcing the ACA market reforms in Part A of title XXVII of the PHS Act at the time of application and will continue enforcing the Federal market reforms for the duration of the grant project period. Applicants that are not enforcing the ACA market reforms under Part A of Title XXVII of the PHS Act at the time of application must submit a letter indicating that they plan to transition to an active enforcement role with respect to all the market reforms and consumer protections under Part A of Title XXVII of the PHS Act within the first year and half of their Cycle I grant award.
   - Each applicant must submit a letter attesting that the State is not receiving other Federal grant dollars for the same activity(s) for which it will receive the Health Insurance Enforcement and Consumer Protections grant funding.
   - State certification of Maintenance of Effort verifying that the grant funds will not supplant existing State expenditures for market reform activities. There is no designated form for the State certification of "Maintenance of Effort."

b) The State must provide a clear delineation of the roles and responsibilities of project staff and how they will contribute to achieving the project's objectives including:
   - The State's capacity to implement the proposed project and manage grant funds, including a reasonable and cost-efficient budget; and
   - An organizational chart and job descriptions of staff who will be dedicated to the project indicating the time that staff will spend on grant activities. The number and

role of current State actuaries as well as any budgeted plans to hire additional actuaries must be highlighted.

3. Unique Agency Identifier and System for Award Management (SAM)

An applicant (unless the applicant is an individual or Federal awarding agency that is excepted from those requirements under 2 CFR 25.110(b) or (c), or has an exception approved by the Federal awarding agency under 2 CFR 25.110(d)) is required to:

(i) Be registered in SAM before submitting its application;

(ii) provide a valid unique entity identifier in its application; and

(iii) continue to maintain an active SAM registration with current information at all times during which it has an active Federal award or an application or plan under consideration by a Federal awarding agency.

HHS may not make a Federal award to an applicant until the applicant has complied with all applicable unique entity identifier and SAM requirements and, if an applicant has not fully complied with the requirements by the time HHS is ready to make a Federal award, HHS may determine that the applicant is not qualified to receive a Federal award and use that determination as a basis for making a Federal award to another applicant.

Please refer to Section III. Eligibility Information, for more information on the Unique Agency Identifier and System for Award Management requirements.

4. Submission Dates and Times

All grant applications must be submitted electronically and be received through http://www.grants.gov by **3:00 pm Eastern – Baltimore MD - Time on August 15, 2016.**

5. Intergovernmental Review

Applications for these grants are not subject to review by States under Executive Order 12372, "Intergovernmental Review of Federal Programs" (45 CFR 100). Please check box "C" to item 19 of the SF-424 (Application for Federal Assistance) as Review by State Executive Order 12372 do not apply to these grants.

6. Funding Restrictions

a. Indirect Costs and Cost Allocation Plans

If the applicant entity has a current negotiated indirect cost rate agreement (NICRA) and is requesting indirect costs, a copy of the current NICRA must be submitted with the application. Applicants are required to use the rate agreed to in the Indirect Cost Rate Agreement. Any non-Federal entity that has never received a negotiated indirect cost rate, except for those non-Federal entities described in Appendix VII to 45 CFR Part 75 (D)(1)(b) may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC) which may be used indefinitely. As described in §75.403 *Factors affecting allowability of costs*, costs must be consistently charged as either indirect or direct costs, but may not be double charged or inconsistently charged as both. If chosen, this methodology once elected must be used consistently for all Federal awards until such time as a non-Federal entity chooses to negotiate for a rate, which the non-Federal entity may apply to do at any time.

Modified Total Direct Cost (MTDC) means all direct salaries and wages, applicable fringe benefits, materials and supplies, services, travel, and up to the first $25,000 of each subaward (regardless of the period of performance of the subawards under the award). MTDC excludes equipment, capital expenditures, charges for patient care, rental costs, tuition remission, scholarships and fellowships, participant support costs and the portion of each subaward in excess of $25,000. Other items may only be excluded when necessary to avoid a serious inequity in the distribution of indirect costs, and with the approval of the cognizant agency for indirect costs. See 45 CFR § 75.2, Definitions.

b. Reimbursement of Pre-Award Costs

As permitted by the cost principles under 45 CFR Part 75 (implementing 2 CFR part 200) and further clarified by the Health and Human Services Grants Policy Statement, funds awarded under this FOA may be used to reimburse pre-award costs that are allowable and incurred up to 90 days before grant award. The applicant must seek prior approval in writing before incurring pre-award costs. If a State does not receive a grant award, HHS is not liable for costs incurred by the applicant. See 45 CFR § 75.458, Pre-Award costs.

c. Prohibited Uses of Grant Funds

No grant funds awarded under this Funding Opportunity Announcement may be used for any item listed in the Prohibited Uses of Grant Funds as detailed in Attachment A.

7. Mandatory Disclosures

Submission is required for all applicants, in writing, to the awarding agency and to the HHS Office of Inspector General (OIG) all information related to violations of federal criminal law

involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to:

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
Office of Acquisition and Grants Management
Attn: Director, Division of Grants Management
7500 Security Blvd, Mail Stop B3-30-03
Baltimore, MD 21244-1850

Materials should also be scanned and emailed to the Grants Management Specialist assigned to this FOA. See Section VII.

AND

U.S. Department of Health and Human Services
Office of Inspector General
ATTN: Mandatory Grant Disclosures, Intake Coordinator
330 Independence Avenue, SW, Cohen Building
Room 5527
Washington, DC 20201

URL: http://oig.hhs.gov/fraud/reportfraud/index.asp (Include "Mandatory Grant Disclosures" in subject line)
Fax: (202) 205-0604 (Include "Mandatory Grant Disclosures" in subject line) or
Email: MandatoryGranteeDisclosures@oig.hhs.gov

V. APPLICATION REVIEW INFORMATION

1. Criteria

This Funding Opportunity Announcement provides States with the opportunity to plan, implement and/or enhance market reforms activities related to the five pre-selected requirements established under Part A of title XXVII of the PHS Act. Applicants will be evaluated according to the type of activities proposed and based on the information outlined in Sections III. *Eligibility Information* and IV. 2. *Content and Form of Application Submission*.

In order to receive a grant award, States must submit an application, in the required format, no later than the deadline date. If an applicant does not submit all of the required documents and does not address each of the topics described in the Application and Submission Information section, the applicant risks not being awarded a grant.

As indicated in Section IV, *Application and Submission Information*, all applicants must submit the following:

1. Standard Forms
2. Applicant's Cover Letter
3. Project Abstract
4. Project Narrative
5. Work Plan
6. Budget and Budget Narrative
7. Business Assessment of Applicant Organization
8. Required Supporting Documentation

2. Review and Selection Process

A panel of experts will review all applications. The review process will include the following:

A. Applications will be screened to determine eligibility for further review using the criteria detailed in Section III, *Eligibility Information*, and Section IV, *Application and Submission Information*, of this FOA. Applications that are received late or fail to meet the eligibility requirements as detailed in this FOA or do not include the required forms will not be reviewed.

B. Procedures for assessing the technical merit of grant applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. The Review criteria described in Section V (*Application Review Information***)** will be used. Applications will be evaluated by an objective review committee. The objective review committee may include Federal and/or non-Federal reviewers. Applicants should pay strict attention to addressing all these grant criteria, as they are the basis upon which the reviewers will evaluate their applications.

C. The results of the objective review of the applications by qualified experts will be used to advise the CMS approving official. Final award decisions will be made by a CMS approving official. In making these decisions, the CMS approving official will take into consideration: recommendations of the review panel; the readiness of the applicant to conduct the work required; the scope of overall projected impact on the aims; reviews for programmatic and grants management compliance; the reasonableness of the estimated cost to the government and anticipated results; and the likelihood that the proposed project will result in the benefits expected. However, the CMS/OAGM/GMO, in her or her sole discretion, may continue the review process for an ineligible application if it is in the best interest of the government to meet the objectives of the program.

