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

The Health Insurance Rate Review Grant Program

Grants to Support States in Health Insurance Rate Review-Cycle II

Initial Announcement
Invitation to Apply for 2011

Funding Opportunity Number: TBA
CFDA: 93.511

Date: February 24, 2011

Cycle II Applicable Dates:

Voluntary Letter of Intent to Apply:	July 1, 2011
Phase I: Application Due Date:	August 15, 2011
Phase II: Application Due Dates:	August 15, 2012; August 15, 2013
Anticipated Notice of Grant Award Phase I:	Prior to September 30, 2011
Anticipated Notice of Grant Award Phase II:	Prior to September 30, 2012
	Prior to September 30, 2013

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-XXXX**. The time required to complete the application associated with this information collection is estimated to **average 475 hours per response**, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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I. FUNDING OPPORTUNITY DESCRIPTION

1. Funding Description Overview

a. Statutory Provisions

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act. On March 30th, 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. The Affordable Care Act includes a wide variety of provisions designed to promote accountability, affordability, quality, and accessibility in the health care system. The Affordable Care Act also includes significant grant funding for States to work with the Federal government to implement health reform.

Section 1003 of the Affordable Care Act adds a new section 2794 to the Public Health Service (PHS) Act entitled, "Ensuring That Consumers Get Value for Their Dollars". Specifically, Section 2794 requires the Secretary of Health and Human Services (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. The statute specifies that the process established by the Secretary "shall require health insurance issuers to submit to the Secretary and the relevant State a justification for unreasonable premium increases prior to the implementation of the increase," and that "such issuers shall prominently post such information on their Internet websites." The Secretary shall ensure public disclosure of information on such increases and justifications for all health insurance issuers."

In addition, Section 2794 directs the Secretary to carry out a program to award grants to States to help them develop, or improve and enhance their current health insurance rate review and reporting processes.[2] Congress has appropriated $250 million for this grant program for the federal fiscal years (FFYs) 2010-2014.

Preliminary results indicate that effective rate review is helping States to slow down premium growth. In Connecticut, for instance, the State Insurance Commissioner rejected a proposed 19.9 percent premium increase by the State's largest insurer that would have raised costs for 48,000 consumers. Heightened scrutiny of rate increases in California has led to increased review of a proposed 59 percent increase in one company's rates.

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[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] For the Rate Review Grants established under Section 2794 of the PHS Act, the United States Territories of American Samoa, Guam, Northern Mariana Islands, Puerto Rico and the Virgin Islands are included in the definition of "State."

Finally, in Massachusetts, insurance authorities over the past year rejected 235 of 274 rate filings that the division found to be "unreasonable or excessive," with some carriers applying for base rate increases of up to 34 percent. As a result, rate increases submitted by the state's nine major carriers and approved by the Division of Insurance range from a weighted average increase of 1.4 percent to 9.9 percent for the quarter starting April 1, 2011 when more than 250,000 Massachusetts residents will renew their health plans."

b. Cycle I Rate Review Grants

The Cycle I Funding Opportunity Announcement (FOA) was released on June 7, 2010, with the first grant awards made to States on August 9, 2010. During Cycle I, forty-five States and the District of Columbia applied for grants, and each was awarded $1 million in grant funds. The grant recipients proposed to use Cycle I grant funding in a number of ways including seeking additional legislative authority to review health insurance rate increases, expanding the scope of rate review, improving the rate review process, and making information on health insurance rates more publicly available through transparency initiatives and by developing and upgrading technology.

Many states are already making progress toward enhancing their rate review processes as a result of receiving Cycle I funds. For instance, Montana currently lacks the authority to collect rate filings. As part of the current Cycle 1 grant program, they are seeking legislation to give them the necessary authority to collect such filings. Arkansas plans to increase their rate review authority by seeking legislation that would allow them to implement an enhanced rate review process, while simultaneously hiring a new team to improve rate review within their current authority. Finally, New Jersey has made significant strides in staffing their rate review team through the use of grant funds. The period of performance for Cycle I of the Rate Review Grant Program for the forty-five States and the District of Columbia ends on September 30, 2011. A second Cycle I FOA was released on September 1, 2010 to enable the U.S. Territories to apply. The award announcement from this FOA is still pending.

c. Proposed Rule

On December 23, 2010, HHS published a Notice of Proposed Rulemaking (NPRM) describing how it proposed to implement the rate review process described in Section 2794 of the (PHS) Act.[3] The regulation proposed that any rate increase of 10 percent or more would be "subject to review." The proposed regulation sets forth a proposal that insurers report certain health insurance rate information to both the Secretary and the States in which they operate, including:

- Preliminary data justifying any rate increase that is "subject to review"; and

[3] See Rate Increase Disclosure and Review, 75 Fed. Reg. 81004 (December 23, 2010)

- Final justifications prior to implementation for rate increases determined by a State or HHS to be unreasonable.

Under the proposed rule, whether it is HHS, or the State, that makes the determination that a rate increase is unreasonable will depend on whether the State has an "effective rate review program."

d. Cycle II: Baseline Rate Review Grants

The Cycle II grant funding opportunity is designed to further assist States in improving and enhancing their health insurance rate review and reporting processes. Specifically, the funds should be used to meet the requirements for an "effective rate review program" as set forth in the final rate review rule. Even though the regulation is not yet final, for simplicity this FOA will refer to a program that meets the criteria that will be outlined in the final rule as an "effective rate review program."

The goals of the Cycle II Rate Review Grant Program include:

- Establishing or enhancing a meaningful and comprehensive effective rate review program that is transparent to the public, enrollees, policyholders and to the Secretary, and under which rate filings are thoroughly evaluated and, to the extent permitted by applicable State law, approved or disapproved; as well as

- Developing an infrastructure to collect, analyze, and report to the Secretary critical information about rate review decisions and trends, including, to the extent permitted by applicable State law, the approval and disapproval of proposed rate increases.

The Cycle II grant funding opportunity is designed to provide States with multiple opportunities to apply for funding (during Phase I or during Phase II), depending on the status of their progress toward meeting the criteria for an effective rate review program.

The Cycle II, Phase I grants will be awarded for a period of approximately three years, through FFY 2014. The Cycle II, Phase II grants will be awarded for a period of one or two years, depending upon the start date provided on the Notice of Grant Award. The multi-year grant awards will provide States with the opportunity to plan and budget their effective rate review program needs for the remaining period of the Rate Review Grant Program.

In order to be eligible for and receive Cycle II, Phase I funding, a State must demonstrate that, as of the Cycle II, Phase I application due date, it either: (i) already meets the effective rate review criteria described in the final regulation; or (ii) as a result of receiving Cycle II, Phase I grant funds, it will have the resources to meet those criteria within the twelve month period following the receipt of the Notice of Grant Award. Further, a State will have to demonstrate in its

quarterly reports that it is meeting the milestones in its application that support the development or enhancement of an effective rate review program.

