U.S. Department of Health and Human Services
Office of Consumer Information and Insurance Oversight

Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges

Announcement Type: New

Funding Opportunity Number: IE-HBE-11-004
CFDA: 93.525

Date: January 20, 2011

Applicable Dates
Letter of Intent: February 22, 2011

Level One Establishment
Application Due Dates: March 30, 2011; June 30, 2011; September 30, 2011; December 30, 2011

Level Two Establishment
Application Due Dates: March 30, 2011; June 30, 2011; September 30, 2011; December 30, 2011; March 30, 2012, June 29, 2012

Anticipated notice of award: 45 days after application due date

Period of Performance: Level One Establishment: Up to one year after date of award; Level Two Establishment: From date of award up through December 31, 2014

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OVERVIEW INFORMATION

Agency Name: Department of Health and Human Services
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Anticipated notice of award: 45 days after application due date

Period of Performance: Level One Establishment: Up to one year after date of award; Level Two Establishment: From date of award up through December 31, 2014
Pre-Application Conference Calls: (See Section III.C for more information)

I. FUNDING OPPORTUNITY DESCRIPTION

1. Purpose

This Funding Opportunity Announcement (FOA) provides States, the District of Columbia, and consortia of States with financial assistance for the establishment of State-operated health insurance Exchanges (Exchanges). States may choose whether to apply for *Level One Establishment* or *Level Two Establishment* based on their progress. States can also choose at what point to apply for grant funding based on their own needs and planned expenditures. Throughout this announcement, States, the District of Columbia, and consortia of States will all be referred to as "State(s)." If there are any activities that are distinct for the District of Columbia or consortia, these will be identified separately.

This cooperative agreement funding opportunity is designed to give States multiple opportunities to apply for funding as they progress through Exchange establishment, which helps support their progress toward the establishment of an Exchange. States may initially apply in this announcement for either *Level One* or *Level Two Establishment* grants. *Level One Establishment* grantees may reapply for another year of funding in the *Level One Establishment* category. *Level One Establishment* grantees may apply for *Level Two Establishment* awards once sufficient progress has been made in the initial *Level One Establishment* project period and they are able to satisfy the eligibility criteria for *Level Two Establishment* defined in Section III.1.

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (P.L. 111-148). On March 30, 2010, the Health Care and Education Reconciliation Act of 2010 was signed into law. The two laws are collectively referred to as the Affordable Care Act. The Affordable Care Act creates new competitive private health insurance markets – called "Exchanges" – that will give millions of Americans and small businesses access to affordable coverage. Exchanges will help individuals and small employers shop for, select, and enroll in high-quality, affordable private health plans that fit their needs at competitive prices. Exchanges will also assist eligible individuals to receive premium tax credits and cost sharing reductions or help individuals enroll in other Federal or State health care programs. By providing one-stop shopping, Exchanges will make purchasing health insurance easier and more understandable and will put greater control and greater choice in the hands of individuals and small businesses.

The Affordable Care Act provides that each State may elect to establish an Exchange that would: 1) facilitate the purchase of qualified health plans (QHPs); 2) provide for the establishment of a Small Business Health Options Program ("SHOP Exchange") designed to assist qualified employers in facilitating the enrollment of their employees in QHPs offered in the SHOP Exchange; and 3) meet other requirements specified in the Affordable Care Act.

These grants are a critical step so that States can be on track for achieving certification by January 1, 2013 in accordance with Section 1321 of the Affordable Care Act. This planning process, will lead to State action, by legislation or other means, to create an Exchange entity with the authority necessary to meet all the Exchange requirements of the Affordable Care Act. In States that choose, now or at a later point in the process, not to establish an Exchange, the Department of Health and Human Services (HHS) working with the State, will establish an Exchange for residents and small businesses in the State.

2. Authority

This Cooperative Agreement is being issued by HHS Section 1311 of the Patient Protection and Affordable Care Act (P.L. 111-148) authorizes the funding for this opportunity.

3. Background

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act. On March 30, 2010, the Health Care and Education Reconciliation Act of 2010 was 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 expand coverage, provide more health care choices, enhance the quality of health care for all Americans, hold insurance companies more accountable, and lower health care costs.

The Affordable Care Act provides each State with the option to set up a State-operated Exchange. If a State elects not to operate an Exchange, or in the case of an Exchange that does not meet the requirements of the law, HHS shall (directly or through agreements with a not-for-profit entity) establish and operate such Exchange within the State. An Exchange is an organized marketplace to help consumers and small businesses buy health insurance in a way that permits easy comparison of available plan options based on price, benefits, and quality. By pooling people together, reducing transaction costs, and increasing price and quality transparency, Exchanges create more efficient and competitive health insurance markets for individuals and small employers.

Determining eligibility – including changes in eligibility – for various types of coverage can be difficult and confusing for consumers. Exchanges will help consumers negotiate and overcome these kinds of complexities. As a result, another key benefit of Exchanges will be more streamlined access to and continuity of coverage.

Inability to afford coverage has been a principle factor causing tens of millions of Americans to be uninsured. Historically, the individual and small group health insurance markets have suffered from adverse selection and high administrative costs, resulting in low value and higher premiums for consumers. Exchanges will allow individuals and small businesses to benefit from more effective pooling of risk, which could help reduce premiums and increase market leverage and economies of scale that large businesses currently enjoy in the insurance market.

The Exchange will carry out a number of functions as required by the Affordable Care Act, including certifying qualified health plans, administering premium tax credits and cost-sharing reductions, responding to consumer requests for assistance, and providing an easy-to-use website and written materials that individuals can use to assess eligibility and enroll in health insurance coverage, and coordinating eligibility for and enrollment in other state health subsidy programs, including Medicaid and CHIP.

HHS has used a four phase approach to provide States with resources for implementing Exchanges. On September 30, 2010, HHS awarded the first phase of Exchange funding to 48 States and the District of Columbia. Exchange Planning grants assist with initial planning activities related to the implementation of the Exchanges. In connection with those planning grants, nine core areas were identified for States to focus on in the planning process: Background Research, Stakeholder Involvement, Governance, Program Integration, Regulatory/Legislative Actions, Technical Infrastructure, Finance, Resources and Capabilities, and Business Operations. States that received these funds have been carrying out planning activities under each of these nine core areas.

In an effort to reduce replication and the cost of work on the IT components of the Exchange, the Cooperative Agreement to Support Innovative Exchange Information Technology Systems Funding Opportunity, which was announced in October 2010. In February of 2011, HHS will award its second phase of Exchange funding to up to five States or consortia of States to develop Exchange IT systems that will serve as models for other States. This approach aims to reduce the

need for each State to "reinvent the wheel" and aids States in Exchange establishment by accelerating the development of Exchange IT systems.

In an effort to ensure that all States have the opportunity to receive funds, HHS announced a third funding opportunity on January 19, 2011. The funding opportunity announcement Limited Competition for State Planning and Establishment Grants for the Affordable Care Act's Exchanges provides the opportunity for those States that did not already receive Exchange Planning grant funds an opportunity to apply.

Authorized costs integral to the planning and establishment of Exchanges are eligible for Federal funding through January 1, 2015. This fourth phase of HHS funding will provide States with financial support for activities related to the establishment of a State-operated Exchange, including the development of Exchange IT systems. After January 1, 2015, Exchanges must be self funded.

4. Exchange Principles and Priorities and Determinations by HHS

As noted above, HHS appreciates that States are in varying stages of development in establishing an Exchange and is fully committed to working with each State wherever it is in this process. In order to understand the Program Requirements for successful applicants, it is important to have a solid understanding of Exchange Principles and key determinations to be made by HHS.

Principles and Priorities

The Exchange Program Requirements are based on the provisions of the Affordable Care Act and expressed in the Initial Guidance to States on Exchanges, released November 18, 2010. Further information can be found at:
http://www.healthcare.gov/center/regulations/guidance_to_states_on_exchanges.html

Principles and priorities of the Exchange include:

- Establishing a State-based Exchange
- Promoting Efficiency
- Avoiding Adverse Selection
- Streamlined Access and Continuity of Care
- Public Outreach and Stakeholder Involvement
- Public Accountability and Transparency
- Financial Accountability

An additional key priority of the Exchange is providing effective assistance to individuals and small businesses.

Determinations by HHS

Title I, Subtitle D of the Affordable Care Act requires HHS to make determinations regarding a State's ability to establish an Exchange and the Exchange's readiness to commence operations.

- In order to fund continued grant awards, HHS must find that each State is making progress towards establishing an Exchange, implementing insurance market reforms, and meeting such other benchmarks as the Secretary may establish (Sec. 1311(a)(4)(A)). For example, one critical source of information that will inform the Secretary's decision will be data collected by State Consumer Assistance programs and other related ombudsman services regarding the kinds of health insurance questions and problems consumers encounter and actions taken by State to resolve them. (Please see Appendix B for a discussion of milestones for Exchange establishment.)

- HHS must make a determination on or before January 1, 2013, that a State will in fact have an Exchange in operation by 2014 and that the Exchange meets the requirements of the Affordable Care Act and HHS guidance. If a State elects not to operate an Exchange, or in the case where HHS determines that the State will not be able to have an Exchange operational by 2014 that meets the law's requirements, HHS, shall (directly or through agreements with a not-for-profit entity) establish and operate such Exchange within the State. (Sec. 1321(c)(1)).

- For Exchanges established prior to the passage of the Affordable Care Act, , HHS will provide a process for bringing those Exchanges into compliance with the standards promulgated under the Affordable Care Act. (Sec. 1321(e)).

5. Program Requirements

In an effort to build a strong foundation for a certified and sustainable Exchange, this funding opportunity encourages a step by step approach to the establishment of a State-operated Exchange. In order to promote this approach, we have provided in Appendix B milestones States and Exchanges may use to develop their Work Plans as they work toward (1) certification by January 1, 2013, (2) the start of operations and health insurance coverage for enrollees on January 1, 2014, and (3) self-sustainability by 2015. The milestones in **BOLD** and preceded by two asterisks (**) must be included in the Work Plan and are expected to be completed in the specified timeframe. HHS reserves the right to restrict drawdown of funds for activities based on completion of milestones.