D. As noted in 45 CFR Part 75, CMS will do a review of risks posed by applicants prior to award. In evaluating risks posed by applicants, CMS will consider the below factors as

part of the risk assessment (applicant should review the factors in their entirety at http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=30572eb720fd047981e26dcf89370678&ty=HTML&h=L&r=PART&n=pt45.1.75#se45.1.75_1205):

- Financial stability;
- Quality of management systems and ability to meet the management standards prescribed;
- History of performance (including, for prior recipients of Federal awards: timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous federal awards, extent to which previously awarded amounts will be expended prior to future awards);
- Reports and findings from audits performed under Subpart F of 45 CFR Part 75 and
- Applicant's ability to effectively implement statutory, regulatory, and other requirements imposed on non-federal entities.

E. HHS reserves the right to conduct pre-award Negotiations with potential awardees.

F. Factors other than merit that may be used in selecting applications for award:

CMS may assure that grant/cooperative agreement awardees represent diversity in project approaches based on key factors, such as:

- Use of strategies most likely to achieve success;
- Level of need in area project will operate; and
- Balanced geographic distribution of grants awards.

CMS may distribute grant funds (as detailed in the "Federal Award Information section of this solicitation) based upon the number and quality of applications received. CMS will not fund activities that are duplicative of efforts funded through its grant programs (including Navigator Grants) or other federal resources.

Based on this review, CMS will determine which applicants will receive grant awards and, consistent with the guidelines outlined in Section II. *Federal Award Information*, the dollar amount of each award. Successful applicants will receive one grant award based on this solicitation.

3. <u>Federal Awardee Performance and Integrity Information System (FAPIIS)</u>

i. CMS, prior to making a Federal award with a total amount of Federal share greater than the simplified acquisition threshold, is required to review and

consider any information about the applicant that is in the designated integrity and performance system accessible through SAM (currently FAPIIS) (see 41 U.S.C. 2313);

ii. An applicant, at its option, may review information in the designated integrity and performance systems accessible through SAM and comment on any information about itself that the HHS awarding agency previously entered and is currently in the designated integrity and performance system accessible through SAM;

iii. CMS will consider any comments by the applicant, in addition to the other information in the designated integrity and performance system, in making a judgment about the applicant's integrity, business ethics, and record of performance under Federal awards when completing the review of risk posed by applicants as described in 45 CFR §75.205.

VI. Federal Award Administration Information

1. Federal Award Notices

Successful applicants will receive a Notice of Award (NoA) signed and dated by the HHS Grants Management Officer. The NoA is the document authorizing the grant award and will be issued to the applicant as listed on the SF-424 and available to the organization through the online grants management system used by CMS and awardee organizations. Any communication between HHS and applicants prior to issuance of the NoA is not an authorization to begin performance of a project.

Unsuccessful applicants are notified within 30 days of the final funding decision and will receive a disapproval letter via U.S. Postal Service or electronic mail.

2. Administrative and National Policy Requirements

A. National/Public Policy Requirements

By signing the application, the Authorized Organizational Official (AOR) certifies that the Recipient will comply with applicable public policies. Once a grant is awarded, the Recipient is responsible for establishing and maintaining the necessary processes to monitor its compliance and that of its employees and, as appropriate, subrecipients and contractors under the grant with these requirements. Recipient should consult the applicable Appropriations Law, Exhibit 3 of the HHS Grants Policy Statement, titled *Public Policy Requirements*, located in Section II, pages 3-6, as well as the terms and conditions of award for information on potentially applicable public policy requirements.

Non-Discrimination

All awardees receiving awards under this grant program must comply with all applicable Federal statutes relating to nondiscrimination, including, but not limited to:

a. Title VI of the Civil Rights Act of 1964,
b. Section 504 of the Rehabilitation Act of 1973,
c. The Age Discrimination Act of 1975, and
d. Title II, Subtitle A of the Americans with Disabilities Act of 1990.

Accessibility Provisions

Award recipients, as recipients of federal financial assistance (FFA) from the U.S. Department of Health and Human Services (HHS), must administer their programs in compliance with federal civil rights laws. This means that award recipients must ensure equal access to their programs without regard to a person's race, color, national origin, disability, age and, in some circumstances, sex and religion. It is HHS' duty to ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations.

HHS provides guidance to award recipients on meeting their legal obligation to take reasonable steps to provide meaningful access to their programs by persons with limited English proficiency. In addition, award recipients will have specific legal obligations for serving qualified individuals with disabilities by providing information in alternate formats.

Several sources of guidance provided below:

1. http://www.hhs.gov/civil-rights/for-providers/index.html

2. http://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html

3. http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

4. http://www.hhs.gov/ocr/civilrights/understanding/section1557/index.html

5. HHSAR 352.270-1

6. http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html

Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under federal civil rights laws at http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html or call 1-800-368-1019 or TDD 1-800-537-7697.

B. Administrative Requirements

- All equipment, staff, and other budgeted resources and expenses must be used exclusively for the projects identified in the applicant's original grant application or agreed upon subsequently with HHS, and may not be used for any prohibited uses.

- Consumers and other stakeholders must have meaningful input into the planning, implementation, and evaluation of the project.

- This award is subject to 45 CFR Part 75, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS awards [available at http://www.ecfr.gov/cgi-bin/textidx?node=pt45.1.75&rgn=div5], which implements 2 CFR Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards ("Uniform Guidance") effective December 26, 2014. See below for more information.

Uniform Administrative Requirements, Cost Principles, and Audit Requirements
Applicants and recipients should take particular note of the following information found in 45 CFR Part 75:

Uniform Administrative Requirements
In accordance with 45 CFR §75.112, all award recipients receiving federal funding from CMS must establish and comply with the conflict of interest policy requirements outlined by CMS (available for applicants upon request).

In accordance with 45 CFR §75.113, *Mandatory Disclosures*, the non-Federal entity or applicant for a Federal award must disclose, in a timely manner, in writing to the HHS awarding agency or pass-through entity all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Non-Federal entities that have received a Federal award including the term and condition outlined in Appendix XII to 45 CFR Part 75 are required to report certain civil, criminal, or administrative proceedings to SAM. Failure to make required disclosures can result in any of the remedies described in 45 CFR §75.371, including suspension or debarment. (See also 2 CFR Parts 180 and 376, and 31 U.S.C. 3321). For specific information on reporting such disclosures to CMS and HHS please see Sections IV.7. *Mandatory Disclosures* and VI.3. *Terms and Conditions* of this FOA.

Cost Principles
CMS grant awards provide for reimbursement of actual, allowable costs incurred and are subject to the Federal cost principles. The cost principles establish standards for the allowability of costs, provide detailed guidance on the cost accounting treatment of costs as direct or indirect, and set

forth allowability and allocability principles for selected items of cost. Applicability of a particular set of cost principles depends on the type of organization. Award recipients must comply with the cost principles set forth in HHS regulations at 45 CFR Part 75, Subpart E with the following exceptions: (1) hospitals must follow Appendix IX to 45 CFR Part75 and commercial (for-profit) organizations are subject to the cost principles located at 48 CFR Subpart 31.2. As provided in those costs principles, allowable travel costs may not exceed those established by the FTR.

There is no universal rule for classifying certain costs as either direct or indirect (also known as Facilities &Administration (F&A) costs) under every accounting system. A cost may be direct with respect to some specific service or function, but indirect with respect to the Federal award or other final cost objective. Therefore, it is essential that each item of cost incurred for the same purpose is treated consistently in like circumstances either as a direct or F&A cost in order to avoid double-charging of Federal awards. Guidelines for determining direct and F&A costs charged to Federal awards are provided in §§75.412 to 75.419, well as Appendices III, IV, VII, IX to 45 CFR Part 75.