For States that, as of the Cycle II, Phase I application due date, cannot demonstrate that they would satisfy the requirements outlined in the preceding paragraph, this FOA provides the opportunity to apply for Cycle II, Phase II grants. In order to be eligible for and receive Cycle II, Phase II funding, a State must demonstrate that, as of the Cycle II, Phase II application due date, it either: (i) already meets the effective rate review criteria described in the final regulation; or (ii) as a result of receiving Cycle II, Phase II grant funds, will have the resources to meet those criteria within the twelve month period following the receipt of the Notice of Grant Award. As is the case for State's receiving Cycle II, Phase I grants, a State receiving Phase II grant funds will have to demonstrate in its quarterly reports that it is meeting the milestones in its application that support the development or enhancement of an effective rate review program.

The Cycle II Rate Review Grant FOA may be updated and/or adjusted based on the final rate review regulation.

e. Cycle II: Additional Rate Review Grant Funds

In addition to the Baseline Grant Award, two additional segments of funds are also available under the Cycle II, Phase I and Phase II grants. "*Workload"* funds are available to States based on population and the number of health insurance issuers in the state. While the proposed rate review regulation would not require that States have the authority or ability to disapprove rates in order to be considered a State with an effective rate review program, the "*Performance"* funds are available to those States that have the authority to disapprove unreasonable rate increases. States with such authority may also have larger workloads and therefore have higher resource needs.

Certain States will be eligible, and awarded both the "*Workload*" and the "*Performance*" funds. The "*Workload*" and "*Performance*" funds can be for a period of one, two, or three years, as stipulated in the Notice of Grant Award. States receiving the "*Workload*" or "*Performance*" funds will be required to use these funds in support of enhancing or developing an effective rate review program as discussed in Section I, Part 3 (*Program Requirements*).

More information on the methodology for determining the "*Workload*" and the "*Performance*" fund eligibility and amount is provided in Section II (*Award Information*), Part 2 (*Award Amount*) and Attachment G ("*Workload*" and "*Performance*" Awards Allocation and Example).

Additional details on the Cycle II Phase I and Phase II eligibility criteria, application criteria, and grant programmatic requirements are outlined in Sections III (*Eligibility Information*), Section IV (*Application and Submission Information*) and Section V (*Application Review and Selection Information*).

2. Authority

This grant program is being administered by HHS under the authority of section 2794 of the Public Health Service Act entitled, "Ensuring That Consumers Get Value for Their Dollars."

3. Program Requirements

a. Eligibility

The complete eligibility criteria for the Cycle II Rate Review Grant Program are outlined in Section III (*Eligibility Information)*.

b. Effective Rate Review Program

In order to be eligible for an award under Cycle II, for either Phase I or II awards, a State must be able to demonstrate at the time of the application either that it already meets the criteria for an effective rate review program, or that with the funding resources from the grant it can achieve an effective rate review program.

An effective rate review program meets the following criteria:

1. The State receives data and documentation sufficient to determine whether a rate increase is unreasonable;

2. The State has adequate resources to effectively review that data and documentation in a timely manner;

3. The State's review examines the reasonableness of the assumptions used by the issuer in developing its rate proposal and the validity of the historical data underlying those assumptions, in accordance with specific areas of analysis set forth in the regulation; and

4. The State's determination of whether a rate increase is unreasonable is based on a standard set forth in State statute or regulation.

States that do not qualify as an effective review State at the time of application must use grant funds to achieve this status by meeting the criteria outlined above *within the first year of their Cycle II grant award*.

c. Establish or Enhance Rate Review Activities

States will be required to use grant funds to develop or enhance their current capacity to review and, to the extent permitted by State law, approve or deny rate increases in the individual and group markets through an effective rate review program. For example, a State may use a Cycle II grant award as a basis for seeking additional legislative authority to review rate increases, to hire additional actuaries to conduct thorough reviews of rate increases, or to invest in information technology (IT) systems that allow for the public disclosure of rate

information and trends. Each State must include in its grant Project Narrative and Rate Review Work Plan a proposal for program activities that enhance its current effective rate review program or must demonstrate how it would lead to the development of an effective rate review program.

d. Reporting to the Secretary on Rate Increase Patterns

States will be required to submit certain rate filing data to HHS as a condition of participating in the Cycle II Rate Review Grant Program. See Section IV, *Application and Submission Information*, for additional information.

e. Rate Review Work Plan

Each State applying for Cycle II funding will be required to develop and submit a Rate Review Work Plan that outlines specific milestones for successful development and enhancement of its rate review program. For example, a State seeking to establish an effective rate review program by using grant funds to hire actuaries should include as a milestone the anticipated number of new actuaries on staff or under contract at the end of the first grant year. These milestones must be articulated clearly, be measureable, and be appropriate for the award time period. Section IV (*Application and Submission Information*) provides additional information and examples of rate review enhancement milestones. A State applying for a Cycle II, Phase I award will need to provide a Rate Review Work Plan with milestones from date of award in FFY 2011 through FFY 2014. A State applying in Cycle II, Phase II must provide a Rate Review Work Plan with milestones from date of award in FFY 2012 or FFY 2013 through FFY 2014.

f. Demonstrating Progress toward Milestones

Progress toward the milestones outlined in the Rate Review 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 Rate Review Work Plans on a quarterly basis throughout the Cycle II grant program. However, a State cannot alter its Work Plan to defer the objective of establishing an effective rate review program within the first year of receiving the grant. HHS will work closely with a State in the event that a State updates its Work Plan as the Rate Review Grant Program further evolves, and HHS will make technical assistance available to facilitate and support State progress throughout the grant program.

State progress will be evaluated based on the submission of quarterly progress reports and progress toward the described rate review enhancement 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 and the reporting structure in the Notice of Grant award.

g. Recommendations to a State Exchange once established

Section 2794 of the PHS Act requires grant participants to make recommendations, as appropriate, to the applicable State Exchange about whether particular health insurers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified rate increases. The applicant should discuss initial plans to provide such recommendations to a State Exchange once established.

h. Data Centers (Optional)

States may use up to $500,000 from Cycle II funds to establish Data Centers that compile and publish fee schedule information if they meet statutory requirements. States that did not request funding for a Data Center during Cycle I are permitted to request Data Center funding during Cycle II. Additional information is provided on the Data Centers in Section IV (*Application and Submission Information*).

i. Commit to Mentor States (Optional)

States that currently meet the proposed effective rate review program requirements may agree to mentor States that are in the process of developing effective rate review programs.

II. AWARD INFORMATION

1. Total Funding:

Under Section 2794 of the Public Health Service Act, funds are available to support grants as necessary to fulfill the purpose of this funding opportunity to the fifty States, the District of Columbia and the U.S. Territories. A total of $199 million is available for the Cycle II Rate Review grants. The grants will be awarded for a budget/project period of up to three years. The award amount will vary based on the application category (Phase I or Phase II) and the eligibility for additional "*Workload*" and "*Performance*" funds. During Cycle II, both Phase I and Phase II grantees will be provided a Baseline Award. The full Baseline Award amount will be awarded in the Notice of Grant Award for the Phase (either Phase I or Phase II) in which the State applies. In addition to the Baseline Award, certain States will be eligible for additional funding available from two funding pools. This additional funding will be provided to certain States based on 1) "*Workload*": population and number of health insurance carriers and 2) "*Performance*": the ability to disapprove unreasonable rate increases in at least one market (i.e. individual or small group).

2. Award Amount:

- Baseline Award Amount Cycle II, Phase I: Each State awarded a Phase I grant will receive up to a $3 million base grant award. A Notice of Grant Award for less than $3 million will be awarded in certain cases where the proposed budget does not support a $3 million grant award.