A: Exchange Establishment Core Areas

In connection with these Establishment grants, HHS has identified 11 Core Areas in which States are expected to carry out activities, which can be found in Appendix A. These Core Areas expand on the nine Core Areas provided under the Exchange Planning Grant. In carrying out activities related to the Exchange IT Systems components of Exchange establishment, it is expected that States will carry out due diligence in assessing the applicability of models developed by "Early Innovator" States (this does not apply to the States that will be awarded funding as "Early Innovators").

Eleven Exchange Establishment Core Areas (see Appendix A for descriptions)

1. Background Research
2. Stakeholder Consultation
3. Legislative and Regulatory Action

4. Governance
5. Program Integration
6. Exchange IT Systems
7. Financial Management
8. Oversight and Program Integrity
9. Health Insurance Market Reforms
10. Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints
11. Business Operations of the Exchange

B: Demonstrating progress toward milestones

Exchanges will need to be operating for consumers by January 1, 2014. In order to provide coverage on this date, Exchanges will need to begin certification of qualified health plans in early 2013, which necessitates that systems to support issuer certification be built and tested in 2012. Also, open enrollment for Exchange coverage may begin as early as mid-2013 in order to offer consumers a reasonable window of opportunity to enroll. States will need to undertake numerous tasks in order to ensure they can meet these timeframes.

Each State applying for funding will be required to develop and submit a Work Plan that includes milestones for each Core Area of Exchange establishment according to the length of the project period for each award. For example, a State applying for a *Level Two Establishment* award will need to provide a Work Plan with milestones through 2014. HHS will work closely with each State to keep its Work Plan up to date as additional guidance on the Exchanges is published, and will provide technical assistance as needed to facilitate State progress. State progress will also be evaluated based on the submission of quarterly progress reports. If the grantee does not show progress on the required milestones, HHS may restrict funds for those activities until the milestones are met. More information will be provided on these reports in the Notice of Grant Award.

Appendix B of this document provides a series of milestones organized under each Core Area from which States may draw to develop their Work Plans. Each State's progress under this Cooperative Agreement will be evaluated against its Work Plan. Each State Exchange must include each of the milestones in **BOLD** and preceded by two asterisks (**) in its Work Plan. The milestones in **BOLD** and preceded by two asterisks (**) indicate that these tasks must be completed in the timeframe provided. We encourage States to draw on the example milestones and tasks that are not **BOLD** and not preceded by two asterisks (**) and include these in each Work Plan. The timeframe of these example milestones and tasks, while suggested, is not required to be met in order to show progress for purposes of receiving additional grant funds. States are encouraged to include additional milestones at the discretion of the State to meet their specific needs.

C: Early Deliverables

In an effort to promote the establishment of a consumer-centric Exchange and efficiency in the use of public dollars, there are certain activities that the State may choose to carry out on an accelerated time frame. These include but are not limited to: completion of research related to the

insurance markets in the State, creation of an informational website geared toward consumers, establishment and strengthening of assistance provided to individuals and small businesses, including establishment of an Exchange call center or hotline, identification of possible organizations who could serve as Navigators, and public education and outreach to inform consumers about access to health insurance through the Exchange. Each Exchange will establish a Navigator program, as required by Section 1311(i) of the Affordable Care Act, under which it awards grants (funded from the operational funds of the Exchange) to entities that will assist consumers in navigating their choices in the health insurance marketplace.

In addition, States should ensure they get started early on the necessary coordination of eligibility determinations with Medicaid, CHIP, and other Health and Human Services Programs with which the State may wish to coordinate eligibility, referral, verification or other functions. Early coordination should be carried out to ensure alignment with State health information exchange activities.

D. Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints

States may choose to utilize Exchange Establishment grant funding to set up State services to provide assistance to individuals and small businesses within Exchanges or to transition existing programs currently providing these services into Exchange operations. Effective capacity to provide these services is an essential element of a well-functioning Exchange. States have the option of using Exchange planning grant or establishment grant funds to build on existing programs within the Exchange or to contract with another entity to carry them out. Navigators (funded from the operational funds of the Exchange) will assist consumers to enroll qualified health plans through the Exchange. States that choose to undertake these activities within the Exchange should provide a description in their Project Narrative in the Proposal to meet Program Requirements of these activities and how they will be integrated into Exchange operations.

E: Exchange Certification

The law requires that each State-operated Exchange be certified by HHS no later than January 1, 2013. To achieve certification, Exchanges must demonstrate that the State's Exchange will be operational and provide access to health insurance coverage to enrollees by January 1, 2014 with open enrollment starting as early as mid-2013. HHS intends to use the grant process and its evaluation of a State's progress in completing its Work Plan as the opportunity to provide hands-on assistance and counseling to States. Our mutual goal is the successful certification and operation of each State's Exchange. HHS will provide future guidance on State Exchange certification in forthcoming regulations.

II. AWARD INFORMATION

1. Total Funding

In determining grant amounts, HHS will look for efficiencies and consider if the proposed budget is sufficient, reasonable and cost effective to support the activities proposed in the State's

application. Grants will only fund costs for implementation activities and functionalities that are *integral* to Exchange operations and meeting Exchange requirements, including those defined in future guidance and regulations issued by HHS.

2. Award Amount

Funds are available to support grants as necessary to fulfill the purpose of this funding opportunity to the fifty States, District of Columbia, and/or consortia of States. The award amount will vary based on application category and the specific needs of each State. Additional funding may be requested by the applicant to support an increased scope of work for all applicants that apply under this Funding Opportunity Announcement. The applicant will be required to submit a justification to support the budget request. Both the budget and budget justification to provide additional funds are subject to approval by the respective program and grant officials.

3. Anticipated Award Dates

The anticipated award date for both *Level One Establishment* and *Level Two Establishment* awards is approximately 45 days after the application due date.

4. The Period of Performance

The project period for each Cooperative Agreement will vary based on when a State is awarded an Establishment Cooperative Agreement. *Level One Establishment* awards will be for up to one year after the date of award. *Level Two Establishment* awards will be for up to four years starting from the date of award and ending December 31, 2014.

5. Number of Awards

For *Level One Establishment*, up to fifty-one (51) States will receive awards. For *Level Two Establishment*, up to fifty-one (51) States will receive awards. See also Section III.1.

6. Type of Award

These awards will be structured as Cooperative Agreements. HHS will work closely with each State to evaluate its progress against its Exchange Work Plan and may condition funding quarterly based on this progress and adherence to Federal guidance and Exchange requirements. HHS Project Officers will track State progress and provide technical assistance when needed.

III. ELIGIBILITY INFORMATION

1. Eligible Applicants

This funding opportunity is open to all the 50 States, consortia of States, and the District of Columbia to establish State-operated Exchanges.

The Governor of a State (the Mayor, if from the District of Columbia) may designate a governmental agency or quasi-governmental entity to apply for grants on behalf of that State. Non-profit organizations (private organizations that are non-governmental) are not eligible to apply. Only one application per State is permitted. Each applicant must submit:

1) A letter from the Governor (or the Mayor, if from the District of Columbia) officially endorsing the grant application and the proposed Cooperative Agreement. For *Level Two Establishment* applicants, this letter must express a commitment by the Governor that the State will establish a State-operated Exchange.
2) A letter of support from the State Medicaid Director agreeing to collaborate with the Exchange on developing shared functionalities and ensuring coordinated approaches to shared or related functions, and briefly describing likely key areas of collaboration. The letter also should also include a statement avoiding duplication efforts, not fund Medicaid and/or CHIP specific functions with Exchange grant funds, and
3) A letter from the Commissioner of the State Department of Insurance agreeing to work with the Exchange on implementation and coordinate efforts as appropriate.
There are two application categories for this funding opportunity:

Level One Establishment is open to States that received Exchange Planning grants. "Early Innovator" States are also eligible to apply. These cooperative agreements provide up to one year of funding to States that have made some progress under their Exchange Planning grant but are not yet able to meet the eligibility requirements of *Level Two Establishment*, defined below.

Level Two Establishment is open to States that received Exchange planning grants. "Early Innovator" States are also eligible to apply. Level Two Establishment awards will provide funding through December 31, 2014. This category is designed to provide funding to applicants that are further along in the establishment of an Exchange and that can demonstrate achievement of specific eligibility criteria outlined below. *Level One Establishment* grantees are eligible to apply for *Level Two Establishment* after making sufficient progress in *Level One* and once they are able to meet the *Level Two* eligibility criteria defined below:

A. Has the necessary legal authority to establish and operate an Exchange that complies with Federal requirements available at the time of the application.
B. Has established a governance structure for the Exchange.
C. 1) Submits a complete budget through 2014;
   2) Submits an initial plan discussing financial sustainability by 2015; and
   3) Submits a plan outlining steps to prevent fraud, waste, and abuse.
D. Submits a plan describing how capacity for providing assistance to individuals and small businesses in the State will be created, continued, and/or expanded, including provision for a call center.

Central Contracting Registration (CCR) Requirement: All prime grantees 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. 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. Prime grantees must maintain current registration with Central Contracting Registration (CCR) database. Prime grantees may make subawards only to entities that have DUNS numbers. Organization 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 subaward reports and Executive Compensation is Iris Grady (grantsmanagement@hhs.gov).

2. Cost-Sharing / Matching Medicaid Federal Financial Participation

State Cost-Sharing and Matching payments are not required for this program. Please refer to Section IV.5.B.vi. for more information about how States must address the cost allocation for Medicaid, the Children's Health Insurance Program (CHIP), and other federally financed health and human services programs in connection with the IT systems developed or modified to support the Exchange. States may use information available at: http://www.federalregister.gov/articles/2010/11/08/2010-27971/medicaid-federal-funding-for-medicaid-eligibility-determination-and-enrollment-activities.