Indirect Costs
If the applicant entity has a current negotiated indirect cost rate agreement (NICRA) and is requesting indirect costs, a copy of the current NICRA must be submitted with the application. Applicants are required to use the rate agreed to in the Indirect Cost Rate Agreement. Any non-Federal entity that has never received a negotiated indirect cost rate, except for those non-Federal entities described in Appendix VII to 45 CFR Part 75 (D)(1)(b) may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC) which may be used indefinitely. As described in §75.403 *Factors affecting allowability of costs*, costs must be consistently charged as either indirect or direct costs, but may not be double charged or inconsistently charged as both. If chosen, this methodology once elected must be used consistently for all Federal awards until such time as a non-Federal entity chooses to negotiate for a rate, which the non-Federal entity may apply to do at any time. The provisions of 45 CFR §§75.412 to 75.419 as well as Appendices III, IV, and VII to 45 CFR Part 75 govern reimbursement of indirect costs under this solicitation.

Commercial (For-Profit) Organizations: Indirect Costs are allowable under awards to for-profit organizations. For-profit organizations must still obtain a negotiated indirect cost rate agreement which covers the grant supported activities. Indirect cost rate agreements which exclusively cover contracts will not be acceptable. For-profit entities which receive the preponderance of their federal awards from HHS may contact the Division of Financial Advisory Services (DFAS), Indirect Cost Branch, available at http://oamp.od.nih.gov/dfas/indirect-cost-branch to negotiate an indirect cost rate. Otherwise, for-profit organizations are limited to the 10% de minimis rate in accordance with 45 CFR §75.414(f).

Cost Allocation

In accordance with 45 CFR §75.416 and Appendix V to 45 CFR Part 75 – State/Local Government wide Central Service Cost Allocation Plans, each state/local government will submit a plan to the Department of Health and Human Services Cost Allocation Services for each year in which it claims central service costs under Federal awards. Guidelines and illustrations of central service cost allocation plans are provided in a brochure published by the Department of Health and Human Services entitled "A Guide for State, Local and Indian Tribal Governments: Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government." A copy of this brochure may be obtained from the HHS' Cost Allocation Services at https://rates.psc.gov. A current, approved cost allocation plan must be provided to CMS if central service costs are claimed.

Public Assistance Cost Allocation Plans

Appendix VI to 45 CFR Part 75 – Public Assistance Cost Allocation Plans, state public assistance agencies will develop, document and implement, and the Federal Government will review, negotiate, and approve, public assistance cost allocation plans in accordance with Subpart E of 45 CFR Part 95. The plan will include all programs administered by the state public assistance agency. Where a letter of approval or disapproval is transmitted to a state public assistance agency in accordance with Subpart E, the letter will apply to all Federal agencies and programs. This Appendix (except for the requirement for certification) summarizes the provisions of Subpart E of 45 CFR Part 95.

Audit Requirements

The audit requirements in 45 CFR Part 75, Subpart F apply to each award recipient fiscal year that begins on or after December 26, 2014. A non-Federal entity that expends $750,000 or more during the non-Federal entity's fiscal year in Federal awards must have a single or program-specific audit conducted for that year in accordance with the provisions of 45 CFR Subpart F, Audit Requirements.

Commercial Organizations (including for-profit hospitals) have two options regarding audits, as outlined in 45 CFR §75.501 (see also 45 CFR §75.215).

3. Terms and Conditions

This solicitation is also subject to the *Department of Health and Human Services Grants Policy Statement (HHS GPS)* at http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary. Standard and program specific terms of award will accompany the NoA. Potential applicants should be aware that special requirements

could apply to grants based on the particular circumstances of the effort to be supported and/or deficiencies identified in the application by the HHS review panel. The recently released HHS regulation (45 CFR Part 75) supersedes information on administrative requirements, cost principles, and audit requirements for grants and cooperative agreements included in the current HHS Grants Policy Statement where differences are identified. Awardees must also agree to respond to requests that are necessary for the evaluation of national efforts and provide data on key elements of their own cooperative agreement activities.

HHS may terminate any CMS award for material noncompliance. Material noncompliance includes, but is not limited to, violation of the terms and conditions of the award; failure to perform award activities in a satisfactory manner; improper management or use of award funds; or fraud, waste, abuse, mismanagement, or criminal activity.

In the event a Recipient or one of its sub-Recipients enters into proceedings relating to bankruptcy, whether voluntary or involuntary, the Recipient agrees to provide written notice of the bankruptcy to CMS. This written notice shall be furnished within five (5) days of the initiation of the proceedings relating to bankruptcy filing and sent to the CMS Grants Management Specialist and Project Officer. This notice shall include the date on which the bankruptcy petition was filed, the identity of the court in which the bankruptcy petition was filed, a copy of any and all of the legal pleadings, and a listing of Government grant and cooperative agreement numbers and grant offices for all Government grants and cooperative agreements against which final payment has not been made.

The non-Federal entity may copyright any work that is subject to copyright and was developed, or for which ownership was acquired, under a Federal award. The Federal awarding agency reserves a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use the work for Federal purposes, and to authorize others to do so. Recipients under this solicitation must comply with the provisions of 45 CFR §75.322, Intangible property and copyrights.

In accordance with 45 CFR §75.113, *Mandatory Disclosures,* submission is required for all recipients, in writing, to the awarding agency and to the HHS Office of Inspector General (OIG) all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to:

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
Office of Acquisition and Grants Management
Attn: Director, Division of Grants Management

7500 Security Blvd, Mail Stop B3-30-03
Baltimore, MD 21244-1850

Materials should also be scanned and emailed to the Grants Management Specialist assigned to this FOA. See Section VII of this FOA.

AND

U.S. Department of Health and Human Services
Office of Inspector General
ATTN: Mandatory Grant Disclosures, Intake Coordinator
330 Independence Avenue, SW, Cohen Building
Room 5527
Washington, DC 20201

URL: http://oig.hhs.gov/fraud/reportfraud/index.asp (Include "Mandatory Grant Disclosures" in subject line)
Fax: (202) 205-0604 (Include "Mandatory Grant Disclosures" in subject line) or
Email: MandatoryGranteeDisclosures@oig.hhs.gov

4. Reporting

All successful applicants under this announcement must comply with the following reporting and review activities:

A. Quarterly Progress Reports

Grantees must provide HHS with information such as, but not limited to, project status, implementation activities initiated, accomplishments, barriers, and lessons learned in order to ensure that funds are used for authorized purposes. Such performance includes submission of the State's progress toward the milestones identified in its Work Plan. HHS reserves the right to restrict funds for activities related to unmet milestones. More details of the quarterly report will be outlined in the Notice of Award. The report must include, but will not be limited to:

1. Progress on the required milestones
2. Updates on Work Plan components, timeline, and Progress Metrics
3. Budget updates
4. Changes in authority; if applicable
5. Lessons learned

B. Annual Report

Grantees must provide HHS with an Annual Report for each grant year, with the exception of the final grant year. For the final grant year, a Final report will replace the Annual Report.

The report will demonstrate the State's progress toward the milestones identified in its Work Plan. HHS reserves the right to restrict funds for activities related to milestones not met. More details of the annual report, including the due date, will be outlined in the Notice of Award.

C. Final Report

Grantees must provide HHS with a Final Report following the end of the Grant Program. The Final Report will include an evaluation of the State's progress toward the milestones identified in its Work Plan and overarching success of the State's implementation of the market reforms. More details of the Final Report will be outlined in the Notice of Award.

D. Work Plan Updates

Each State will be required to submit an updated Work Plan along with the quarterly reports in order to exhibit progress toward identified milestones contained in the Work Plan. HHS Project Officers will track State progress using these updated Work Plans and progress made towards milestones. Also, States will be required to submit updated Progress Metrics on each of their activities in their work plan.

E. Performance Review

HHS is interested in enhancing the performance of its funded programs within communities and States. As part of this agency-wide effort, grantees will be required to participate, where appropriate, in an on-site performance review of their HHS-funded project(s) by a review team. The timing of the performance review is at the discretion of HHS.

F. Federal Financial Report (FFR)

The Federal Financial Report (FFR or Standard Form 425) has replaced the SF-269, SF-269A, SF-272, and SF-272A financial reporting forms. All grantees must utilize the FFR to report cash transaction data, expenditures, and any program income generated.