- Baseline Award Amount Cycle II, Phase II: Each State awarded a Phase II grant will receive up to a $2 million base grant award or a $1 million award if applying in the last year. A Notice of Grant Award for less than $2 million will be awarded in certain cases where the proposed budget does not support a $2 million grant award.
- The total Baseline Award pool for Cycle II, Phase I and Phase II approximates $149 million.
- The total amount available for the "*Workload*" and "*Performance*" funds approximates $50 million.

- Cycle II, Phase I and Phase II additional Funding: Certain States will be eligible to receive additional grant funds based on:

  1) "*Workload":* the State population size and the number of issuers with 5 percent or more market share (combined individual and small group market) within the State; and

  2) "*Performance":* the ability to disapprove unreasonable rate increases in at least one market.

The "*Workload"* funds will be awarded along with the baseline grant in the Notice of Grant Award. The "*Performance*" funds may also be awarded along with the baseline grant award for eligible States. States that are not initially eligible to receive the "*Performance"* funds at the time they receive their baseline award in their Notice of Grant Award will have the opportunity to later receive "*Performance"* funds after meeting the eligibility requirements. Such States must provide written documentation to HHS regarding their eligibility for the "*Performance*" funds and officially request such funds from HHS.

See Attachment G ("*Workload*" and "*Performance*" Funds Allocation and Example) for additional information.

3. Anticipated Award Date:

The anticipated award date for both Cycle II, Phase I and Phase II is approximately 45 days after the application due date.

As stated above, the full baseline Award amount will be specified in the Notice of Grant Award for the Phase (Phase I or Phase II) in which the State applies. The "*Workload"* funds will be awarded to eligible states along with the baseline Award in the Notice of Grant Award. The "*Performance"* funds will also be awarded along with the baseline Award in the Notice of Grant Award for those States that are eligible to receive the "*Performance*" award at the time of application.

4. The Period of Performance:

The project budget period for each grant will vary based on when a State is awarded a Cycle II Rate Review Grant. Cycle II, Phase I grants will be for approximately three years (from the date of award through the end of FFY 2014). Phase II grants may be for either one or two years

(depending upon the initial date of award) through FFY 2014, which ends on September 30, 2014.

5. Milestones and Funding:

The drawdown of funds will be dependent on the annual 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 Grant Award.

6. Number of Awards:

No more than fifty-seven baseline grants. The number of awards includes the 50 States, the District of Columbia and the five U.S. Territories. One State will be eligible for two separate awards.[4]

7. Type of Award:

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

III. ELIGIBILITY INFORMATION

1. Eligible Applicants:

This grant funding opportunity is open to all 50 States, the District of Columbia and the five U.S. Territories to develop or enhance their respective rate review programs. Specifically, this funding is available to States' Departments of Insurance (DOI) or the State entity with the primary statutory and regulatory authority for the regulation of private health insurance.

2. Commitment to Effective Rate Review:

Phase I Eligibility:

States meeting the following criteria are eligible to apply during Phase I of the Cycle II grant program:

- States that currently meet the effective rate review program requirements under the final rate review regulation in both the individual and small group markets, commit to using Cycle II grant funds to enhance their rate review programs;

[4] This provision 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.

- States that currently have an effective rate review program in either the individual or small group market and commit to using Cycle II grant funds to meet these requirements in the remaining market within twelve months of receiving a Cycle II Notice of Grant Award; and

- States that do not currently have an effective rate review program in either the individual or small group market, and commit to using Cycle II funds to meet these requirements in both markets within twelve months of receiving a Cycle II Notice of Grant Award.

Phase II Eligibility:

Phase II funding is reserved for States that would not meet the above criteria during the time frame outlined in the grant schedule for the Phase I program. A State not eligible for Phase I, will have two opportunities to apply for a Cycle II, Phase II grant once it meets, or can commit to meeting, the above eligibility criteria.

3. Eligibility for Additional Funds:

"Workload" Funds: "*Workload*" funds will be awarded to eligible States in order to address variations in population and in the number of health insurance carriers among States (and resulting workload). The "*Workload*" funds will be awarded along with the baseline grant in the Notice of Grant Award.

"*Performance" Funds:* "*Performance*" funds will be awarded to eligible States based on the States' ability to disapprove unreasonable rate increases in at least one market. The "*Performance*" funds will be awarded either at the time of the Notice of Grant Award or a grantee may request based on eligibility.

4. Continued Eligibility:

A State must meet the milestones proposed in the grant application and outlined in the Rate Review Work Plan to continue to be eligible throughout the project period.

5. Central Contracting Registration (CCR) Requirement: All prime grantees and sub-recipients must provide a DUNS number in order to be able to register in FSRS as a prime grantee user. If your organization does not have a DUNS number, you will need to obtain one from Dun & Bradstreet by calling 866-705-5711. Once you have obtained a DUNS Number from D&B, you must then register with the Central Contracting Registration (CCR) at www.ccr.gov. Prime grantees must maintain current registration with the Central Contracting Registration (CCR) database. Prime grantees may make sub awards only to entities that have DUNS numbers. Organizations must report executive compensation as part of the registration profile at www.ccr.gov by the end of the month following the month in which this award is made, and annually thereafter. After you have completed your CCR registration, you will now be able to register in FSRS as a prime grantee user.

The Grants Management Specialist assigned to monitor the sub award reports and Executive Compensation is Iris Grady (grantsmanagement@hhs.gov).

6. Cost Sharing/Matching

Awardees are not required to provide matching contributions.

7. Maintenance of Effort:

The State share of funds expended for rate review activities under the State's proposed plan for rate review shall not be less than the State (non-grant) funds expended for rate review activities in the fiscal year preceding the fiscal year for which the grant is awarded. All applicants must provide assurances that grant funds will only be used to enhance the State's existing rate review efforts, and not as a substitute for existing funding for such efforts. Applicants are allowed to use Cycle II funding to continue Cycle I activities.

8. One Application Requirement, with exception:

With one exception, only one application may be submitted by a single eligible State for funding in Cycle II. In a State in which there are two regulating entities, each with a primary responsibility over the regulation of a portion of the private health insurance market, two applications from the State will be permitted. A State with two applications will be required to split the total grant award allocated for that State and therefore must collaborate with the other applicable entity regarding a proposed budget. However, each State entity will be viewed as a distinct grantee responsible for submitting separate programmatic and financial reports.

9. Pre-Application Conference Call:

HHS will hold pre-application conference calls for potential applicants. On the conference call HHS staff will provide an overview of this grant program, will offer budget guidance, will review the guidance provided by this FOA and other available materials, and will include 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. Address to Request Application Package:

This Funding Opportunity Announcement 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.

It is recommended that a Letter of Intent be submitted by 4:00 pm Eastern Standard Time on July 1, 2011. The Letter of Intent should include a brief explanation of a State's intent to apply for the Cycle II Grant Program. The purpose of the Letter of Intent is to estimate the number of

applications for planning purposes. The signed Letter of Intent must be submitted electronically in PDF format to Jacqueline.Roche@hhs.gov

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 grants.gov, contact support@grants.gov or call 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. The Funding Opportunity Announcement can also be viewed on HHS's website at http://www.hhs.gov/.