States may utilize funds from this announcement to adapt models for Exchange IT systems developed by "Early Innovator" States. States should allocate costs associated with eligibility determination between Medicaid, CHIP and Exchanges, as Exchanges will determine Medicaid and CHIP eligibility for individuals seeking coverage if they are not already enrolled in Medicaid or CHIP. Eligibility determination includes costs of intake, verification, adjudication, and resolution, including customer support for these processes. The Medicaid and CHIP programs will also pay for the costs of transmitting Medicaid and CHIP cases to those programs once eligibility for those programs is determined. Other costs may also be shared, depending on the level of integration States choose to pursue. States should review the cost allocation rules in OMB circulate A-87 (see Section IV.5.B.vi. for more information.) States may utilize funds from this announcement to adapt models for Exchange IT systems developed by "Early Innovator" States, supported by the cooperative agreement awarded in February 2011, in addition to carrying out the tasks necessary to establish an Exchange that will begin offering health insurance coverage to enrollees on January 1, 2014.

3. Other

This funding opportunity is open to the 50 States, consortia of States, and the District of Columbia to establish State-operated Exchanges.

It is recommended that a Letter of Intent be submitted by 11:59pm on February 22, 2011. The Letter of Intent should indicate which category an applicant is applying for and at which due date. The purpose of the Letter of Intent is to estimate the number of applications. The signed Letter of Intent must be submitted electronically in PDF format to Katherine.Bryant@hhs.gov

4. Pre-Application Conference Call

HHS will hold pre-application conference calls for potential applicants. The conference calls will provide an overview of this project, budget guidance, review the guidance provided by this Funding Opportunity Announcement and other available materials, and will include an opportunity for States to ask questions. The pre-application call information is as follows:

- February 3, 2011 – 2:00 PM EST
  - Call in number: 877-989-4936; Participant passcode: 3654293
- March 3, 2011 – 2:00 PM EST

- Call in number: 877-989-4936; Participant passcode: 3654293
- March 24, 2011 – 2:00 PM EST
  - Call in number: 877-989-4936; Participant passcode: 3654293
- June 2, 2011 – 2:00 PM EST
  - Call in number: 877-989-4936; Participant passcode: 3654293
- September 1, 2011 – 2:00 PM EST
  - Call in number: 877-989-4936; Participant passcode: 3654293
- December 1, 2011 – 2:00 PM EST
  - Call in number: 877-989-4936; Participant passcode: 3654293
- March 1, 2012 – 2:00 PM EST
  - Call in number: TBA; Please monitor OCIIO's website where we will announce
- May 31, 2012 – 2:00 PM EST
  - Call in number: TBA; Please monitor OCIIO's website where we will announce

- A recording and transcript of each call will be on HHS's website.

IV. APPLICATION AND SUBMISSION INFORMATION

1. Address to Request Application Package

This Funding Opportunity Announcement serves as the application package for this Cooperative Agreement and 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 11:59pm on February 22, 2011. The Letter of Intent should indicate which category an applicant is applying for and at which due date. The purpose of the Letter of Intent is to estimate the number of applications. The signed Letter of Intent must be submitted electronically in PDF format to Katherine.Bryant@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 on http://www.grants.gov. You must search the downloadable application page by the CFDA number **93.525.**
- 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 Organization Representative: The Authorized Organization 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, the E-Biz POC will receive an email notification. The E-Biz POC must login to Grants.gov (using your organization's DUNS number for a username and the "M-PIN" password obtained in Step 2) and approve the AOR, thereby giving him or her permission to submit applications.
- 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 form from Grants.gov.
- After HHS retrieves your application form 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 11:59 pm Eastern Standard Time on the respective due date.

Level One Establishment: March 30, 2011; June 30, 2011; September 30, 2011; December 30, 2011.
Level Two Establishment: March 30, 2011; June 30, 2011; September 30, 2011; December 30, 2011; March 30, 2012, June 29, 2012

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:** (1) adhere to the timelines for Central Contractor Registry (CCR), (2) Grants.gov registration, or (3) 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. This number is located on the first page of this announcement.
- 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 sent directly to the Division of Grants Management Division by the application due date.

To be considered timely, applications must be sent 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. Content and Form of Application Submission

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

- The total size of all uploaded files may not exceed the equivalent of 80 pages when printed by HHS, or a total file size of 10 MB. This 80-page limit includes the project abstract, project and budget narratives, attachments, letters of commitment and support, and other applicable documents. Standard forms are **NOT** included in the page limit.

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: **Cooperative Agreements to Support Establishment of State-Operated Health Insurance Exchanges.**
- 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 (i.e. up to one year for *Level One Establishment*, from date of award up through December 31, 2014 for *Level Two Establishment*).

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 Cooperative Agreement. In addition, *Level Two Establishment* applicants must submit a letter from the Governor that expresses a commitment to establish a State-operated Exchange.

Each applicant also must submit the following letters of support: (a) a letter of support from the State Medicaid Director agreeing not to duplicate efforts between the Exchange and State Medicaid office and to work with the Exchange on developing shared functionalities, and (b) a letter of support from the State Insurance Commissioner agreeing to work with the Exchange on implementation and to coordinate efforts as appropriate. States are encouraged, but not required, to submit letters from other agencies or offices that are responsible for health and human service programs for which the Exchange – in the short or long run – will facilitate applications or enrollment.

C. Applicant's Application Cover Letter

A letter from the applicant must identify the:

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

D. Project Abstract

Provide a summary of the application. Because the abstract is often distributed to provide information to the public and Congress, prepare this so that it is clear, accurate, concise, and without reference to other parts of the application. It must include a brief description of the grant proposal, including the needs to be addressed, the proposed projects, and the population group(s) to be served.

The abstract must be single-spaced and limited to one page in length. 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
- Address
- Congressional district(s) served
- Project Director phone numbers (phone and fax)
- Email address
- Organizational Website address, if applicable
- Category of Funding
- Projected date(s) for project(s) completion

The abstract narrative should include:

- A brief history of the applicant organization;

- A brief description of the populations served by the project;
- A brief description of the proposed projects and deliverables; and
- A brief description of any other relevant information, including the proposed impact of the funding.

E. Project Narrative

i. *Level One Establishment*

The project narrative must include the following sections:

a. Demonstration of Past Progress in Exchange Planning Core Areas
This section should describe and quantify, where possible, progress the State made in Exchange planning activities. This includes but is not limited to the discussion points highlighted below:

- Background Research: Discuss the research conducted, including key findings and plans that resulted from this research.
- Stakeholder Consultation: Discuss partnerships with various stakeholders and how public input into the Exchange planning process was gained, such as State HIT Coordinators and the State's health information exchange program, State officials, representatives of State Agencies, employers, insurers, advocacy groups, and consumer groups.
- State Legislative/ Regulatory Actions: Discuss the progress made toward the creation of the necessary legal authority to establish and operate an Exchange that complies with Federal requirements available at the time of the application and provides for establishment of governance and Exchange structure
- Governance: Discuss the progress made toward establishing the administrative structure (State agency, quasi-governmental agency, or non-profit organization) and governance structure of the Exchange (composition of governing body, conflict of interest standards, selection process).
- Program Integration: Discuss how coordination with the State insurance regulatory entity (e.g. Department of Insurance), State Medicaid, CHIP, other State health subsidy programs, and other health and human services programs as appropriate, has been carried out during the planning process, and outcomes of these coordination efforts. Include planning activities related to streamlining eligibility and enrollment, and coordinating with the State Department of Insurance on issues including the financial stability of insurance companies, certification of plans, rate review, State licensure, solvency, and market conduct. Discuss any efforts that have taken place or may be planned to facilitate coordination with other specific health and human services programs.
- Exchange IT Systems: Discuss steps taken toward the first phase of development of Exchange IT systems in accordance with the most current Federal IT guidance. Please reference Appendix D as well. including compliance with the standards adopted by the Secretary under Section 1561 of

the Affordable Care Act. Discuss steps taken to ensure a modular, flexible approach to systems development, including use of open interfaces and exposed application programming interfaces; the separation of business rules from core programming; and the availability of business rules in both human and machine readable formats.

- Financial Management: Describe the financial management infrastructure the Exchange has established for financial management of the Exchange and Exchange grants using Planning grant funds (or other funds made available by the State for this purpose).
- Program Integrity: Discuss planning activities related to auditing, financial integrity, oversight, and prevention of fraud, waste and abuse.
- Health Insurance Market Reforms: Discuss progress in implementing Insurance Market Reforms under Subtitles A and C of the Affordable Care Act.
- Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints: Discuss planning efforts related to ensuring individuals have access to assistance services in the State.
- Business Operations/ Exchange Functions: Discuss the planning activities leading to the development of goals, milestones and timeframes for each function of the Exchange, to the extent that there is sufficient Federal guidance to do so at the time of the application. This includes:
    - Certification, recertification, and decertification of qualified health plans
    - Call center
    - Exchange website
    - Premium tax credit and cost-sharing reduction calculator
    - Quality rating system
    - Navigator program
    - Eligibility determinations for Exchange participation, advance payment of premium tax credits, cost-sharing reductions, and Medicaid
    - Seamless eligibility and enrollment process with Medicaid and other State health subsidy programs
    - Enrollment process
    - Applications and notices
    - Individual responsibility determinations
    - Administration of premium tax credits and cost-sharing reductions
    - Adjudication of appeals of eligibility determinations
    - Notification and appeals of employer liability
    - Information reporting to IRS and enrollees
    - Outreach and education
    - Free Choice Vouchers
    - Risk adjustment and transitional reinsurance
    - SHOP Exchange-specific functions

b. Proposal to Meet Program Requirements

The Project Narrative must include a proposal that explains the approach the applicant is considering to establish a State-operated Exchange. This section should be in alignment with the Work Plan and may provide a narrative description of the approach to achieve milestones or tasks outlined in the Work Plan. The applicant should describe how the Exchange will meet each of the program requirements set forth in this Funding Opportunity Announcement (see Section I.5). This proposal must include a description of the approach and the activities the State will undertake under each Exchange Establishment Core Area. If a State intends to apply for funds in certain Core Areas and not others, the applicant should provide a description of the activities it will undertake.