Grantees must report on a quarterly basis cash transaction data via the Payment Management System (PMS) using the FFR in lieu of completing a SF-272/SF272A. The FFR, containing cash transaction data, is due within 30 days after the end of each quarter. The quarterly reporting due dates are as follows: 4/30, 7/30, 10/30, 1/30. A Quick Reference Guide for completing the FFR in PMS is at: www.dpm.psc.gov/grant_recipient/guides_forms/ffr_quick_reference.aspx.

In addition to submitting the quarterly FFR to PMS, Grantees must also provide an annual and a final FFR to CMS which includes their expenditures and any program income generated for the applicable time period. More details will be outlined in the Notice of Award.

G. Transparency Act Reporting Requirements

Awards issued under this funding opportunity announcement are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109–282), as amended by Section 6202 of Public Law 110–252 and implemented by 2 CFR Part 170. Grant and cooperative agreement recipients must report information for each first-tier subaward of $25,000 or more in Federal funds and executive total compensation for the recipient's and subrecipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (available online at www.fsrs.gov).

H. Audit Requirements

Grantees must comply with audit requirements outlined in HHS regulation 45 CFR Part 75 (implementing 2 CFR Part 200). See Subpart F – Audit Requirements. http://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75#sp45.1.75.f

I. Payment Management Requirements

Grantees must submit a quarterly electronic SF 425 via the Payment Management System. The report identifies cash transactions against the authorized funds for the grant. Failure to submit the report may result in the inability to access grant funds. The SF 425 Certification page should be faxed to the PMS contact at the fax number listed on the SF 425, or it may be submitted to the:

Division of Payment Management
HHS/ASAM/PSC/FMS/DPM
PO Box 6021
Rockville, MD 20852
Telephone: (877) 614-5533

VII. CMS CONTACTS

1. Programmatic Contact

Programmatic questions about the "Grants to States for Planning and Implementing the Insurance Market Reforms under Part A of Title XXVII of the Public Health Service Act, Cycle I" can be directed to:

Jim Taing
The Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
(301) 492-4182
James.Taing@cms.hhs.gov

2. Grants Management Specialist/Business Administration

Iris Grady
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
(301) 492-4321
Iris.Grady@cms.hhs.gov

VIII. APPENDICES

APPENDIX A

Prohibited Uses of Grant Funds

The Department of Health and Human Services funds for the Cycle I Health Insurance Enforcement and Consumer Protections grants may not be used for any of the following:

1. To cover the costs to provide direct services to individuals.
2. To match any other Federal funds.
3. To provide services, equipment, or supports that are the legal responsibility of another party under Federal or State law (e.g.; vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
4. To supplant existing State, local, Tribal, or private funding of infrastructure or services such as staff salaries, etc.
5. To provide goods or services not allocable to the approved budget.
6. To be used by local entities to satisfy state matching requirements.
7. To pay for construction.
8. To pay for capital expenditures for improvements to land, buildings, or equipment which materially increase their value or useful life as a direct cost, except with the prior written approval of the Federal awarding agency.
9. To pay for the cost of independent research and development, including their proportionate share of indirect costs (unallowable in accordance with 45 CFR 75.476).
10. To use as profit to any award recipient even if the award recipient is a commercial organization, (unallowable in accordance with 45 CFR 75.215(b)), except for grants awarded under the Small Business Innovative Research (SBIR) and Small Business Technology Transfer Research (STTR) programs (15 U.S.C. 638). Profit is any amount in excess of allowable direct and indirect costs.

Other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government, funds for the Cycle I Health Insurance Enforcement and Consumer Protections grants may not be used to pay the salary or expenses of any grant recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the Congress or any State government, State legislature or local

legislature or legislative body. Grant recipients may lobby at their own expense if they can segregate Federal funds from other financial resources used for that purpose.

APPENDIX B

Application Check-Off List

REQUIRED CONTENTS

A complete application consists of the following materials. Please ensure that the Project Narrative is page-numbered.

- ☐ Required Forms/Mandatory Documents (Grants.gov) (with an original signature)
  - ☐ SF-424: Application for Federal Assistance
  - ☐ SF-424A: Budget Information
  - ☐ SF-424B: Assurances-Non-Construction Programs
  - ☐ SF-LLL: Disclosure of Lobbying Activities
  - ☐ Project Site Location Form(s)

All documents below are required unless stated otherwise.

- ☐ Applicant's Application Cover Letter (excluded from page limitations)
- ☐ Project Abstract (excluded from page limitations)
- ☐ Project Narrative (maximum of 20 pages)
- ☐ Work Plan (maximum of 15 pages)
- ☐ Budget Narrative (maximum of 10 pages)
- ☐ Business Assessment of Applicant Organization (maximum of 10 pages)
- ☐ Required Supporting Documentation (excluded from page limitations)
  - ☐ State Certification of Maintenance of Effort
  - ☐ Descriptions of Key Personnel & Organizational Chart
  - ☐ Letter attesting to current State enforcement of ACA market reforms or transitioning to an active enforcement role for all of the ACA market reforms within one and a half years of receiving grant funds
  - ☐ Letter attesting to not receiving other grant funding for the selected reforms that the State plans pursuing.

APPENDIX C

Guidance for Preparing a Budget Request and Narrative in Response to SF424A

INTRODUCTION

This guidance is offered for the preparation of a budget request. Following this guidance will facilitate the review and approval of a requested budget by ensuring that the required or needed information is provided. This is to be for done for each 12 month period of the grant project period. Applicants should be careful to only request funding for activities that will be funded by the Cycle I Health Insurance Enforcement and Consumer Protections Grant Program**.** In the budget request, States should distinguish between activities that will be funded under this grant and activities funded with other sources, including other HHS grant programs, and other funding sources as applicable.

A. (Personnel) Salaries and Wages

For each requested position, provide the following information: name of staff member occupying the position, if available; annual salary; percentage of time budgeted for this program; total months of salary budgeted; and total salary requested. Also, provide a justification and describe the scope of responsibility for each position, relating it to the accomplishment of program objectives.

Sample budget

Personnel Total $_____
Market Reform Cycle I Grant $_____
Funding other than Market Reform Cycle I Grant $_____
Sources of Funding_____

Position Title and Name	*Annual*	*Time*	*Months*	*Amount Requested*
Project Coordinator Susan Taylor	*$45,000*	*100%*	*12 months*	*$45,000*
Finance Administrator John Johnson	*$28,500*	*50%*	*12 months*	*$14,250*
Outreach Supervisor (Vacant)*	*$27,000*	*100%*	*12 months*	*$27,000*

Sample Justification
The format may vary, but the description of responsibilities should be directly related to specific program objectives.

Job Description: Project Coordinator - (Name)

This position directs the overall operation of the project; responsible for overseeing the implementation of project activities, coordination with other agencies, development of materials, provisions of in-service and training, conducting meetings; designs and directs the gathering, tabulating and interpreting of required data; responsible for overall program evaluation and for staff performance evaluation; and is the responsible authority for ensuring necessary reports/documentation are submitted to HHS. This position relates to all program objectives.

B. Fringe Benefits

Fringe benefits are usually applicable to direct salaries and wages. Provide information on the rate of fringe benefits used and the basis for their calculation. If a fringe benefit rate is not used, itemize how the fringe benefit amount is computed.

Sample Budget

Fringe Benefits Total $_____
Market Reform Cycle I Grant $_____
Funding other than Market Reform Cycle I Grant $_____
Sources of Funding_____

25% of Total salaries = Fringe Benefits

If fringe benefits are not computed by using a percentage of salaries, itemize how the amount is determined.

Example:	*Project Coordinator — Salary*	=	*$45,000*
	Retirement 5% of $45,000	=	*$2,250*
	FICA 7.65% of $45,000	=	*3,443*
	Insurance	=	*2,000*
	Workers' Compensation	=	

Total:_____

C. Travel

Dollars requested in the travel category should be for **staff travel only**. Travel for consultants should be shown in the consultant category. Travel for other participants, advisory committees, review panel, etc. should be itemized in the same way specified below and placed in the **"Other"** category. Travel incurred through a contract should be shown in the contractual category.