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 **93.511.**
- 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 delay.
- All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number. 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 the block with the applicant's name and address on the cover page of the application (Item 8c on the Form SF 424, Application for Federal Assistance). The name and address in the application should be exactly as given for the DUNS number.
- The applicant must also register in the Central Contractor Registration (CCR) database in order to be able to submit the application. Applicants are encouraged to register early. You should allow a minimum of five days to complete the CCR registration. Information about CCR is available at http://www.ccr.gov. The central contractor registration process is a separate process from submitting an application. In some cases, the registration process can take approximately two weeks to be completed. Therefore, registration should be completed in sufficient time 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. http://grants.gov/applicants/get_registered.jsp. AORs must wait one business day after registration in CCR before entering their profiles in Grants.gov.
- 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.

- You must submit all documents electronically in PDF format, including all information included on the SF 424 and all necessary assurances and certifications, and all other attachments.
- Prior to application submission, Microsoft Vista and Office 2007 users should review the Grants.gov compatibility information and submission instructions provided at http://www.grants.gov. Click on "Vista and Microsoft Office 2007 Compatibility Information."
- After you electronically submit your application, you will receive an automatic acknowledgement from http://www.grants.gov that contains a Grants.gov tracking number. HHS will retrieve your application from Grants.gov.
- 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.
- Each year organizations and entities registered to apply for Federal grants through http://www.grants.gov will need to renew their registration with the Central Contractor Registry (CCR). You can register with the CCR online; registration will take about 30 minutes to complete (http://www.ccr.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, unless a waiver is granted per the instructions below.

All grant applications must be submitted electronically and be received through http://www.grants.gov by 4:00 pm Eastern Standard Time on the due date.

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

The applicant must seek a waiver **at least** ten days prior to the application deadline if the applicant wishes to submit a paper application. Applicants that receive a waiver to submit paper application documents must follow the rules and timelines that are noted below.

In order to be considered for a waiver application, an applicant **must:** adhere to the timelines for both the Central Contractor Registry (CCR), and Grants.gov registration, as well as request timely assistance with technical problems.

Please be aware of the following:

- Search for the application package in Grants.gov by entering the CFDA number 93.511.
- Paper applications are not the preferred method for submitting applications. However, 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).

- 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 and a waiver from the agency must be obtained.
- If it is determined that a waiver is needed, you must submit a request in writing (emails are acceptable) to Michelle.Feagins@hhs.gov with a clear justification for the need to deviate from our standard electronic submission process.
- If the waiver is approved, the application should be received by the Division of Grants Management Division by the application due date.

To be considered timely, applications must be received on or before the published deadline date. However, a general extension of a published application deadline that affects all applicants or only those applicants 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.

2. Format, Standard Form (SF) and Application Content Requirements:

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; there is no page limit for the Budget Narrative. The additional supporting documentation listed below is excluded from the page limitation.

The following documents are required for a complete application:

A. Standard Forms

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
- Project Site Location Form(s)
- Lobbying Certification Form (HHS checklist, 5161)

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 Support States in Health Insurance Rate Review-Cycle II**

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

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

B. Required Letters of Support

Each applicant must submit a letter from the Governor (or the Mayor, if from the District of Columbia) officially endorsing the grant application and the proposed program plan.

C. Applicant's Application Cover Letter or Cover Page

A letter from the applicant must identify the:

- Project Title
- Applicant Name
- Project Director Name (with email and phone number)

D. Project Abstract

A one-page abstract should 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 enhance health insurance rate review in the State.

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

- Application title
- Applicant organization name
- Program applying under, including funding opportunity number
- Project Director
- Project Director Address
- Project Director contact phone numbers (phone and fax)
- Project Director Email address
- Organizational Website address, if applicable
- Projected date(s) for project(s) completion

E. Project Narrative (as outlined below)

The Project Narrative must include the following sections:

a) Description of past progress and current rate review program/process

As part of the program narrative all applicants must provide a detailed description of their current rate review process. States awarded a Cycle I grant must include in the project narrative a comprehensive description and update of how Cycle I grant funds enhanced the State's current authority and/or process for reviewing and disclosing rates in the areas outlined below**.** A State that did not receive a Cycle I grant must also address its current health insurance rate review capacity in all of these areas.

- An explanation of the current level of resources and capacity for reviewing health insurance rates: *Information Technology (IT) and systems capacity*
    - A description of the extent to which current IT systems such as the System for Electronic Rate and Form Filing (SERFF), support the State's rate review process.

- An explanation of the current level of resources and capacity for reviewing health insurance rates: *Budget and Staffing*
    - A description of the annual overall total budget and revenue for the Insurance Department.
    - The budgetary breakdown for resources allocated to rate review for health insurance coverage in the individual and/or group markets.
    - A description of the qualifications (education and professional background) of each of the Insurance Department staff members responsible for rate review. To the extent that actuarial services are contracted, please provide the name of the company and description of the nature and scope of the contract service.
    - If available, provide the total number of health insurance rate filings that are received for the individual and/or group markets (annually and/or monthly), and the average amount of time that is required to complete the review process.

- Consumer protections:
    - Are rate filings publicly disclosed? If so, what is the mechanism for public access to rates and rate filings? Describe the State laws and regulations that govern disclosure and public access to rate filings and public access to the Insurance Department documents in general.
    - Are summaries of rate changes offered in plain language for consumers? Please provide an example.
    - How much advanced notice is given to consumers prior to proposed rate changes? Are consumers provided with official comment periods to review and comment on proposed rate changes?
    - What processes exist for public meetings and/or hearings on rate filings?
    - Provide the number and summarize the nature of consumer inquiries and complaints related to health insurance rates that have been received for the past two plan years.

- Examination and Oversight:
    - Describe actions taken against insurance companies during the past years regarding health insurance rates. Include in the description a discussion of the

market share and the number of affected policyholders for the cited insurance company.

- Describe formal agency (e.g., Department of Insurance) hearings held during the past year regarding health insurance rates.

When possible, applicants should incorporate additional summary information related to rate review and approval activities in order to highlight accomplishments and to provide context for the scope of activities occurring during the past year. The description should also discuss challenges to the operation of an effective rate review program remaining in the current rate review processes.

b) Proposal to Meet Cycle II Program Requirements

1) For each proposed grant activity the Project Narrative and/or Rate Review Work Plan must include, but is not limited to:

- Detailed description of all proposed rate review enhancements including a line item description in the Rate Review Work Plan and budget.
- Clearly articulated goals, *measurable* objective(s) milestone(s) and timeline for each proposed rate review enhancement. Developing clear goals, with measurable objectives and milestones for rate review enhancements, is particularly important as progress will be monitored closely throughout the grant reporting process.
- All proposed grant activities (including any proposed studies) must be specifically for the purpose of developing or enhancing an effective rate review program.

2) Rate Review Enhancement Milestones

i. For States that meet the effective rate review requirements in both the individual and small group markets at the time of application milestones may include, but are not limited to:

- Improving rate filing requirements: States may use grant funds to develop and implement more rigorous rate filing requirements that better document the underlying factors that influence proposed rate increases. For example, States may require more comprehensive supporting documentation and actuarial attestations, such as exhibits that describe the underlying assumptions and factors used to derive medical trend estimates, require companies to separately report and justify administrative expenses (salaries, advertising, broker commissions, etc.) and take into consideration an insurance company's overall finances (profits/investment income) when making rate change determinations.