For example, to meet program requirements for performing Stakeholder Consultation, the proposal to meet program requirements must answer questions such as **which** stakeholders are involved in the Exchange establishment process, **what** roles the stakeholders have in the process, and **how** collaboration with stakeholders will continue throughout the establishment process. To answer questions such as these, the applicant could describe what forums will be used to engage with stakeholders, how stakeholder input will be gained and applied to inform the establishment process, and how the Exchange will identify stakeholders.

Providing assistance to individuals and small businesses is a priority of the Exchange. Therefore, the proposal must address how the Exchange will work to meet the needs of consumers and ensure that these services are provided.

In the discussion of the Exchange IT Systems Exchange Establishment Core Area, applicants must address how the Exchange will carry out due diligence in assessing the applicability of the system models developed by "Early Innovator" States. If the applicant does not intend to use these models, this must be justified. (Awardees of Early Innovator Cooperative Agreements do not have to include this in their discussion.) States may choose to develop their own systems, which may be done in many ways, including use of commercial off the shelf products (COTS); or States may adapt systems developed by other States. Systems must be interoperable and/or integrated or interface with both the State Medicaid and Children's Health Insurance Program (CHIP) programs and be able to interface with HHS in order to verify and acquire data as needed. Describe if your proposed solution will be an independent application, an enhancement to existing functionality, or some other solution option. Outline how tightly coupled your proposed exchange will be with your existing Medicaid systems. States are encouraged to consider how the Exchange system can be integrated with other health and human services systems in the state since the eligibility function the Exchange will perform has significant similarities to eligibility determinations in other programs. States are encouraged to consider how the Exchange system can be integrated with other specific health and human services systems in the State since the eligibility function the Exchange will perform has significant similarities to eligibility determinations in other programs. Further, States are encouraged to consider steps necessary to achieve interoperability with other

specific health and human services programs for purposes of coordinating eligibility determinations, referrals, verification or other functions.

The proposal to meet program requirements should explain how Exchange establishment will progress, leading to certification in January 2013, operation and provision of health insurance coverage to enrollees in 2014, and self-sustainability in 2015.

c. Summary of Exchange IT Gap Analysis
The applicant must conduct an Exchange IT Gap Analysis and provide a summary of the results of this analysis in the Project Narrative. Please refer to Appendix C for an explanation of the gap analysis that should be conducted.

d. Evaluation Plan
The project narrative must include specific measures of how the grantee will evaluate its progress and measure success in each of the Exchange Establishment Core Areas. Please provide baseline information or data for each measure. The grantee will be expected to update information and data for each measure quarterly and provide an evaluation plan that will assess progress 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 key indicators to be measured;
- Baseline Data for each indicator;
- Methods and their efficacy to monitor progress and evaluate the achievement of program goals; and
- Inclusion of plans for timely interventions when targets are not met or unexpected obstacles delay plans.
- Inclusion of a plan for ongoing evaluation of Exchange functioning once it is operational.

ii. *Level Two Establishment*

The project narrative must include the following sections:

a. Demonstration of Past Progress in Exchange Planning Core Areas
This section should describe and quantify, where possible, progress the State made in Exchange planning activities. This includes but is not limited to the discussion points highlighted below:

- Background Research: Discuss the research conducted, including key findings and plans that resulted from this research.
- Stakeholder Consultation: Discuss partnerships with various stakeholders and how public input into the Exchange planning process was gained, such as State HIT Coordinators and the State's health information exchange program, State officials, representatives of State Agencies, employers, insurers, advocacy groups, and consumer groups.
- State Legislative/ Regulatory Actions: Discuss the progress made toward the creation of the necessary legal authority to establish and operate an Exchange

that complies with Federal requirements available at the time of the application and provides for establishment of Exchange governance and structure

- Governance: Discuss the progress made toward establishing the administrative structure (State agency, quasi-governmental agency, or non-profit organization) and governance structure of the Exchange (composition of governing body, conflict of interest standards, selection process).
- Program Integration: Discuss how coordination with the State insurance regulatory entity (e.g. Department of Insurance), State Medicaid, CHIP, other State health subsidy programs, and other specific health and human services programs as appropriate, has been carried out during the planning process, and outcomes of these coordination efforts. Include planning activities related to streamlining eligibility and enrollment, and coordinating with the State Department of Insurance on issues including the financial stability of insurance companies, certification of plans, rate review, State licensure, solvency, and market conduct.
- Exchange IT Systems: Discuss steps taken toward the first phase of development of Exchange IT systems in accordance with the most current Federal IT guidance, including compliance with the standards adopted by the Secretary under Section 1561 of the Affordable Care Act. Please reference Appendix D as well. Discuss steps taken to ensure a modular, flexible approach to systems development, including use of open interfaces and exposed application programming interfaces; the separation of business rules from core programming; and the availability of business rules in both human and machine readable formats.
- Financial Management: Describe the financial management infrastructure the Exchange has established using planning grant funds (or other funds made available by the State for this purpose).
- Program Integrity: Discuss planning activities related to auditing, financial integrity, oversight, and prevention of fraud, waste and abuse.
- Health Insurance Market Reforms: Discuss progress in implementing Insurance Market Reforms under Subtitles A and C of the Affordable Care Act.
- Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints: Discuss planning efforts related to ensuring that assistance services are provided to individuals and small businesses in the State.
- Business Operations/ Exchange Functions: Discuss the planning activities leading to the development of an implementation plan that lays out goals, milestones and timeframes for each function of the Exchange, to the extent that there is sufficient Federal guidance to do so at the time of the application. This includes:
    - Certification, recertification, and decertification of qualified health plans
    - Call center
    - Exchange website
    - Premium tax credit and cost-sharing reduction calculator

- Quality rating system
- Navigator program
- Eligibility determinations for Exchange participation, advance payment of premium tax credits, cost-sharing reductions, and Medicaid
- Seamless eligibility and enrollment process with Medicaid and other State health subsidy programs
- Enrollment process
- Applications and notices
- Individual responsibility determinations
- Administration of premium tax credits and cost-sharing reductions
- Adjudication of appeals of eligibility determinations
- Notification and appeals of employer liability
- Information reporting to IRS and enrollees
- Outreach and education
- Free Choice Vouchers
- Risk adjustment and transitional reinsurance
- SHOP Exchange-specific functions

b. Proposal to Meet Program Requirements

The Project Narrative must include a proposal that explains the approach the applicant is considering to establish a State-operated Exchange. This section should be in alignment with the Work Plan and may provide a narrative description of the approach to achieve milestones or tasks outlined in the Work Plan. The proposal should exhibit the State's readiness to establish an Exchange and place emphasis on how it has met the eligibility criteria for a *Level Two Establishment* award (Section III.1.). The applicant should describe how the Exchange will meet each of the program requirements set forth in this Funding Opportunity Announcement (see Section I.5). This proposal must include a description of the approach and the activities the State will undertake under each Exchange Establishment Core Area.

For example, to meet program requirements for performing Stakeholder Consultation, the proposal to meet program requirements should answer questions such as **which** stakeholders are involved in the Exchange establishment process, **what** roles the stakeholders have in the process, and **how** collaboration with stakeholders will continue throughout the establishment process. To answer questions such as these, the applicant could describe what forums will be used to engage with stakeholders, how stakeholder input will be gained and applied to inform the establishment process, and how the Exchange will identify stakeholders.

Providing assistance to individuals is a priority of the Exchange. Therefore, the proposal must address how the Exchange will work to meet the needs of consumers and ensure that these services are provided.

In the discussion of the Exchange IT Systems Exchange Establishment Core Area, applicants must address how the Exchange will carry out due diligence in assessing

the applicability of the system models developed by "Early Innovator" States. If the applicant does not intend to use these models, this must be justified. (Awardees of these grants do not have to include this in their discussion.) States may choose to develop their own systems, which may be done in many ways, including use of commercial off the shelf products (COTS); or States may adapt systems developed by other States. Systems must be interoperable and/or integrated or interface with State Medicaid/Children's Health Insurance Program (CHIP) programs and be able to interface with HHS in order to verify and acquire data as needed. Describe if your proposed solution will be an independent application, an enhancement to existing functionality, or some other solution option. Outline how tightly coupled your proposed exchange will be with your existing Medicaid systems. States are encouraged to consider how the Exchange system can be integrated with other specific health and human services systems in the State since the eligibility function the Exchange will perform has significant similarities to eligibility determinations in other programs. Further, States are encouraged to consider steps necessary to achieve interoperability with other specific health and human services programs for purposes of coordinating eligibility determinations, referrals, verification or other functions.

The proposal to meet program requirements should explain how Exchange establishment will progress, leading to certification in January 2013, operation and provision of health insurance coverage to enrollees in 2014, and self-sustainability in 2015.

c. Summary of Exchange IT Gap Analysis

The applicant must conduct an Exchange IT Gap Analysis and provide a summary of the results of this analysis in the Project Narrative. Please refer to Appendix C for an explanation of the gap analysis that should be conducted.

d. Evaluation Plan

The project narrative must include specific measures of how the grantee will evaluate its progress and measure success in each of the Exchange Establishment Core Areas. Please provide baseline information or data for each measure. The grantee will be expected to update information and data for each measure quarterly and provide a multi-year evaluation plan that will assess progress 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 key indicators to be measured;
- Baseline Data for each indicator;
- Methods and their efficacy to monitor progress and evaluate the achievement of program goals; and
- Inclusion of plans for timely interventions when targets are not met or unexpected obstacles delay plans.
- Inclusion of a plan for ongoing evaluation of Exchange functioning once it is operational.