In-State Travel—Provide a narrative justification describing the travel staff members will perform. List where travel will be undertaken, number of trips planned, who will be making the trip, and approximate dates. If mileage is to be paid, provide the number of miles and the cost per mile. The mileage rate cannot exceed the rate set by the General Services Administration (GSA). If travel is by air, provide the estimated cost of airfare. If per diem/lodging is to be paid, indicate the number of days and amount of daily per diem as well as the number of nights and estimated cost of lodging. Costs for per diem/lodging cannot exceed the rates set by GSA. Include the cost of ground transportation when applicable. Please refer to the GSA website by using the following link http://www.gsa.gov/portal/content/104877.

Out-of-State Travel—Provide a narrative justification describing the same information requested above. Include HHS meetings, conferences, and workshops, if required by HHS. Itemize out-of-State travel in the format described above.

Sample Budget

Travel (in-State and out-of-State) Total $_____
Market Reform Cycle IV Grant $_____
Funding other than Market Reform Cycle I Grant $_____
Sources of Funding_____

In-State Travel:

1 trip x 2 people x 500 miles r/t x .27/mile	=	*$270*
2 days per diem x $37/day x 2 people	=	*148*
1 nights lodging x $67/night x 2 people	=	*134*
25 trips x 1 person x 300 miles avg. x .27/mile	=	*2,025*
Total		*$ 2,577*

Sample Justification

The Project Coordinator and the Outreach Supervisor will travel to (location) to attend an eligibility conference. The Project Coordinator will make an estimated 25 trips to local outreach sites to monitor program implementation. This travel furthers our efforts to accomplish specific project goals for the following reasons

_____.

Sample Budget

Out-of-State Travel:

1 trip x 1 person x $500 r/t airfare	=	*$500*

3 days per diem x $45/day x 1 person	=	*135*
1 night's lodging x $88/night x 1 person	=	*88*
Ground transportation 1 person	=	*50*
	Total	*$773*

Sample Justification
The Project Coordinator will travel to HHS, in Atlanta, GA, to attend the HHS Conference. This travel furthers our efforts to accomplish specific project goals for the following reasons _____.

D. Equipment

Equipment is tangible nonexpendable personal property, including exempt property, charged directly to the award having a useful life of more than one year and an acquisition cost of $5,000 or more per unit. However, consistent with recipient policy, lower limits may be established. Technology items such as computers that do not meet the $5,000 per unit threshold or an alternative lower limit set by recipient policy that may therefore be classified as supplies, must still be individually tagged and recorded in an equipment/technology database. This database should include any information necessary to properly identify and locate the item. For example: serial # and physical location of equipment (e.g. laptops, tablets, etc.).

Provide justification for the use of each item and relate it to specific program objectives. Maintenance or rental fees for equipment should be shown in the "Other" category. All IT equipment should be uniquely identified. Show the unit cost of each item, number needed, and total amount.

Equipment Total $_____
Market Reform Cycle I Grant $_____
Funding other than Market Reform Cycle I Grant $_____
Sources of Funding_____

Item Requested	*How Many*	*Unit Cost*	*Amount*
All-in-one Printer, Copier,			
and Scanner (large scale)	*1 ea.*	*$5,800*	*$5,800*
X-Ray Machine	*1 ea.*	*$8,000*	*$8,000*
			Total $13,800

Sample Justification

Provide complete justification for all requested equipment, including a description of how it will be used in the program. For equipment and tools which are shared amongst programs, please cost allocate as appropriate. Applicants should provide a list of hardware, software and IT equipment which will be required to complete this effort. Additionally, they should provide a list of non-IT equipment which will be required to complete this effort.

E. Supplies

Supplies includes all tangible personal property with an acquisition cost of less than $5,000 per unit or an alternative lower limit set by recipient policy. Individually list each item requested. Show the unit cost of each item, number needed, and total amount. Provide justification for each item and relate it to specific program objectives. If appropriate, General Office Supplies may be shown by an estimated amount per month times the number of months in the budget category.

Sample Budget

Supplies Total $_____
Market Reform Cycle I Grant $_____
Funding other than Market Reform Cycle I Grant $_____
Sources of Funding_____

Laptop Computer	*=*	*$1,000*
Printer	*=*	*$200*
General office supplies (pens, pencils, paper, etc.)		
12 months x $240/year x 10 staff	*=*	*$2,400*
Educational Pamphlets (3,000 copies @) $1 each)	*=*	*$3,000*
Educational Videos (10 copies @ $150 each)	*=*	*$1,500*
		Total $8,100

Sample Justification

General office supplies will be used by staff members to carry out daily activities of the program.

The education pamphlets and videos will be purchased from XXX and used to illustrate and promote safe and healthy activities. The laptop computer and printer will be used to support staff working on this project – to include compiling data for the project, creating reports, printing forms and documents. These items will be used 100% for the project.

F. Consultant/Contractual Costs

All consultant/contractual costs should include complete descriptions and cost breakdowns – for each consultant or contract. The following information, outlined below, should also be provided for each consultant or contract.

REQUIRED REPORTING INFORMATION FOR CONSULTANT HIRING

This category is appropriate when hiring an individual who gives professional advice or provides services (e.g. training, expert consultant, etc.) for a fee and who is not an employee of the grantee organization. Submit the following required information for consultants:

1. Name of Consultant: Identify the name of the consultant and describe his or her qualifications.
2. Organizational Affiliation: Identify the organization affiliation of the consultant, if applicable.
3. Nature of Services to be rendered: Describe in outcome terms the consultation to be provided including the specific tasks to be completed and specific deliverables. A copy of the actual consultant agreement should not be sent to HHS.
4. Relevance of Service to the Project: Describe how the consultant services relate to the accomplishment of specific program objectives.
5. Number of Days of Consultation: Specify the total number of days of consultation.
6. Expected Rate of Compensation: Specify the rate of compensation for the consultant (e.g., rate per hour, rate per day). Include a budget showing other costs such as travel, per diem, and supplies.
7. Justification of expected rates: Provide a justification for the rate, including examples of typical market rates for this service in your area.
8. Method of Accountability: Describe how the progress and performance of the consultant will be monitored. Identify who is responsible for supervising the consultant agreement.

If the above information is unknown for any consultant at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. In the body of the budget request, a summary should be provided of the proposed consultants and amounts for each.

REQUIRED INFORMATION FOR CONTRACT APPROVAL

All recipients must submit to HHS the following required information for establishing a third-party contract to perform project activities.

1. Name of Contractor: Who is the contractor? Identify the name of the proposed contractor and indicate whether the contract is with an institution or organization.
2. Method of Selection: How was the contractor selected? State whether the contract is sole source or competitive bid. If an organization is the sole source for the contract, include an explanation as to why this institution is the only one able to perform contract services.
3. Period of Performance: How long is the contract period? Specify the beginning and ending dates of the contract.
4. Scope of Work: What will the contractor do? Describe in outcome terms, the specific services/tasks to be performed by the contractor as related to the accomplishment of program objectives. Deliverables should be clearly defined.
5. Method of Accountability: How will the contractor be monitored? Describe how the progress and performance of the contractor will be monitored during and on close of the contract period. Identify who will be responsible for supervising the contract.
6. Itemized Budget and Justification: Provide an itemized budget with appropriate justification. If applicable, include any indirect cost paid under the contract and the indirect cost rate used.

If the above information is unknown for any contractor at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. Copies of the actual contracts should not be sent to HHS, unless specifically requested. In the body of the budget request, a summary should be provided of the proposed contracts and amounts for each.

G. Construction (not applicable)

H. Other

This category contains items not included in the previous budget categories. Individually list each item requested and provide appropriate justification related to the program objectives.