- Enhancing rate review process - *Staffing*: Permitted use of funds includes additional insurance department staffing and consultant expertise through qualified actuaries familiar with the Actuarial Standards of Practice (ASOPs) and Guidelines for Professional Conduct.

- Enhancing rate review process - *IT capacity*: States may develop new analytic capacities to assess the validity of rate increases and improve the IT infrastructure that supports health insurance rate review functions, including more robust data analysis and data exchange capabilities both within the State as well as with the Federal government. For example, States may request funding to plan, develop and implement enhanced electronic filing and approval processes for rates and policy forms, and implement electronic reporting of financial data used by insurance regulators.

- Enhancing consumer protection standards: States may enhance transparency of the rate filing process, for example, by posting to a public website information about rate filings and the issuer's justification for increases in easy to understand language for the public; requiring insurers to post rate increase information, including all accompanying documentation, on their websites; implementing a public hearings process for proposed rate increases; and providing consumers with increased advanced notice before rate changes become effective.

ii. For States that meet the effective rate review program requirements in only one market (or for only some products) at the time of application, but that commit to use Cycle II funds to meet these requirements in both markets.

Market (or products) with effective review: Milestones may be developed from the enhancements provided above.

Market (or products) without effective review: The State **must commit** to use Cycle II funds to meet all of the effective review program criteria in this market including:

- Secure needed authority to:
  - Receive from issuers, data and documentation in connection with rate increases that are sufficient to:
    - Conduct rate reviews;
    - Report required rate trend data to the Secretary; and
    - Base a determination that a rate increase is unreasonable on a standard set forth in a state statute or regulation.

- Secure and utilize resources necessary to enable the State to:
  - Conduct an effective and timely review of the data and documentation,
  - Conduct a thorough examination of:

- The reasonableness of the assumptions used to develop the rate increase and the validity of the historical data underlying those assumptions;
- The data related to past projections and actual experience for the rate increase; and
- Factors that affect a rate increase.

iii. For States whose rate review processes do not meet the effective rate review program requirements in either market at the time of application, but that commit to using Cycle II funds to meet these requirements in both markets.

A State **must commit** to use Cycle II funds to meet all of the effective review program criteria in both markets including:

- Secure needed authority to:
  - Receive from issuers, data and documentation in connection with rate increases that are sufficient to
    - Conduct rate review,
    - Report required rate trend data to the Secretary, and
    - Base a determination that a rate increase is unreasonable on a standard set forth in a state statute or regulation.

- Secure and utilize resources necessary to enable the State to:
  - Conduct an effective and timely review of the data and documentation,
  - Conduct a thorough examination of:
    - The reasonableness of the assumptions used to develop the rate increase and the validity of the historical data underlying those assumptions;
    - The data related to past projections and actual experience for the rate increase; and
    - Factors that affect a rate increase.

c) Reporting to the Secretary on Rate Increase Patterns

Section 2794 of the PHS Act requires grant participants to provide data to the Secretary on health insurance rate trends in premium rating areas. In the Project Narrative, the applicant must attest that it will comply with the reporting requirements outlined in section 2794 and describe the process that will be used to collect and provide these data to the Secretary. Grant funding may be used to improve current IT systems to prepare for more robust data exchange and rate analysis.

For Cycle II, each grantee will be required to provide certain rate filing data to the Secretary for the individual and small group market segments for which the State Insurance Commissioner has

jurisdiction or review and approval authority. During Cycle I, HHS, the States and the National Association of Insurance Commissioners (NAIC) collaborated on a set of data indicators (Tables A-D and the Rate Review Health Insurance Data Elements). An identical set of data will be required on a quarterly basis throughout Cycle II and will be outlined in the Special Terms and Conditions (STCs) provided to all States who have been awarded a grant.

d) Recommendations to the Applicable State Exchange on Insurer Participation

Section 2794 of the PHS Act requires grant participants to make recommendations, as appropriate, to the applicable State Exchange about whether particular health insurers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified rate increases. In the Project Narrative, the applicant should discuss initial plans to provide such recommendations to a State Exchange once established. Applicants will have the opportunity to provide updates on progress toward implementation of this requirement in the quarterly reports and updated Rate Review Work Plan.

e) Optional Data Center Funding

In addition to funding State rate review activities, section 2794 of the PHS Act provides that grants can also be used to establish Data Centers to compile and publish fee schedule information. Because the primary purpose of the grants is the enhancement of the rate review process, the amount of grant funds that can be allocated to Data Centers in Grant Cycle II is limited to $500,000 per State.

Applicants must assure that all Data Centers that receive grant funding under this FOA meet the following requirements:

- Institution requirements: **Data Centers must be academic or other nonprofit research institutions**. Data Centers shall adopt by-laws that the center and all governing board members are independent and free of all ***conflicts of interest*** as specified in section 2794 of the PHS Act.
- Research functions of Data Center: Data Centers must collect and analyze medical reimbursement data from insurers. As part of their research, the centers must develop fee schedule databases and regularly update them to reflect rate changes. Applicants must assure that Data Centers will demonstrate use of appropriate analytic methods and must describe how the proposed research will add to the existing body of available fee schedule research (i.e., ensuring that Data Center efforts are not duplicative).
- Public disclosure requirements: The Data Centers must make data and research findings (and statistical methodologies) publically available to issuers, health care providers, health researchers, health policymakers and the public. Additionally, the centers must make cost information available to the general public that allows consumers to evaluate service costs in their area.

An applicant requesting funds for Data Centers must identify its plans for establishing a relationship with an eligible non-profit or academic institution, and for assuring each entity meets the requirements listed above (*including the conflict of interest provision*), clearly outline the function and scope of work for the Data Center, and describe how the Data Center will contribute to the states rate review process and improve quality in the private insurance market. In establishing the Data Center's scope of work, an applicant may describe how the Data Center would study within-market fee schedule variation. An applicant proposing to use grant funds for a Data Center should also discuss any planned enhancements to the state insurance department IT infrastructure in order to share information for enhanced data analysis and reporting.

f) Commit to Mentor States (Optional)

States that currently meet the proposed effective rate review program requirements may agree to mentor States that are in the process of developing effective rate review programs.

g) Evaluation Plan:

The project narrative must include specific measures on how the grantee will evaluate its progress and measure success within its Rate Review Grant 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.

Examples may include:

- Effect on rate review process—timeliness of reviews, # of reviews completed, # of staff dedicated to rate review. In addition, hearings held (if applicable) and improvements in the public engagement process (# of public comments received, etc).

- Number of rate increases, approved/disapproved; impact of program on rising health insurance premiums

- Impact of grant funding on Department of Insurance infrastructure—in preparation for Exchange operations

F. Rate Review Work Plan

The Rate Review Work Plan must demonstrate a sufficient level of planning to justify a multi-year award (up to three years for Cycle II, Phase I applicants) by the inclusion of detailed milestones with specified timeframes for completion through the project period. The Rate Review 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, from the date of award up through September 30, 2014. 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 Rate Review Work Plan.