F. Work Plan

Each applicant must submit a detailed Work Plan by Exchange Establishment Core Area and each of the Business Operations of the Exchange.

For *Level One Establishment* applicants, the Work Plan submitted with the application should document all tasks the applicant must carry out over the entire project period, which is up to one year following the date of award. To the extent that the State is able to include milestones through 2014, we strongly encourage the State to do so. Appendix B of this document provides a series of example milestones organized under each Core Area. Each State applicant may include each of these milestones in its Work Plan. Certain milestones are **BOLD** and preceded by two asterisks (**) which indicates that these tasks must be included in the Work Plan and completed in the timeframe provided in order to receive approval to drawdown on grant funds related to these activities.

For *Level Two Establishment* applicants, the Work Plan submitted with the application should document all tasks the applicant must carry out over the entire project period, which is from the date of award up through December 31, 2014. *Level Two Establishment* applicants are expected to exhibit an advanced state of readiness to establish an Exchange by providing a complete and robust Work Plan through 2014. Appendix B of this document provides a series of example milestones organized under each Core Area. Each State Exchange may include each of these milestones in its Work Plan. Each State's progress will be evaluated against its completion of these specified milestones. Certain milestones are **BOLD** and preceded by two asterisks (**) which indicates that these tasks must be included in the Work Plan and completed in the timeframe provided in order to receive approval to drawdown on grant funds related to these activities.

For *Level One Establishment* and *Level Two Establishment* applicants, milestones should be developed under each Core Area in their Work Plan, including the month and year of anticipated completion. The incremental steps needed to reach these milestones should also be identified by the months and years in which they start, are carried out, and are completed. Time for quality assurance, including independent verification and validation should be integrated into the Work Plan timeline. Identify by name and title of the individual responsible for accomplishing each goal.

Applicants are encouraged to use the Systems Development Life Cycle (SDLC) framework for the IT aspects of Exchange establishment in developing the Work Plan (an example of an SDLC framework can be found here: http://www.cms.gov/ILCPhases/01_Overview.asp#TopOfPage). The applicant may complete an IT work plan separately if preferred, however it is still encouraged that the applicant follow the SDLC framework.

G. Budget Narrative

The proposed budget should include only costs for activities and functionalities that are *integral* to Exchange operations and meeting Exchange requirements.

Each applicant must submit a detailed budget narrative by Exchange Establishment Core Area and each of the Business Operations of the Exchange. The applicant must include costs by Exchange Establishment Core Area and each of the Business Operations of the Exchange, as demonstrated in Appendices E and F.

Provide a narrative that explains the amounts requested for each line in the budget for the entire project period. The budget justification should specifically describe how each line item will support the achievement of proposed objectives in alignment with the Work Plan. HHS will look for justifications that directly align with the tasks in the Work Plan and should be able to understand funding needs for each set of tasks the Exchange will carry out. The Budget Narrative should break down funding needs by quarter to the extent possible. It should also clearly identify funds that were spent prior to the project period (up to 90 days prior to the start of the project period).

Include a description that indicates which elements of your proposal you expect will also benefit your State's Medicaid/CHIP system(s) and other specific health and human services programs. Include a description of your proposal for allocating costs between these sources of funding in line with the cost-sharing/matching requirements in Section IV.5.B.vi., and an explanation of the methodology used to support the allocation is required.

Include a description of the State's capacity to oversee multiple grant funding streams if the applicant has received other grant funding from HHS. It is the responsibility of the grantee to ensure that these funding streams are maintained and accounted for separately. It is imperative that each applicant's budget clearly distinguishes between activities that are funded using Establishing Cooperative Agreement funding and activities funded using other funding sources.

Line item information must be provided to explain the costs entered in the appropriate form, Application Form 5161-1. **The budget justification must clearly describe each cost element and explain how each cost contributes to meeting the project's objectives/goals on a quarterly basis and by core area.** Carefully justify each item in the "other" category. The budget justification MUST be concise. Do NOT use the justification to expand the project narrative.

The Budget Narrative/Justification should be provided using both the format included in Appendices E and F, Guidelines for Budget Preparation of this FOA. . In addition, applicants are encouraged to review Appendix G on Federal Procurement Requirements for Grantees.

More guidance on preparing a budget request can be found in Appendices E and F.

States that are awarded funding under the Cooperative Agreements to Support Innovative Exchange Information Technology Systems will have to clearly identify how the funds provided under this Funding Opportunity Announcement are supporting tasks that are

clearly distinct from those funded by the Cooperative Agreements to Support Innovative Exchange Information Technology Systems.

Level One Establishment and *Level Two Establishment* applicants should clearly identify how the funds provided under this Funding Opportunity Announcement are supporting tasks that are **clearly distinct** from those funded by their Exchange Planning grants and other funding sources. States may use funding from this award to build on the activities established under other grants as they are relevant to the establishment of the Exchange and do not supplant grant funds.

H. Additional Letters of Agreement and/or Description(s) of Proposed/Existing Project

Provide any documents that describe additional working relationships between the applicant and agencies and programs cited in the application. Documents that confirm actual or pending contractual agreements should clearly describe the roles of the subcontractors and any product. Letters of agreements must be dated and must contain the following language:

"Under 45 CFR 92.34, HHS retains 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 subgrant or subcontract, and in any rights to a copyright purchased with grant support. HHS shall be provided with a working electronic copy of the software (including object source and code) with the right to distribute it to others for Federal purposes consistent with and throughout the execution of the Cooperative Agreement."

I. Descriptions for Key Personnel & Organizational Chart

Applicants must present a staffing plan and provide a justification for the plan that includes education and experience qualifications and rationale for the amount of time being requested for each staff position. Position descriptions that include the project specific roles, responsibilities, and qualifications of proposed project staff must be included as an Attachment. An organizational chart should be included as well. Copies of biographical sketches for any key employed personnel that will be assigned to work on the proposed project must be included as an Attachment.

J. Documentation Supporting Eligibility of Applicant (Level Two Establishment Only)

Applicants for *Level Two Establishment* awards must include documentation that demonstrates completion of the eligibility criteria defined in Section III.1. This includes documentation of:

1. The necessary legal authority to establish and operate an Exchange that complies with Federal requirements
2. The established governance structure;

3. a) A complete budget through 2014
   b) An initial plan discussing financial sustainability by 2015; and
   c) A plan outlining steps to prevent fraud, waste, and abuse.
4. A plan describing how capacity for providing assistance to individuals and small businesses in the State will be created, continued, and/or expanded, including provision for a call center.

3. Submission Dates and Times

All grant applications must be submitted electronically and be received through http://www.grants.gov by 11:59 pm Eastern Standard Time on the respective due date.

Level One Establishment: March 30, 2011; June 30, 2011; September 30, 2011; December 30, 2011.
Level Two Establishment: March 30, 2011; June 30, 2011; September 30, 2011; December 30, 2011; March 30, 2012; June 29, 2012

4. Intergovernmental Review

Applications for these Cooperative Agreements 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, does not apply to these grants.

5. Funding Restrictions

A. Reimbursement of Pre-Award Costs

Funds awarded under this funding opportunity may be used to reimburse pre-award costs that are allowable and incurred up to 90 days before grant award that can't be covered under existing funding from planning, Early Innovator , or establishment grants and cooperative agreements. If a State does not receive a grant award, HHS is not liable for costs incurred by the applicant.

B. Prohibited Uses of Grant Funds

The Department of Health and Human Services Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges may not be used for any of the following:

i. To cover the costs to provide direct health care services to individuals;
ii. To meet matching requirements of any other Federal program;
iii. To cover excessive executive compensation;
iv. To contract with organizations or individuals that have a conflict of interest, such as individuals or companies that sell insurance or insurance-like products, including discount plans.
v. To promote Federal or State legislative and regulatory modifications;
vi. To improve systems or processes solely related to Medicaid/ CHIP, or any other State or Federal program's eligibility:
    a. State applicants must allocate the costs of their IT system(s) work and other applicable costs per OMB Circular A-87, between the Exchange and

other health and human services programs for those activities that will benefit other health and human services programs. Examples of IT modules and other activities we anticipate needing to be cost-allocated include eligibility, enrollment, and verification. Examples where we think it is unlikely that costs need to be allocated between sources of funding are Exchange administration and qualified health plan certification and administration processes.

b. Following determination of the final awardees, States will need to submit an Advance Planning Document (APD) to CMS requesting Federal financial participation (FFP) of the Medicaid/CHIP portion of the allocated costs, or costs attributable to other Federal programs, Agencies, or Offices. HHS will work collectively and expeditiously to review grant solicitations and APD submissions. HHS will provide technical assistance and leadership throughout this process.

vii. Activities unrelated to Exchange planning and establishment such as:

a. Staff retreats;

b. Promotional giveaways; and

c. 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.

V. APPLICATION REVIEW AND SELECTION INFORMATION

In order to receive a Cooperative Agreement for establishing a State-operated Exchange, States must submit an application, in the required format, no later than the deadline dates.

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 awarded a grant.

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

1. Standard Forms
2. Three Required Letters of Support (Governor or Mayor (if DC), State Medicaid agency, State Department of Insurance)
3. Applicant's Application Cover Letter
4. Project Abstract
5. Project Narrative
6. Work Plan
7. Budget Narrative
8. Letters of Agreement and/or Description(s) of Proposed/Existing Project
9. Descriptions for Key Personnel & Organizational Chart

10. *Level Two Establishment* ONLY: Applicants for *Level Two Establishment* awards must include documentation that demonstrates completion of the eligibility criteria defined in Section III.1. This includes documentation of:
    a) The necessary legal authority to establish and operate an Exchange that complies with Federal requirements
    b) The established governance structure;
    c) i) A complete budget through 2014
       ii) An initial plan discussing financial sustainability by 2015; and
       iii) A plan outlining steps to prevent fraud, waste, and abuse.
    d) A plan describing how capacity for providing assistance to individuals and small businesses in the State will be created, continued, and/or expanded, including provision for a call center.