Sample Budget

Other Total $_____
Market Reform Cycle I Grant $_____
Funding other than Market Reform Cycle I Grant $_____
Sources of Funding_____

Telephone ($ ___ per month x ___ months x #staff)	=	*$ Subtotal*
Postage ($ ___ per month x ___ months x #staff)	=	*$ Subtotal*
Printing ($ ___ per x ___ documents)	=	*$ Subtotal*
Equipment Rental (describe) ($ ___ per month x ___ months)	=	*$ Subtotal*
Internet Provider Service ($___ per month x ___ months)	=	*$ Subtotal*
Word Processing Software (@ $400—specify type)	=	*$ 400*

Sample Justification

Some items are self-explanatory (telephone, postage, rent) unless the unit rate or total amount requested is excessive. If the item is not self-explanatory and/or the rate is excessive, include additional justification. Example - Word Processing Software will be used to document program activities, process progress reports, etc. For printing costs, identify the types and number of copies of documents to be printed (e.g., procedure manuals, annual reports, materials for media campaign).

I. Total Direct Costs **$_____**

Show total direct costs by listing totals of each category.

J. Indirect Costs **$_____**

To claim indirect costs, the applicant organization must have a current approved indirect cost rate agreement established with the Cognizant Federal agency unless the organization has never established one (see 45 CFR §75.414 for more information). If a rate has been issued, a copy of the current indirect cost rate agreement must be provided with the application. ***Sample Budget***

The rate is ___% and is computed on the following direct cost base of $_____.

Personnel $_____
Fringe $_____
Travel $_____
Supplies $_____
Other$_____
Total $ x ___% = Total Indirect Costs

If the applicant organization has never received an indirect cost rate, except for those non-Federal entities described in appendix VII to part 75 (D)(1)(b), it may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC) which may be used indefinitely. If the applicant has never received an indirect cost rate and wants to exceed the de minimis rate, then costs normally

identified as indirect costs (overhead costs) can be budgeted and identified as direct costs. These costs should be outlined in the “other” costs category and fully described and itemized as other direct costs.

APPENDIX D

Workload Funds - Example

The Workload Funds:

- **The Workload allocation will be determined after the submission of Letters of Intent**
- If sufficient funding is available, the Workload funds per State will be calculated as follows:

    1. One half of a State's allocation will be based on population size and the other half will be based on the number of health insurance issuers in the State with a market share of 5 percent or more (combined individual and small group markets).
    2. For each State, the State population is calculated as a proportion of the total U.S. population and this proportion is applied to the available funding.
    3. For each State, the number of issuers with a market share of 5 percent or more (combined individual and small group markets) is calculated. All of those State calculations are totaled, and each State's percentage of that total is applied to the available funding. A State's available funds for the Workload award are the total of the two calculations described above.

Example: State **X**

Note: This example assumes that $22 million is available for Workload funds, with $11 million allocated based on population and $11 million allocated based on the number of issuers.

State Population: 10,000,000

Number of insurers with 5 percent or more market share (combined individual and small group markets): 5

State Population as a proportion of the total U.S. population = 0.03445

0.034 X $11 million = **$374,000**

Portion of the Workload funds attributed to population: **$374,000**

Number of insurers in the State with a market share of 5% or more as a proportion of the total of number of such insurers in all States = 0.026

0.026 x 11 million = **$286,000**

Portion of the Workload funds attributed to market size: $**286,000**

Total Workload Funds available for State X= $374,000 + $286,000 = $660,000

Actual awards will be based on population and market share numbers that are current at the time of the awards.

APPENDIX E

List and Summary[8] of Provisions under Part A of Title XXVII of the PHS Act for which Grant Funding is Available[9]

Section 2707 - Non-discrimination under Comprehensive Health Insurance Coverage (Essential Health Benefits Package): A health insurance issuer that offers non-grandfathered health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act, which establishes actuarial values (AV) for metal levels of coverage; limits cost-sharing; contains provisions for child-only plans and catastrophic plans.

Section 2713 - Coverage of Preventive Health Services: Requires issuers of non-grandfathered coverage in the group or individual markets to provide coverage of specified recommended preventive health services without cost-sharing.

Section 2718 - Bringing down the Cost of Health Care Coverage (MLR): Requires health insurance issuers to submit a medical loss ratio (MLR) report to the Secretary and requires them to issue a rebate to enrollees if the issuer's MLR is less than the applicable percentage established in section 2718(b)(1)(A) of the PHS Act.

Section 2719 - Appeals Process: Sets forth requirements for health insurance issuers offering non-grandfathered group or individual health insurance coverage for internal claims appeals, and external review.

Section 2726 - Parity in Mental Health and Substance Use Disorder Benefits: A health insurance issuer offering group or individual health insurance coverage, other than grandfathered or self-funded small employer group health plans and grandfathered small employer group health insurance coverage, that provides both medical and surgical benefits and mental health or substance use disorder benefits must not impose financial requirements or treatment limitations (including nonquantitative treatment limitations) on the mental health or substance use disorder benefits that are more restrictive than requirements and limitations that apply to medical and surgical benefits.

[8] This list offers a summary of some of the Federal market reforms established under Part A of title XXVII of the PHS Act and does not cover all the specifics of the provisions. It provides an informal explanation of the select provisions and should not be considered legal advice or interpretive guidance.
[9] References to group health plans are intentionally omitted.

APPENDIX F

Definitions in this FOA

Affordable Care Act — Public Law 111-148 (March 23, 2010) and Public Law 111-152 (March 30, 2010)

Calendar Year — A twelve-month period beginning on the first day of January and ending on the last day of the following December.

The Employee Retirement Income Security Act (ERISA)- The Employee Retirement Income Security Act of 1974 (ERISA) is a Federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans.

Federal fiscal year — A twelve-month period beginning on the first day of October and ending on the last day of the following September.

Grandfathered plans – Health plans created or purchased on or before March 23, 2010 that meet the criteria outlined in 45 CFR 147.140.

Group health insurance - Coverage offered in connection with a group health plan.

Group health plan — An employee welfare benefit plan (as defined in section 3(1) of ERISA [29 U.S.C. 1002(1)]) to the extent that the plan provides medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

Guaranteed renewability — A requirement that health insurance issuers renew coverage under a health insurance policy at the option of the policyholder, except in certain limited circumstances, including failure to pay premiums, fraud, termination of the product, and relocation of an individual to outside the plan service area.

Health insurance coverage — For purposes of Federal law, as defined in 45 CFR 144.103, benefits providing payment for medical services under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

Health insurance issuer — An insurance company, insurance service, or insurance organization (including a health maintenance organization) 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.

Individual market — The market segment for health insurance coverage sold directly to individuals rather than in connection with a *group health plan*.

Large group market – The market segment for health insurance coverage offered to large employers as defined by applicable State or Federal Law.

Lead Agency — Designated State agency authorized to supervise administration of the grant.

Medical loss ratio — For the purposes of the Affordable Care Act, the percentage of health insurance *premiums* that are spent by the insurance company on health care clinical services and activities that improve health care quality in relation to premiums received.

Mental Health Parity and Addiction Equity Act (MHPAEA) — The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a Federal law that generally prevents group health plans and health insurance issuers, other than grandfathered or self-funded small employer group health plans and grandfathered small employer group health insurance coverage, that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

NAIC — The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 States, the District of Columbia, and five U.S. territories.

Non-grandfathered plans — Health plans that became effective after the Patient Protection and Affordable Care Act was signed on March 23, 2010, or health plans that existed before the ACA, but lost grandfathered status.

Office of Management and Budget (OMB) —The Office of Management and Budget (OMB) assists the President in overseeing the preparation of the Federal budget and in supervising its administration in Federal agencies. The OMB also oversees and coordinates the Administration's procurement, financial management, information, and regulatory policies.

Premium — The periodic payment by a consumer required to keep a policy in force.

Rate Review — A State or Federal review of proposed health insurance rates and rate increases.

Self-insured — A health plan is self-insured (or self-funded), when the entity that sponsors the plan (generally an entity engaged in a business, trade, or profession, or a non-profit organization, such as a social, fraternal, labor, educational, religious, or professional organization), carries its own risk for the cost of medical claims instead of contracting with a health insurance issuer to assume the risk.

Small group market — The market segment for health insurance coverage offered to small employers as defined by applicable State or Federal Law.