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 Rate Review Work Plan must indicate which milestones the Rate Review 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 Rate Review Program, such as one devoted exclusively to becoming an effective rate review state in a market in which it is currently not. There is not a specified template for the Rate Review Work Plan.

G. Budget Narrative

A budget with appropriate budget line items and a narrative that identifies the funding needed to accomplish the grant's goals is required. For the budget recorded on form SF 424A, provide a breakdown of the aggregate numbers detailing their allocation to each major set of activities. The proposed budget for the program should distinguish the proportion of grant funding designated for each grant activity. The budget must separate out funding that is administered directly by the lead agency from funding that will be subcontracted to other partners. As the Cycle II grants are multi-year awards, the budget narrative must be comprehensive and justify the State's readiness to receive funding through 2014 including complete explanations and justifications for the proposed grant activities.

The applicant must provide a detailed budget for the grant period. The budget presentation must include the following:

- Estimated Budget Total.
- Current State funding for health insurance rate review efforts, if the State currently devotes funding to such reviews. The amount that was spent in the preceding fiscal year on rate review 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 appropriate OMB Circulars. If requesting indirect costs in the budget, a copy of the indirect cost rate agreement is required.
- 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.

H. Required Supporting Documentation:

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

a) Letter of Support from State:
   - State certification of Maintenance of Effort verifying that the grant funds will not supplant existing State Department of Insurance expenditures for Rate Review activities or explaining State fiscal constraints.
   - A letter from the Governor stating support for grant activities including enhancement of statewide rate review activities.

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. Submission Dates and Times:

All grant applications must be submitted electronically and be received through http://www.grants.gov by 4:00 pm Eastern Standard Time on the respective due date.

Cycle II, Phase I: August 15, 2011
Cycle II, Phase II: August 15, 2012; August 15, 2013

4. 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.

5. Funding Restrictions:

A. Indirect Costs

Applicable cost principles are as follows:

- **OMB Circular A-87**, Cost Principles for State, Local and Indian Tribal Governments, which establishes the cost principles for allowable costs incurred by State, local and Federally-recognized Indian tribal governments under Federally-sponsored agreements. The application must include a copy of the approved Indirect Cost Rate Agreement used in calculating the budget, if applicable.

B. Reimbursement of Pre-Award Costs

No grant funds awarded under this FOA may be used to reimburse pre-award costs (e.g. consultant fees associated with preparing the Rate Review Grant application).

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. Additionally, in Cycle II, grant funding permitted for the establishment of Data Centers is limited to $500,000.

V. APPLICATION REVIEW AND SELECTION INFORMATION

1. Criteria:

The Cycle II FOA provides the opportunity to coordinate the effective rate review program requirements that will be outlined in the final rule with the resources available through the Rate Review Grant Program. An objective of the Cycle II grants is that each State awarded a grant will, ***at a minimum***, ensure that its rate review process meets the requirements of an effective

rate review program under the final rule and will be, or will begin to be, comprehensively reviewing rates pursuant to the proposed effective rate review program requirements at the start of or by the end of the first grant year of their Cycle II award period. Therefore, in order to receive Cycle II funding, a State must demonstrate that as a result of receiving grant funds, the State will either: 1) have the needed resources to meet the effective rate review program requirements during Cycle II, or 2) continue to meet the effective rate review program requirements and build upon its current rate review process. A State that has received Cycle I grant funds but whose rate review process does not yet meet the effective review program requirements will need to explain why it has not yet met these requirements and demonstrate how, with Cycle II funding (and other changes if necessary), it will meet them. The State's Project Narrative and Rate Review Work Plan will have to demonstrate how it will meet the criteria it does not already meet, and the milestones will have to specifically address the elements of the effective rate review program that the State does not currently meet. Further, the Rate Review Project Narrative must include plans for disclosing rates to the public and to the Secretary as described in this section.

In order to receive a grant award for Cycle II of the Health Insurance Rate Review Grant Program, 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 below, the applicant risks not being award a Cycle II grant.

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

1. **Standard Forms**
2. **Required Governor Letter of Support**
3. **Applicant's Cover Letter**
4. **Project Abstract**
5. **Project Narrative**
6. **Rate Review Work Plan**
7. **Budget Narrative**
8. **Required Supporting Documentation**

2. Review and Selection Process

A team consisting of qualified experts will review all applications. The review process will include the following:

1. Applications will be screened to determine eligibility for further review using the criteria detailed in Section III, *Eligibility Information* of this Funding Opportunity Announcement. Applications that are received late or fail to meet the eligibility

requirements as detailed in this Funding Opportunity Announcement or do not include the required forms will not be reviewed.

2. 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 Criteria and Required Information**)** will be used to review applications. Applications will be evaluated by an objective review committee. Applicants should pay strict attention to addressing all these grant criteria, as they are the basis upon which the reviewers will evaluate their applications.

3. Final award decisions will be made by an HHS program official. In making these decisions, the HHS program official will take into consideration the following: recommendations of the review panel; 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.

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

VI. Award Administration Information

1. Award Notices

Successful applicants will receive a Notice of Grant Award signed and dated by an HHS Grants Management Officer. The Notice of Grant Award is the document authorizing the grant award and it will be sent through electronic mail to the State as listed on the SF 424. Any communication between HHS and applicants prior to issuance of the Notice of Grant Award 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.

Federal Funding Accountability and Transparency (FFATA) sub award Reporting Requirement: Awards issued under this FOA 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 recipients must report information for each sub award of $25,000 or more in Federal funds and executive total compensation for the recipient's and sub recipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170. Information about the Federal Funding and Transparency Act Sub award Reporting System (FSRS) is available at www.fsrs.gov.

2. Administrative and National Policy Requirements

The following standard requirements apply to applications and awards under this FOA:

A. Specific administrative requirements, as outlined in 2 CFR Part 215 and 45 CFR Part 92, apply to grants awarded under this announcement.

B. All States receiving awards under this grant project must comply with all applicable Federal statutes relating to nondiscrimination including, but not limited to:
   i. Title VI of the Civil Rights Act of 1964,
   ii. Section 504 of the Rehabilitation Act of 1973,
   iii. The Age Discrimination Act of 1975,
   iv. Hill-Burton Community Service nondiscrimination provisions, and
   v. Title II Subtitle A of the Americans with Disabilities Act of 1990.

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

3. Terms and Conditions

Grants issued under this FOA are subject to the *Health and Human Services Grants Policy Statement (HHS GPS)* at http://www.hhs.gov/grantsnet/adminis/gpd/. Standard terms and special terms of award will accompany the Notice of Grant Award. Potential applicants should be aware that special requirements could apply to grant awards based on the particular circumstances of the effort to be supported and/or deficiencies identified in the application by the HHS review panel. The general terms and conditions that are outlined in section II of the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the Notice of Grant Award).

Sub award Reporting and Executive Compensation: Awards issued under this FOA 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 recipients must report information for each sub award of $25,000 or more in Federal funds and total executive compensation for the recipient's and sub recipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170. Information about the Federal Funding and Transparency Act Sub award Reporting System (FSRS) is available at www.fsrs.gov.