1. Criteria

Level One Establishment

The review criteria for *Level One Establishment* applications are based on a total of 100 points allocated among the following areas:

A. Project Narrative – 55 points

i. **Demonstration of Progress in Exchange Planning Grant Core Areas** (15 points) The applicant should describe and quantify progress toward carrying out activities in the Core Areas listed below. Applicants must show progress in each of these planning Core Areas in order to be determined ready to move to establishment of an Exchange.

- Background Research
  - Research started, including market analysis
  - Inclusion of discussion of how research will inform Exchange planning and policy
- Stakeholder Consultation
  - Stakeholder meetings have been scheduled and/or convened
  - Inclusion of a discussion of how input from stakeholders has been and will be integrated into the planning process
- State Legislative/Regulatory Actions
  - The necessary legal authority to establish and operate an Exchange that complies with Federal requirements and provides for establishment of governance and Exchange structure
- Governance
  - Governance and Exchange structure have been determined and drafted
- Program Integration
  - Coordination has been established with the State Medicaid agency and the State Department of Insurance, and at the option of the

State, other specific health and human services programs where applicable.

- Exchange IT Systems
  - State has begun development of business requirements for Exchange IT systems, which comply with standards endorsed or adopted by the Secretary of HHS pursuant to Sections 1104 and 1561 of the Affordable Care Act, HIPAA transaction standards, and standards to ensure accessibility as well as security and privacy standards consistent with Federal law.
- Financial Management
  - Inclusion of a discussion of a plan for ensuring sufficient funding for ongoing operations after January 1, 2015
- Discussion of progress in the remaining Core Areas, listed below:
  - Program Integrity
  - Health Insurance Market Reforms
  - Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints
  - Business Operations/ Exchange Functions

ii. **Proposal to meet Program Requirements** (30 points)

- The applicant should describe how the State will achieve progress during the project period in each of the Core Areas found in the Program Requirements section. This proposal should describe the approach the applicant will take to Exchange establishment under each Core Area. This discussion should build upon the progress the State has made under the above Core Areas. If the applicant identifies that it will only undertake activities in certain Core Areas, the applicant should describe how it will ensure it conducts activities in all Core Areas before it applies for *Level Two Establishment* funding.
- This proposal will be reviewed based on:
  - How substantively the applicant describes its approach under each Core Area and the extent to which Exchange IT Systems have been considered;
  - Degree of interoperability with other programs;
  - The reasonableness of the proposed approach; and
  - The extent to which the applicant demonstrates a plan in and for compliance with any guidance relating to the Exchange from HHS
- The applicant should specifically address IT Systems in the Proposal to meet Program Requirements. This will be reviewed considering the:
  - Extent to which the applicant has demonstrated governance and technical competence in addressing Key Principles and Core Exchange Functions supported by IT found in Appendix D.
  - Completeness of the IT Gap Analysis conducted by the State, provided in summary form in the Project Narrative (found in Appendix C).
  - Extent to which the applicant provides a thorough understanding of the importance of using IT standards and is committed to their use in the Exchange. For details on Section 1561 standards, see:

http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3161.

- Extent to which the applicant demonstrates a plan for compliance with any IT guidance relating to the Exchange or Medicaid issued by HHS.
- If applicable (if a State has submitted an APD to CMS for Medicaid, CHIP, ACF, USDA/FNS, or any other applicable Agency or Office systems funding in last three years), whether the applicants provides a summary of any submission(s) and CMS' response.

iii. **Evaluative Measures** (10 points)

- Inclusion of a detailed impact evaluation plan for the duration of the project period;
- Discussion of key indicators to be measured;
- Effectiveness of methods proposed to monitor progress and evaluate the achievement of proposed program goals;
- Inclusion of plans for timely interventions when targets are not met or unexpected obstacles delay plans; and
- Inclusion of baseline data.
- Inclusion of a plan for ongoing evaluation of Exchange functioning once it is operational.

B. Work Plan (25 points)

The Work Plan for this project must include each of the required milestones in **BOLD** and preceded by two asterisks (**) found in Appendix B. The Work Plan should be as detailed as possible, and reflect the processes specific to each State for achievement of the required milestones as well as those developed by the State throughout the project period. For example, if the State procurement procedure requires six months to develop a request for proposal, review applications, and award a contract, these steps and the associated time it takes to complete them should be taken into account in the lead time to achieving each milestone affected by procurement. All such processes should be described in detail throughout the Work Plan and identified in a timeline.

The reasonableness and completeness of the specific tasks to be conducted throughout the project period will be reviewed as well as the adequacy of the projected timeframes. The Work Plan must indicate what milestones the Exchange plans to meet with associated timeframes. For each milestone under each Core Area in the Work Plan, the month and year of anticipated achievement should be included. The incremental steps to achieving these milestones should also be identified by the months and years in which they start, are carried out, and are completed. States may wish to do separate Work Plans for different aspects of Exchange establishment, such as one Work Plan exclusively devoted to IT systems development.

It is imperative that States distinguish in their Work Plans between activities pursued under the Exchange Planning grant and/or the Cooperative Agreement to Support Innovative Exchange Information Technology Systems, and establishment activities funded under this Funding Opportunity in their Work Plans.

C. Budget Narrative (20 points)

- Completeness of the budget and reasonableness of requested funding level according to the tasks proposed.
- Extent to which the applicant exhibits the budgetary resources that are needed according to its Work Plan. The budget must show the resources needed on a quarterly basis where the State is able to make these determinations at the time of application and explain why other costs can't be distributed quarterly. The proposed budget should include only costs for activities and functionalities that are *integral* to Exchange operations and meeting Exchange requirements.
- Inclusion of a description that indicates which elements of the proposal the applicant expects to also benefit the State's Medicaid/CHIP system, and other specific health and human service programs as applicable. Include a description of your proposal for allocating costs between these sources of funding.
- Explanation of how the establishment activities funded under this Funding Opportunity Announcement will be coordinated with funding previously awarded under the Exchange Planning grant and State Consumer Assistance Grants.
- Inclusion of a description of the State's capacity to manage multiple grant funding streams.

Level Two Establishment

Applicants that apply for *Level Two Establishment* funding and are not recommended for funding could revise and resubmit their application for either *Level One Establishment* or *Level Two Establishment* provided that the final application due date has not passed.

The review criteria for *Level Two Establishment* applications are based on a total of 100 points allocated among the following areas:

A. Project Narrative – 55 points

i. **Demonstration of Progress in Exchange Planning Grant Core Areas** (15 points)

The applicant should describe and quantify progress toward carrying out activities in the Core Areas listed below. Applicants must show steps that have been completed and provide evidence of the significant progress in each of these planning Core Areas in order to be determined ready to receive funding through December 31, 2014. This discussion should include a discussion of how the State has met the eligibility criteria for a *Level Two Establishment* award.

- Background Research
  - Research completed, including market analysis
  - Inclusion of discussion of how research has informed Exchange planning and policy

- Stakeholder Involvement
  - Stakeholder meetings have been convened
  - Inclusion of a discussion of how input from stakeholders has been integrated into the planning process
- State Legislative/Regulatory Actions
  - The State has the necessary legal authority to establish and operate an Exchange that complies with Federal requirements and provides for establishment of governance and Exchange structure
- Governance
  - Governance and Exchange structure have been determined and established
- Program Integration
  - Coordination has been established with the State Medicaid agency and the State Department of Insurance, and other specific health and human services programs as applicable.
- Exchange IT Systems
  - State has begun development of business requirements for Exchange IT systems, which comply with standards endorsed or adopted by the Secretary of HHS pursuant to Sections 1104 and 1561 of the Affordable Care Act, HIPAA transaction standards, and standards to ensure accessibility as well as security and privacy standards consistent with Federal law.
- Financial Management
  - Inclusion of a discussion of a plan for ensuring sufficient funding for ongoing operations after January 1, 2015
- Discussion of progress in the remaining Core Areas, listed below:
  - Program Integrity
  - Health Insurance Market Reforms
  - Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints
  - Business Operations/ Exchange Functions

ii. **Proposal to meet Program Requirements** (30 points)

- The applicant should describe how the State will achieve progress through 2014 in each of the Core Areas found in the Program Requirements section. These applicants should demonstrate an advanced state of readiness to establish an Exchange and receive funding through 2014. This proposal should describe the approach the applicant will take to Exchange establishment under each Core Area. This discussion should build upon the progress the State has made under the above Core Areas.
- This proposal will be reviewed based on:
  - How substantively the applicant describes its approach under each Core Area and the extent to which Exchange IT Systems have been considered;
  - Degree of interoperability with other programs;
  - The reasonableness of the proposed approach; and

- The extent to which the applicant demonstrates a plan in and for compliance with any guidance relating to the Exchange from HHS.

- The applicant should specifically address IT Systems in the Proposal to meet Program Requirements. This will be reviewed considering the:
  - Extent to which the applicant has demonstrated governance and technical competence in addressing Key Principles and Core Exchange Functions supported by IT found in Appendix D.
  - Completeness of the IT Gap Analysis conducted by the State, provided in summary form in the Project Narrative (found in Appendix C).
  - Extent to which the applicant provides a thorough understanding of the importance of using IT standards and is committed to their use in the Exchange. For details on Section 1561 standards, see: http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3161.
  - Extent to which the applicant demonstrates a plan for compliance with any IT guidance relating to the Exchange or Medicaid issued by HHS.
  - If applicable (if a State has submitted an APD to CMS for Medicaid, CHIP, ACF, USDA/FNS, or any other applicable Agency or Office systems funding in last three years), whether the applicants provides a summary of any submission(s) and CMS' response.
  - Extent to which the applicant demonstrates an advanced state of readiness to engage in early phases of a systems development lifecycle process (e.g., initiation, concept development, requirements, etc.).

iii. **Evaluative Measures** (10 points)

- Inclusion of a detailed impact evaluation plan for the duration of the project period; Discussion of key indicators to be measured;
- Effectiveness of methods proposed to monitor progress and evaluate the achievement of proposed program goals;
- Inclusion of updated plans for timely interventions when targets are not met or unexpected obstacles delay plans; and
- Inclusion of updated baseline data.
- Inclusion of a plan for ongoing evaluation of Exchange functioning once it is operational.