APPENDIX G

Accessibility Provisions

CMS and its grantees are responsible for complying with federal laws regarding accessibility as noted in the Award Administration Information/Administration and National Policy Requirements Section.

The grantee may receive a request from a beneficiary or member of the public for materials in accessible formats. All successful applicants under this announcement must comply with the following reporting and review activities regarding accessible format requests:

Accessibility Requirements:

1. Public Notification: If you have a public facing website, you shall post a message no later than **30** business days after award that notifies your customers of their right to receive an accessible format. Sample language may be found at: https://www.medicare.gov/about-us/nondiscrimination/nondiscrimination-notice.html Your notice shall be crafted applicable to your program.
2. Processing Requests Made by Individuals with Disabilities:
    a. Documents:
        i. When receiving a request for information in an alternate format (e.g., Braille, Large print, etc.) from a beneficiary or member of the public, you must:
            1. Consider/evaluate the request according to civil rights laws.
            2. Acknowledge receipt of the request and explain your process within **2** business days.
            3. Establish a mechanism to provide the request.
        ii. If you are unable to fulfill an accessible format request, CMS may work with you in an effort to provide the accessible format. You shall refer the request to CMS within **3** business days if unable to provide the request. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:
            1. The e-mail title shall read "Grantee (Organization) Alternate Format Document Request."
            2. The body of the e–mail shall include:
                a. Requester's name, phone number, e-mail, and mailing address.
                b. The type of accessible format requested, e.g., audio recording on compact disc (CD), written document in Braille, written document in large print, document in a format that is read by qualified readers, etc.
                c. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.

d. The document that needs to be put into an accessible format shall be attached to the e-mail.
e. CMS may respond to the request and provide the information directly to the requester.

iii. The Grantee shall maintain record of all alternate format requests received including the requestor's name, contact information, date of request, document requested, format requested, date of acknowledgment, date request provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

b. Services

i. When receiving request for an accessibility service (e.g., sign language interpreter) from a beneficiary or member of the public, you must:
1. Consider/evaluate the request according to civil rights laws.
2. Acknowledge receipt of the request and explain your process within **2** business days.
3. Establish a mechanism to provide the request.

ii. If you are unable to fulfill an accessible service request, CMS may work with you in an effort to provide the accessible service. You shall refer the request to CMS within **3** business days if unable to provide the service. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:
1. The e-mail title shall read "Grantee (Organization) Accessible Service Request."
2. The body of the e–mail shall include:
a. Requester's name, phone number, e-mail, and mailing address.
b. The type of service requested (e.g., sign language interpreter and the type of sign language needed).
c. The date, time, address and duration of the needed service.
d. A description of the venue for which the service is needed (e.g., public education seminar, one-on-one interview, etc.)
e. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
f. Any applicable documents shall be attached to the e-mail.
g. CMS will respond to the request and respond directly to the requester.

iii. The Grantee shall maintain record of all accessible service requests received including the requestor's name, contact information, date of request, service requested, date of acknowledgment, date service provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

3. Processing Requests Made by Individuals with Limited English Proficiency (LEP):

a. Documents:

i. When receiving a request for information in a language other than English from a beneficiary or member of the public, you must:

1. Consider/evaluate the request according to civil rights laws.
2. Acknowledge receipt of the request and explain your process within **2** business days.
3. Establish a mechanism to provide the request as applicable.

ii. If you are unable to fulfill an alternate language format request, CMS may work with you in an effort to provide the alternate language format as funding and resources allow. You shall refer the request to CMS within **3** business days if unable to provide the request. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:
   1. The e-mail title shall read "Grantee (Organization) Alternate Language Document Request."
   2. The body of the e–mail shall include:
      a. Requester's name, phone number, e-mail, and mailing address.
      b. The language requested.
      c. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
      d. The document that needs to be translated shall be attached to the e-mail.
      e. CMS may respond to the request and provide the information directly to the requester.

iii. The Grantee shall maintain record of all alternate language requests received including the requestor's name, contact information, date of request, document requested, language requested, date of acknowledgment, date request provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

b. Services

i. When receiving request for an alternate language service (e.g., oral language interpreter) from a beneficiary or member of the public, you must:
   1. Consider/evaluate the request according to civil rights laws.
   2. Acknowledge receipt of the request and explain your process within **2** business days.
   3. Establish a mechanism to provide the request as applicable.

ii. If you are unable to fulfill an alternate language service request, CMS may work with you in an effort to provide the alternate language service as funding and resources allow. You shall refer the request to CMS within **3** business days if unable to provide the service. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:
   1. The e-mail title shall read "Grantee (Organization) Accessible Service Request."
   2. The body of the e–mail shall include:

a. Requester's name, phone number, e-mail, and mailing address.
b. The language requested.
c. The date, time, address and duration of the needed service.
d. A description of the venue for which the service is needed (e.g., public education seminar, one-on-one interview, etc.)
e. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
f. Any applicable documents shall be attached to the e-mail.
g. CMS will respond to the request and respond directly to the requester.

iii. The Grantee shall maintain record of all alternate language service requests received including the requestor's name, contact information, date of request, language requested, service requested, date of acknowledgment, date service provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

Please contact the CMS Office of Equal Opportunity and Civil Rights for more information about accessibility reporting obligations at AltFormatRequest@cms.hhs.gov.

APPENDIX H

Application and Submission Information[10]

Employer Identification Number

All applicants must have a valid Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN) assigned by the Internal Revenue Service.

Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS number)

All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number in order to apply. The DUNS number is a nine-digit identification number that uniquely identifies business entities. Obtaining a DUNS number is easy and free. To obtain a DUNS number, access the following website: www.dunandbradstreet.com or call 1-866-705-5711. This number should be entered in block 8c (on the Form SF-424, Application for Federal Assistance). The organization name and address entered in block 8a and 8e should be exactly as given for the DUNS number**.**

System for Award Management (SAM)

All applicants must register in the System for Award Management (SAM)* database (https://www.sam.gov/portal/public/SAM/) in order to be able to submit an application at http://www.grants.gov. In order to register, applicants must provide their DUNS and EIN numbers. Each year organizations and entities registered to apply for Federal grants through Grants.gov must renew their registration with SAM. **Failure to renew SAM registration prior to application submission will prevent an applicant from successfully applying via Grants.gov. Similarly, failure to maintain an active SAM registration during the application review process can prevent HHS from issuing your agency an award.**

Applicants must successfully register with SAM prior to submitting an application or registering in the Federal Funding Accountability and Transparency Act Subaward Reporting System (FSRS) as a prime awardee user. Primary awardees must maintain a current registration with the SAM database, and **may make subawards only to entities that have DUNS numbers.**

Organizations must report executive compensation as part of the registration profile at https://www.sam.gov/portal/public/SAM/ by the end of the month following the month in which this award is made, and annually thereafter (based on the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109-282), as

[10] Please refer to Section IV.2.(b) of this FOA for additional guidance on the content and form requirements for the application submission.

amended by Section 6202 of Public Law 110-252 and implemented by 2 CFR Part 170). The Grants Management Specialist assigned to monitor the sub-award and executive compensation reporting requirements is Iris Grady, who can be reached at divisionofgrantsmanagement@cms.hhs.gov.

*Applicants were previously required to register with the Central Contractor Registration. The CCR was a government-wide registry for organizations that sought to do business with the federal government. CCR collected, validated, stored, and disseminated data to support a variety of federal initiatives. This function is now fulfilled by SAM. SAM has integrated the CCR and will also incorporate 7 other Federal procurement systems into a new, streamlined system. If an applicant had an active record in CCR prior to the rollout of SAM, an active record would be available in SAM. However, more than a year has passed since the rollout of SAM, so entities must ensure its registration with CCR (through SAM) is still active prior to applying under this funding opportunity. Please consult the SAM website listed above for additional information.

Cost Sharing or Matching

Cost sharing or matching is not required.

Application Information

This FOA contains all the instructions to enable a potential applicant to apply. The application should be written primarily as a narrative with the addition of standard forms required by the Federal government for all grants and cooperative agreements.