All prime grantees will be required to provide a DUNS number in order to be able to register in FSRS as a prime grantee user. If your organization does not have a DUNS number, you will need to obtain one from Dun & Bradstreet. Call D&B at 866-705-5711 if you do not have a DUNS number. Once you have obtained a DUNS Number from D&B, you must then register with the Central Contracting Registration (CCR) at www.ccr.gov. Organizations must report executive compensation as part of the registration profile at www.ccr.gov by the end of the month following the month in which this award is made, and annually thereafter. After you have completed your CCR registration, you will be able to register in FSRS as a prime grantee user.

Intellectual Property

As a term and condition of a grant award, under 45 CFR 92.34, the Federal awarding agency will retain a royalty-free, nonexclusive, irrevocable license to reproduce, publish or otherwise use and authorize others to use, for Federal government purposes, the copyright in any work developed under the grant, or a sub grant or subcontract, and in any rights to a copyright purchased with grant support.

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 Grant Award. The report must include, but will not be limited to:

- Progress on the required milestones
- Updates on Rate Review Work Plan components and/or timeline
- Budget updates
- Changes in authority; if applicable
- Required Rate Review Data Elements
- Lessons learned

B. Annual Report

Grantees must provide HHS with an annual report every twelve months of the grant program. The report will demonstrate the State's progress toward the milestones identified in its Rate Review 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 Grant 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 states rate review program. More details of the Final Report will be outlined in the Notice of Grant Award.

D. Rate Review Work Plan Updates

Each State will be required to submit an updated Rate Review 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.

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)

Grantees must report on a quarterly basis cash transaction data via the Payment Management System (PMS) using the FFR. 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.

Within 90 calendar days of the project period end date, Grantees must also report on the FFR their expenditures and any program income generated in lieu of completing a Financial Status Report (FSR) (SF269/269A). Expenditures and any program income generated should only be included on the final, hard copy FFR.

G. Transparency Act Reporting Requirements

New 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 sub award of $25,000 or more in Federal funds and executive total compensation for the recipient's and sub recipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (available online at www.fsrs.gov). Competing Continuation awardees may be subject to this requirement and will be so notified in the Notice of Award.

H. Audit Requirements

Grantees must comply with audit requirements of the Office of Management and Budget (OMB) Circular A-133. Information on the scope, frequency, and other aspects of the audits can be found on the Internet at www.whitehouse.gov/omb/circulars.

I. Payment Management Requirements

Grantees must submit a quarterly electronic SF 425 via the Payment Management System. The report identifies cash expenditures 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. AGENCY CONTACTS

Programmatic Contact

Programmatic questions about the Grants to States for Health Insurance Rate Review can be directed to:

Jacqueline Roche
The Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
(301) 492 4171
Jacqueline.Roche@hhs.gov

Grants Management Official/Business Administration

Michelle Feagins

Office of Acquisition and Grants Management

Centers for Medicare and Medicaid Services (301) 492-4312

Michelle.Feagins@hhs.gov

List of Attachments

A. Prohibited Uses of Grant Funds
B. Definitions
C. Application Check List
D. Guidance for Preparing a Budget Request and Narrative in Response to SF 424 A
E. Required Reporting Information for Consultant Hiring
F. Federal Procurement Requirement for Grantees
G. "*Workload*" and "*Performance*" Funds Allocation and Example

ATTACHMENT A

Prohibited Uses of Grant Funds

The Department of Health and Human Services Grants for Rate Review Cycle II for FY 2011-2014 funds 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, or private funding of infrastructure or services such as staff salaries, etc.

ATTACHMENT B

Definitions

Actuarial justification — The demonstration by an insurer, as certified by an actuary that the rates collected are justified, relative to the benefits provided under the plan and/or that the allocation of *premiums* among policyholders is proportional to the distribution of their expected benefits, subject to limitations of state and federal law.

Adjusted community rating — A method of pricing insurance where *rates* are not based upon a policyholder's health status, but may be based upon other factors, such as age and geographic location.

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

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

Community rating — A method of pricing insurance, where each policyholder pays the same rate, regardless of health status, age or other factors.

Conflicts of Interest—A circumstance where the private or financial interests of an individual or entity conflict or appear to conflict with official or fiduciary responsibilities.

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(I) of ERISA [29 U.S.C. 10002(1)] to the extent that the plan provides medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

Guaranteed issue — Guaranteed issue is a requirement that a health insurance issuer must allow enrollment regardless of health, age, gender or other factors, such as pre-existing condition, that might predict use of health services.

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, such as failure to pay premiums, fraud, termination of the plan, and relocation of an individual to outside the plan service area.

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

File and Use—A State requirement that a health insurance issuer file a proposed rate increase with the insurance commissioner before implementation, but need not first obtain the commissioner's affirmative approval. The commissioner may or may not have the authority to disapprove the rate after it takes effect.

Health insurance coverage— For purposes of Federal law, as defined in 45 C.F.R. 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 services, or insurance organization (including a health maintenance organization that is licensed to engage in the business of insurance in a State and which is subject to State law insurance regulations and statutes.

HIPAA (Health Insurance Portability and Accountability Act of 1996) — Public Law No. 104-191, 110 Stat. 1936 (1996).

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

Informational filing — A rate filing pursuant to State or regulation that allows a health insurer to increase its rates at will as long as the insurer files the rate increase contemporaneously with or soon after the effective date of the increase, whether or not the State Insurance Commissioner has the authority to disapprove the rate after it takes effect.

Lead Agency – Designated state agency authorized to supervise administration of the grant.

Loss Ratio – relationship of incurred losses plus loss adjustment expense to premiums received.

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.

No file— A State statutory or regulatory provision pursuant to which an insurer is not required to file rates with the State Insurance Commissioner.

Preferred Provider Organization (PPO) — A type of health insurance that provides health care coverage through a network of providers. Typically, the PPO requires the enrollee to pay increased cost sharing for services from an *out-of-network provider*.

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

Prior approval — A State statutory or regulatory requirement that an insurance company obtain the affirmative approval of the insurance commissioner before implementing any rate increase

Prospective premium rating authority —State statutory or regulatory authority requiring prior approval of rates associated with health insurance policies.

Retrospective rating authority—The authority under state law to review and approve or disapprove rates based on actual loss experience.

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 relevant State or Federal Law.

Solvency — The ability of a health insurer to meet all of its financial obligations.

Use and file—A State statute or regulation that allows an insurer to increase its rates at will. Under this scheme although the insurer must file its rates with the State Insurance commissioner, the commissioner has no authority to disapprove the rate.

ATTACHMENT C:

Application Check-Off List

REQUIRED CONTENTS

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

- ☐ 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)
  - ☐ Lobbying Certification Form (HHS checklist, 5161)

- ☐ Required Letters of Support (Governor)
- ☐ Applicant's Application Cover Letter
- ☐ Project Abstract
- ☐ Project Narrative
- ☐ Rate Review Work Plan
- ☐ Budget Narrative
- ☐ Required Supporting Documentation
  - ☐ State Certification of Maintenance of Effort
  - ☐ Descriptions for Key Personnel & Organizational Chart

ATTACHMENT D:
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 insuring 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 Rate Review Grant.** In the budget request, States should distinguish between activities that will be funded under this Cooperative Agreement and activities funded with other sources. Other funding sources include: IT Innovator Cooperative Agreements, Exchange Planning grants, other HHS grant programs, and other funding sources as applicable.