B. Work Plan (25 points)

The Work Plan must demonstrate a sufficient level of planning to justify the award of funding through 2014 by inclusion of detailed milestones throughout the project period. The Work Plan for this project must include each of the required milestones in **BOLD** and preceded by two asterisks (**) found in Appendix B. The Work Plan should be as detailed as possible, and reflect the processes specific to each State for achievement of the required milestones as well as those developed by the State for the entire project period, from the date of award up through December 31, 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 Work Plan and identified in a timeline.

The reasonableness and completeness of the specific tasks to be conducted throughout the project period will be reviewed as well as the adequacy of the projected timeframes. The Work Plan must indicate what milestones the Exchange plans to meet with associated timeframes. For each milestone under each Core Area in the Work Plan, the month and year of anticipated achievement must be included. The incremental steps to achieving these milestones should also be identified by the months and years in which they start, are carried out, and are completed. States may wish to do separate Work Plans for different aspects of Exchange establishment, such as one Work Plan exclusively devoted to IT systems development.

The Work Plan for *Level Two Establishment* applicants must demonstrate an advanced state of readiness by including robust and complete milestones through 2014.

It is imperative that States distinguish in their Work Plans between activities pursued under the Exchange Planning grant and/or the Cooperative Agreement to Support Innovative Exchange Information Technology Systems, and establishment activities funded under this Funding Opportunity in their Work Plans.

C. Budget Narrative (20 points)

The budget narrative justifies the State's readiness to receive funding through 2014, including complete explanations and justifications of proposed funding levels.

- Extent to which the applicant exhibits a sound understanding of the scope of Exchange functions and the funding needed to carry them out;
- Completeness of the budget and reasonableness of requested funding level according to the tasks proposed;
- Extent to which the applicant exhibits the budgetary resources that are needed according to its Work Plan. The budget must show the resources needed on a quarterly basis where the State is able to make these determinations at the time of application and explain why other costs can't be distributed quarterly. The proposed budget should include only costs for activities and functionalities that are *integral* to Exchange operations and meeting Exchange requirements;
- Inclusion of a description that indicates which elements of the proposal the applicant expects to also benefit the State's Medicaid system/CHIP system and other specific health and human services programs as applicable. Include a description of your proposal for allocating costs between these sources of funding;
- Explanation of how the establishment activities funded under this Funding Opportunity Announcement will be coordinated with funding previously awarded under the Exchange Planning grant and State Consumer Assistance Grants.
- Inclusion of a description of the State's capacity to manage multiple grant funding streams.

2. Review and Selection Process

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

A. Applications will be screened to determine eligibility for further review using the criteria detailed in the 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.

B. Procedures for assessing the technical merit of grant applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. Review criteria are used to review and to rank applications. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. Review criteria, according to which all applications will be evaluated, are outlined above with specific detail and scoring points. Applications will be evaluated by an objective review committee. Applicants should pay strict attention to addressing all these criteria, as they are the basis upon which the reviewers will evaluate their applications.

C. Final award decisions will be made by an HHS program official. In making these decisions, the HHS program official will take into consideration: 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.

The Department reserves the right to conduct pre-award Budget Negotiation with potential awardees. If the applicant applies for *Level Two Establishment* and is found to not meet the review criteria, the applicant may reapply for a *Level One Establishment* award provided that the final application due date has not passed.

3. Anticipated Announcement and Award Date

The anticipated dates of award for Cooperative Agreement to Support Establishment of State – operated Health Insurance Exchanges are 45 days after each application due date for *Level One Establishment* and *Level Two Establishment.*

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 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) subaward Reporting Requirement: As required by the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109–282), as amended by section 6202 of Public Law 110–252, recipients must report information for each subaward of $25,000 or more in Federal funds and executive total compensation for each of your five most highly compensated executives for the preceding completed fiscal year as outlined in Appendix A to 2 CFR Part 170. Information about the Federal Funding and Transparency Act Subaward 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 original grant application or agreed upon subsequently with HHS, and may not be used for any prohibited uses.

D. Consumers and other stakeholders must have meaningful input into the planning, implementation, and evaluation of the project. All grant budgets must include some funding to facilitate participation on the part of individuals who have a disability or long-term illness and their families. Appropriate budget justification to support the request for these funds must be included.

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).

Subaward Reporting and Executive Compensation: As required by the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109–282), as amended by Section 6202 of Public Law 110–252, recipients must report information for each subaward of $25,000 or more in Federal funds and total executive compensation for each of your five most highly compensated executives for the preceding completed fiscal year as outlined in Appendix A to 2 CFR Part 170. Information about the Federal Funding and Transparency Act Subaward 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.

4. Cooperative Agreement Terms and Conditions of Award

The following special terms of award are in addition to, and not in lieu of, otherwise applicable OMB administrative guidelines, HHS grant administration regulations at 2 CFR Part 215 and 45 CFR Part 92 (Part 92 is applicable when State and local Governments are eligible to apply), and other HHS and PHS grant administration policies.

The administrative and funding instrument used for this program will be the Cooperative Agreement, an assistance mechanism in which substantial HHS programmatic involvement with the recipient is anticipated during the performance of the activities. Under each Cooperative Agreement, HHS's purpose is to support and stimulate the recipient's activities by involvement in and otherwise working jointly with the award recipient in a partnership role. To facilitate appropriate involvement during the period of this Cooperative Agreement, HHS and the recipient will be in contact monthly and more frequently when appropriate.

Cooperative Agreement Roles and Responsibilities are as follows:

Department of Health and Human Services

HHS will have substantial involvement in program awards, as outlined below:

- Technical Assistance – HHS will provide technical assistance in accordance with requirements to be established by the Secretary through the rulemaking process and guidance issued by HHS.
- Collaboration – To facilitate compliance with the terms of the Cooperative Agreement and to more effectively support recipients, HHS will actively coordinate with certain critical stakeholders, such as:
    - State-Designated Entities
    - State HIT Coordinators and Health Insurance Exchange Leads
    - Other relevant Federal Agencies including but not limited to the U.S. Office of Personnel Management, the Indian Health Service, the Health Resources

and Services Administration, the Internal Revenue Service, the Department of Homeland Security, the Administration for Children and Families, and the Social Security Administration.

- Program Evaluation – HHS will work with recipients to implement lessons learned to continuously improve this program and the nation-wide implementation of the Health Insurance Exchanges.
- Progress against the Exchange Work Plan – HHS will evaluate grant performance and progress against the grantee's Work Plan and will allow access to funding in alignment with State progress.
- Project Officers and Monitoring – HHS will assign specific Project Officers to each Cooperative Agreement award to support and monitor recipients throughout the period of performance. HHS Grants Management Officers and Project Officers will monitor, on a regular basis, progress of each recipient. This monitoring may be by phone, document review, on-site visit, other meeting and by other appropriate means, such as reviewing program progress reports and Federal Financial Reports (SF425). This monitoring will be to determine compliance with programmatic and financial requirements.
- Conference and Training Opportunities – HHS will host opportunities for training and/or networking, including conference calls and other vehicles.

Recipients

Recipients and assigned points of contact retain the primary responsibility and dominant role for planning, directing and executing the proposed project as outlined in the terms and conditions of the Cooperative Agreement and with substantial HHS involvement. Recipient shall:

- Requirements – comply with all current and future requirements of the establishment of an Exchange, including those issued through rulemaking and guidance specified and approved by the Secretary of HHS.
- Collaboration – collaborate with the critical stakeholders listed in this funding opportunity and the HHS team, including the assigned Project Officer. Recipients are also required to collaborate with their State Medicaid Directors, State Insurance Commissioners, and other key State stakeholders such as the HIT Coordinators.
- Reporting – comply with all reporting requirements outlined in this funding opportunity and the terms and conditions of the Cooperative Agreement to ensure the timely release of funds.
- Program Evaluation – cooperate with HHS-directed national program evaluations.

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 subgrant or subcontract, and in any rights to a copyright purchased with grant support.

State grantees under this Cooperative Agreement shall not enter in to any contracts supporting the Exchange systems where Federal grant funds are used for the acquisition

or purchase of software licenses and ownership of the licenses are not held or retained by either the State or Federal government, under the terms described above.

5. 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. Appendix B of this document provides a series of example milestones organized under each Core Area. Each State Exchange should draw from these milestones in the development of its Work Plan. Certain milestones are **BOLD** and preceded by two asterisks (**) which indicates that these tasks are required for Exchanges and should be completed in the timeframe provided. HHS reserves the right to restrict funds for activities related to milestones not met. Tasks that are not bold and preceded by two asterisks (**) will need to be included in each Work Plan but the timeframe, while suggested, is not required. More details of the report will be outlined in the Notice of Grant Award. The report could include, but will not be limited to:

- Progress on the required milestones (in **BOLD** and preceded by two asterisks (**) in Appendix B)
- Progress on State determined goals, milestones, and activities
- Changes in work plan components
- Lessons learned

B. Work Plan Updates

Each State will be required to periodically submit an updated Work Plan 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.

C. Public Report

Grantees will be required to prominently post specific information about establishment grants on their respective Internet websites to ensure that the public has information on the use of funds. More details will be outlined in the Notice of Grant Award.