Application Materials

Application materials will be available for download at http://www.grants.gov. Please note that HHS requires applications for all announcements to be submitted electronically through http://www.grants.gov. For assistance with http://www.grants.gov, contact support@grants.gov or 1-800-518-4726. At http://www.grants.gov, applicants will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the Grants.gov website.

Specific instructions for applications submitted via http://www.grants.gov**:**

- You can access the electronic application for this project at http://www.grants.gov. You must search the downloadable application page by the CFDA number.
- At the http://www.grants.gov website, you will find information about submitting an application electronically through the site, including the hours of operation. HHS strongly recommends that you do not wait until the application due date to begin the application process through http://www.grants.gov because of the time needed to

complete the required registration steps. **Applications not submitted by the due date and time are considered late and will not be reviewed.**

- All applicants under this announcement must have an Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN), to apply. **Please note, applicants should begin the process of obtaining an EIN/TIN as soon as possible after the announcement is posted to ensure this information is received in advance of application deadlines.**
- All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number. **Applicants should obtain this DUNS number as soon as possible after the announcement is posted to ensure all registration steps are completed in time.**
- The applicant must also register in the System for Award Management (SAM) database in order to be able to submit the application. Applicants are encouraged to register early, and must have their DUNS and EIN/TIN numbers in order to do so. Information about SAM is available at https://www.sam.gov/portal/public/SAM/. The SAM registration process is a separate process from submitting an application. **Applicants should begin the SAM registration process as soon as possible after the announcement is posted to ensure that it does not impair your ability to meet required submission deadlines.**
- Authorized Organizational Representative: The Authorized Organizational Representative (AOR) who will officially submit an application on behalf of the organization must register with Grants.gov for a username and password. AORs must complete a profile with Grants.gov using their organization's DUNS Number to obtain their username and password at http://grants.gov/applicants/get_registered.jsp. AORs must wait one business day after successful registration in SAM before entering their profiles in Grants.gov. **Applicants should complete this process as soon as possible after successful registration in SAM to ensure this step is completed in time to apply before application deadlines. Applications that are not submitted by the due date and time as a result of AOR issues will not be reviewed.**
- When an AOR registers with Grants.gov to submit applications on behalf of an organization, that organization's E-Biz POC will receive an email notification. The email address provided in the profile will be the email used to send the notification from Grants.gov to the E-Biz POC with the AOR copied on the correspondence.
- The E-Biz POC must then login to Grants.gov (using the organization's DUNS number for the username and the special password called "M-PIN") and approve the AOR, thereby providing permission to submit applications.
- **Any files uploaded or attached to the Grants.gov application must be PDF file format and must contain a valid file format extension in the filename. Even though Grants.gov allows applicants to attach any file formats as part of their application, CMS restricts this practice and only accepts PDF file formats. Any file submitted as part of the Grants.gov application that is not in a PDF file format, or contains password protection, will not be accepted for processing and will be excluded from the application during the review process. In addition, the**

use of compressed file formats such as ZIP, RAR, or Adobe Portfolio will not be accepted. The application must be submitted in a file format that can easily be copied and read by reviewers. It is recommended that scanned copies not be submitted through Grants.gov unless the applicant confirms the clarity of the documents. Pages cannot be reduced in size, resulting in multiple pages on a single sheet, to avoid exceeding the page limitation. All documents that do not conform to the above specifications will be excluded from the application materials during the review process. Refer to Section IV.2. Format Requirements of Application Submission.

- After you electronically submit your application, you will receive an acknowledgement from http://www.grants.gov that contains a Grants.gov tracking number. HHS will retrieve your application package from Grants.gov. **Please note, applicants may incur a time delay before they receive acknowledgement that the application has been accepted by the Grants.gov system. Applicants should not wait until the application deadline to apply because notification by Grants.gov that the application is incomplete may not be received until close to or after the application deadline, eliminating the opportunity to correct errors and resubmit the application. Applications submitted after the deadline, as a result of errors on the part of the applicant, will not be reviewed.**
- After HHS retrieves your application package from Grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by Grants.gov.

Applications cannot be accepted through any email address. Full applications can only be accepted through http://www.grants.gov. Full applications cannot be received via paper mail, courier, or delivery service.

All grant applications must be submitted electronically and be received through http://www.grants.gov by 3:00 p.m. Eastern Standard or Daylight Time (Baltimore, MD) for the applicable deadline date. Please refer to the Executive Summary for submission date.

All applications will receive an automatic time stamp upon submission and applicants will receive an email reply acknowledging the application's receipt.

Please be aware of the following:

1) Search for the application package in Grants.gov by entering the CFDA number. This number is shown on the cover page of this announcement.
2) If you experience technical challenges while submitting your application electronically, please contact Grants.gov Support directly at: www.grants.gov/customersupport or (800) 518-4726. Customer Support is available to address questions 24 hours a day, 7 days a week (except on Federal holidays).
3) Upon contacting Grants.gov, obtain a tracking number as proof of contact. The tracking number is helpful if there are technical issues that cannot be resolved.

To be considered timely, applications must be received by the published deadline date. However, a general extension of a published application deadline that affects all State applicants or only those in a defined geographical area may be authorized by circumstances that affect the public at large, such as natural disasters (e.g., floods or hurricanes) or disruptions of electronic (e.g., application receipt services) or other services, such as a prolonged blackout. This statement does not apply to an individual entity having internet service problems. In order for there to be any consideration there must be an effect on the public at large.

Grants.gov complies with Section 508 of the Rehabilitation Act of 1973. If an individual uses assistive technology and is unable to access any material on the site, including forms contained with an application package, they can e-mail the Grants.gov contact center at support@grants.gov for help, or call 1-800-518-4726.

Required Reporting Information for Consultant Hiring

This category is appropriate when hiring an individual who gives professional advice or provides services for a fee and who is not an employee of the grantee organization. Submit the following required information for consultants; see also Appendix C. *Guidance for Preparing a Budget Request and Narrative in Response to SF424A, F. Consultants/Contracts*.

1. Name of Consultant: Identify the name of the consultant and describe his or her qualifications.
2. Organizational Affiliation: Identify the organization affiliation of the consultant, if applicable.
3. Nature of Services to be rendered: Describe in outcome terms the consultation to be provided including the specific tasks to be completed and specific deliverables. A copy of the actual consultant agreement should not be sent to HHS.
4. Relevance of Service to the Project: Describe how the consultant services relate to the accomplishment of specific program objectives.
5. Number of Days of Consultation: Specify the total number of days of consultation.
6. Expected Rate of Compensation: Specify the rate of compensation for the consultant (e.g., rate per hour, rate per day). Include a budget showing other costs such as travel, per diem, and supplies.
7. Justification of expected rates: Provide a justification for the rate, including examples of typical market rates for this service in your area.
8. Method of Accountability: Describe how the progress and performance of the consultant will be monitored. Identify who is responsible for supervising the consultant agreement.

Required Information for Contract Approval

All contracts require reporting the following information to HHS.

1. Name of Contractor: Who is the contractor? Identify the name of the proposed contractor and indicate whether the contract is with an institution or organization.

2. Method of Selection: How was the contractor selected? State whether the contract is sole source or competitive bid. If an organization is the sole source for the contract, include an explanation as to why this institution is the only one able to perform contract services.
3. Period of Performance: How long is the contract period? Specify the beginning and ending dates of the contract.
4. Scope of Work: What will the contractor do? Describe in outcome terms, the specific services/tasks to be performed by the contractor as related to the accomplishment of program objectives. Deliverables should be clearly defined.
5. Method of Accountability: How will the contractor be monitored? Describe how the progress and performance of the contractor will be monitored during and on close of the contract period. Identify who will be responsible for supervising the contract.
6. Itemized Budget and Justification: Provide an itemized budget with appropriate justification; see Appendix C. *Guidance for Preparing a Budget Request and Narrative in Response to SF424A, F. Consultants/Contracts*. If applicable, include any indirect cost paid under the contract and the indirect cost rate used.