A. 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 $_____

Rate Review Grant $_____

Funding other than Rate Review Grant $_____

Sources of Funding_____

Position Title and Name	*Annual*	*Time*	*Months*	*Amount Requested*
Project Coordinator	*$45,000*	*100%*	*12 months*	*$45,000*
Susan Taylor				
Finance Administrator	*$28,500*	*50%*	*12 months*	*$14,250*

John Johnson

Outreach Supervisor *$27,000* *100%* *12 months* *$27,000*

(Vacant)*

Sample Justification

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

Job Description: Program Director - (Name and contact information)

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 $_____

Rate Review Grant $_____

Funding other than Rate Review Grant $_____

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. Consultant Costs

This category is appropriate when hiring an individual to give professional advice or services (e.g., training, expert consultant, etc.) for a fee but not as an employee of the grantee organization. Hiring a consultant requires submission of the following information to HHS **(see Required Reporting Information for Consultant Hiring later in this Appendix)**:

1. Name of Consultant;
2. Organizational Affiliation (if applicable);
3. Nature of Services to be Rendered;
4. Relevance of Service to the Project;
5. The Number of Days of Consultation (basis for fee); and
6. The Expected Rate of Compensation (travel, per diem, other related expenses)—list a subtotal for each consultant in this category.

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.

D. Equipment

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. As an example, we should not see a single line item for "software". Show the unit cost of each item, number needed, and total amount.

Sample Budget

Equipment

Total $_____

Rate Review Grant $_____

Funding other than Rate Review Grant $_____

Sources of Funding_____

Item Requested	*How Many*	*Unit Cost*	*Amount*
Computer Workstation	*2 ea.*	*$2,500*	*$5,000*
Fax Machine	*1 ea.*	*600*	*600*

Total $5,600

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 among programs, please cost allocate as appropriate. States 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

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 $_____

Rate Review Grant $_____

Funding other than Rate Review Grant $_____

Sources of Funding_____

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*
Word Processing Software (@ $400—specify type)	=	*$ 400*

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. Word Processing Software will be used to document program activities, process progress reports, etc.

F. 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.

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. 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. Include the cost of ground transportation when applicable.

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 $_____

Rate Review Grant $_____

Rate Review 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 Program Director 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.

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.

G. 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 $_____

Rate Review Grant $_____

Funding other than the Rate Review 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*

Sample Justification

Some items are self-explanatory (telephone, postage, rent) unless the unit rate or total amount requested is excessive. If not, include additional justification. 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).

H. Contractual Costs

Cooperative Agreement recipients must submit to HHS the required information establishing a third-party contract to perform program activities **(see Required Information for Contract Approval later in this Appendix)**.

1. Name of Contractor;
2. Method of Selection;
3. Period of Performance;
4. Scope of Work;

5. Method of Accountability; and

6. Itemized Budget and Justification.

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.

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. A copy of the most recent 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 does not have an approved indirect cost rate agreement, costs normally identified as indirect costs (overhead costs) can be budgeted and identified as direct costs.

ATTACHMENT E:

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:

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. 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. If applicable, include any indirect cost paid under the contract and the indirect cost rate used.

ATTACHMENT F:
FEDRAL PROCUREMENT REQUIREMENTS FOR GRANTEES

A grantee may acquire a variety of commercially available goods or services in connection with a grant-supported project or program. Grantees can use their own procurement procedures the following applicable U.S. Department of Health and Human Services (HHS) regulations:

- HHS regulations at 45 CFR Part 92, Procurement Requirements for State, Local and Tribal Governments http://www.hhs.gov/opa/grants/toolsdocs/45cfr92.html.
- States must follow the requirements at Title 45 CFR Part 92.36(a). Generally, States must follow the same policies and procedures they use for procurements from non-Federal funds http://www.hhs.gov/opa/grants/toolsdocs/45cfr92.html.

Note: Regardless of the portion of the project that is supported by Federal funds, the applicant will be required to follow the Federal procurement requirements for all contracts related to the project.

Responsibility

The grantee is responsible for the settlement and satisfaction of all contractual and administrative issues related to contracts entered into in support of an award. This includes disputes, claims, protests of award, source evaluation, or other matters of a contractual nature.

Simplified Acquisition

Simplified Acquisition Procedures shall be used to the maximum extent practicable for all purchase of supplies or services not exceeding the simplified acquisition threshold. The threshold for purchases utilizing the Simplified Acquisition Procedures cannot exceed $100,000. Procurement actions may not be split to avoid competition thresholds. The simplified acquisition procedures were not developed to eliminate competition but to reduce administrative costs, improve opportunities for small, small disadvantaged, and women-owned small business concerns, promote efficiency and economy in contracting, and avoid unnecessary burdens.

Avoiding Conflicts of Interest

Grantees shall avoid real or apparent organizational conflicts of interests and non-competitive practices in connection with procurements supported by Federal funds. Procurement shall be conducted in a manner to provide, to the maximum extent practical, open and free competition.

In order to ensure objective contractor performance and eliminate unfair competitive advantage, contractors that develop or draft grant applications, or contract specifications, requirements, statements of work, invitations for bids, and/or requests for proposals shall be excluded from competing for such procurements.

Contracts Pre-existing to the Grant Award

When a grantee enters into a service-type contract in which the term is not concurrent with the budget period of the award, the grantee may charge the costs of the contract to the budget period in which the contract is executed if:

- The awarding office has been made aware of this situation either at the time of application or through post-award notification.
- The contract was solicited and secured in accordance with Federal procurement standards.
- The recipient has a legal commitment to continue the contract for its full term.

Contract costs will be allowable only to the extent that they are for services provided during the grant's period of performance. The grantee will be responsible for contract costs that continue after the end of the grant budget period. Modifying existing, open contracts is generally unallowable.

Factors that should be considered when selecting a contractor are:

- Contractor integrity;
- Compliance with public policy;
- Record of past performance;
- Financial and technical resources;
- Responsive bid; and
- Excluded Parties Listing (Debarred Contractors https://www.epls.gov/).

Contracts will normally be competitively bid unless:

- The item is available only from a single source;
- After solicitation of a number of sources, competition is determined inadequate; or
- Meets the requirements of simplified acquisition.

ATTACHMENT G

"Workload" and *"Performance"* Funds- Allocation and Example

The "*Workload"* Funds:

- Approximates **$22.5 million**
- 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 $11.25 million.
    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 $11.25 million. A State's available funds for "*Workload*" are the total of the two calculations described above.

Example: State **X**

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 $11.25 million = $387,562

Portion of the "*Workload*" funds attributed to population: $387,562

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 11.24 million = $292,500

Portion of the "*Workload*" funds attributed to market size: $292,500

Total "*Workload"* Funds available for State X= $387,562+$292,500= **$680,062**

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

The "*Performance"* funds are approximately $**27.5 million** to be allocated to those States that have authority to disapprove a rate, either at the time of the initial Cycle II award or, upon submission of proof that authority has been secured after the initial award date, on the date the authority becomes effective. The "*Performance"* funds will approximate $600,000 for States with disapproval authority in at least one market during Phase I and approximate $400,000 for States with disapproval authority in at least one market during Phase II. The resources for the "*Performance"* funds may be adjusted in the future, based on the availability of funds.