D. 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. States may also be subject to site visits to enable HHS to conduct evaluations of

Exchange progress as needed to support the determinations HHS must make related to Exchange certification, explained in Section I.5 of this announcement.

E. Federal Financial Report (FFR)

The FFR SF425 was designed to replace the Financial Status Report SF269 and the Federal Cash Transactions Report SF272 with one comprehensive financial reporting form. The grantees are required to submit the FFR SF425 on a quarterly basis. More details will be outlined in the Notice of Grant Award.

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

G. Audit Requirements

Grantees must comply with audit requirements of 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.

H. 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

For questions and concerns regarding this cooperative agreement, please contact:

Grants Management Official/Business Administration

Michelle Feagins
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
(301) 492-4312
Michelle.Feagins@hhs.gov

Program Official/Programmatic Management

Katherine Bryant
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
(301) 492-4446
Katherine.Bryant@hhs.gov

VIII. APPENDICES

A. Appendix A: Description of the Eleven Exchange Establishment Core Areas

Although it is emphasized in program integrity and financial management, one of the key principles that will inform federal funding and technical support for State establishment of Exchanges is public accountability and transparency. Accountability requires transparency. Section 1311(d)(7) requires public reports on Exchange activities, and Section 1311(e)(3) requires additional reporting, which should include standardized data reporting on price, quality, benefits, consumer choice and other factors that will help measure and evaluate performance. Successful Exchanges must ensure public accountability in areas such as objective information on the performance of plans; availability of automated comparison functions to inform consumer choice; fair and impartial treatment of consumers, plans and other partners; and prohibitions on conflict of interest.

For more information on the initial guidance provided to States on the Principles and priorities of Exchanges, please go to:
http://www.healthcare.gov/center/regulations/guidance_to_states_on_exchanges.html

Further information on each of these Exchange Establishment Core Areas will be provided in future guidance and regulations.

1. Background Research

As part of their planning activities, many States are currently undertaking studies and other research to determine the best approach for supporting an Exchange. In some States, this research includes evaluating whether or not the State should establish an Exchange, and if so, where it should be housed, how it should be governed, and what approach it will take. For *Level One Establishment* and *Level Two Establishment* applicants, background research will only be considered as a Core Area under previous Exchange grants and will not need to be carried forward under the Establishment Cooperative Agreement except to the extent that the State determines more research is needed.

2. Stakeholder Consultation

Section 1311(d)(6) of the Affordable Care Act requires that each Exchange consult with a variety of key stakeholders in the planning, establishment and ongoing operation of Exchanges. For example, Stakeholder input should be considered in the development of legislative options and drafts of enabling legislation, Exchange design and approach, and Exchange operational issues, among numerous other topics, including coordination with State health information exchanges. Successful Exchanges will undertake multi-faceted outreach to inform the public of their services and coverage options and will work closely with a variety of stakeholders including, but not limited to advocates for consumers, patients, employees, unemployed individuals, self employed individuals, and other consumers likely to be Exchange enrollees as well as consumers likely to be eligible for premium tax credits and cost-sharing reductions, representatives of small

businesses, health insurance issuers, State HIT Coordinators, State Medicaid offices, State human services agency, and health care providers.

In the spirit of Executive Order 13175 the Secretary is anticipating requiring each State that has one or more federally recognized Tribe(s) located within its borders to provide documentation that it has (1) established a process of consultation with such Tribe(s) regarding the start up and ongoing operation of the Exchanges; (2) implemented that process; and (3) assurance that it will continue to conduct and document such Tribal consultations for Exchange matters. Further guidance will be provided on this and other Indian specific issues. States are encouraged to review and adapt to procedures for State Medicaid consultation. States have the option to subcontract with Tribes for activities related to their grant. Please clearly identify funding set aside for such consultation in the budget narrative.

3. Legislative and Regulatory Action

Section 1321(b)(1) of the Affordable Care Act requires that by January 1, 2014, a State that elects to establish an Exchange must adopt and have in effect the Federal standards for Exchanges that will be issued by HHS or that the State have in effect a State law, regulation, or other legal mechanism, that implements these standards. Each State should ensure that it provides its Exchange with the authority necessary to meet all the Exchange requirements of the Affordable Care Act. The State must determine all the necessary steps it must take to have the necessary legal authority to establish and operate an Exchange that complies with Federal requirements. Each State will have its own milestones under this Core Area that correspond to its legislative calendar and the political environment of the State. We provide examples of basic milestones to guide the timeline for this process.

4. Governance

Each Exchange must have in place a governance structure that conforms to the requirements of the Affordable Care Act and the regulations to be issued by HHS. Section 1311(d)(1) provides States with the option of establishing an Exchange within an existing State agency, within a new or existing quasi-governmental entity, or as a separate non-profit. In addition, a State could choose to partner with one or more other States to establish a regional Exchange or to create more than one subsidiary Exchange within the State. Regardless of its organizational form, the Exchange must be publicly accountable, transparent, and have technically competent leadership, adhering to States' conflict of interest requirements, with the capacity and authority to take all actions necessary to meet Federal standards, including the discretion to determine whether health plans offered through the Exchange are in the interests of qualified individuals and qualified employers.

5. Program Integration

As required by Section 1413 of the Affordable Care Act, the Exchange will need to work closely with Medicaid, CHIP, and other Health and Human Services Programs in order to ensure seamless eligibility verification and enrollment processes. To reach this goal, the Exchange and the State Medicaid agency will need to closely partner on systems development and operational

procedures. States are encouraged to consider how the Exchange system can be integrated with other health and human services systems in the State since the eligibility function the Exchange will perform has significant similarities to eligibility determinations in other programs. States are encouraged to consider steps necessary to achieve interoperability with other specific health and human services programs for purposes of coordinating eligibility determinations, referrals, verification, or other functions.

Each Exchange will also need to work closely with the State Department of Insurance in order to successfully carry out the activities of the Exchange. The State Department of Insurance will oversee the regulation and licensure of health insurance issuers, including those that offer qualified health plan coverage through the Exchange. In addition, the State Department of Insurance may be the State entity that processes consumer coverage appeals and complaints. Working with the State Department of Insurance will be essential in ensuring the financial stability of insurance companies, certification of plans, rate review, State licensure, solvency, and market conduct. Key issues, such as adverse selection, related to the functioning of the individual and small group markets inside and outside the Exchange will be important to Exchange success. To the extent Exchanges are not one of these entities, they should get started early in working with these other departments as well as legislators to determine the best approach to mitigating these issues.

6. Exchange IT Systems

Information technology will be a component of many business functions of the Exchange, including those set forth in Section 1311(d)(4) as well as the requirements in Sections 1411, 1412 and 1413 related to eligibility and enrollment. This Core Area encompasses the performance of the Exchange in planning for and establishing these systems in these various functional areas. When planning or developing Exchange IT systems, the State should take steps to ensure a modular, flexible approach to systems development, including use of open interfaces and exposed application programming interfaces; the separation of business rules from core programming; and the availability of business rules in both human and machine readable formats. Milestones related to information technology for establishment of an Exchange will be located under each of the Exchange business functions. Exchanges will be required to follow all applicable Federal IT guidance. In addition, States are encouraged to leverage the expertise of the State health information exchange program (HIE). HIE is defined as the mobilization of healthcare information electronically across organizations within a region, community or hospital system. HIE provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to and retrieval of clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care. HIE is also useful to Public Health authorities to assist in analyses of the health of the population.

7. Financial Management

As required by Section 1313, each Exchange will establish a financial management structure and accounting system that adheres to applicable provisions of generally accepted accounting

requirements and ensures sound financial management of Exchange funds. We have provided some milestones that should be included in the Exchange Work Plan related to establishing these functions. Applicants should create additional milestones that are tailored to their Exchanges' particular management structure and that will ensure the Exchanges are in compliance with State and Federal regulations.

8. Oversight and Program Integrity

Also required by Section 1313, each Exchange will need to ensure program integrity related to Federal and State funds utilized to start-up and operate the Exchange. Exchanges will need to ensure that they take steps to prevent waste, fraud, and abuse. The Financial Management core area includes the infrastructure the Exchange must establish for financial management while this core area includes the oversight and program integrity activities the Exchange undertakes to ensure compliance with Federal and State requirements, including annual audits.

9. Health Insurance Market Reforms

In Sections 1311(a)(4)(A)(ii) and 1321(c)(1)(B)(ii)(II), the Affordable Care Act requires each State to show progress implementing the health insurance market reforms that are set forth in Subtitles A and C of the Affordable Care Act as a condition of receiving establishment grants and for certification of the State's Exchange. Making progress on implementation would include passing State legislation or issuing appropriate regulations implementing these reforms as well as other activities, including stakeholder consultation on these issues and development of a plan to implement these reforms. These activities will be carried out by the State. HHS will release guidance on how States demonstrate progress in implementing these reforms. States must also demonstrate they are enforcing Affordable Care Act consumer protections to be certified as eligible to operate an Exchange.

10. Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints

Exchanges are required to provide certain services for State residents, including responding to requests for informational assistance, providing a toll free telephone hotline, and helping individuals learn whether they are eligible for Medicaid, CHIP and applicable State health subsidy programs and facilitate the enrollment process, where applicable. Exchanges also must offer assistance to individuals and provide for coverage appeals. These requirements are set forth in Sections 1311(d)(4) and 1413 as well as other Sections. Exchanges also must offer assistance through navigators, as required by Section 1311(i) of the Affordable Care Act (funded from the operational funds of the Exchange), to individuals and provide for coverage appeals.

An Exchange may provide these services directly, or through contracts or by referral arrangements to entities or other state agencies that provide such assistance services. Many States already have assistance programs that help residents resolve problems, answer questions, file complaints and appeals, enroll in. When an Exchange provides this assistance through contracting entities or interagency agreements, it must ensure the outside entity has capacity to provide assistance that consumers need. Building sufficient capacity for providing assistance to State residents is a core activity of Exchange planning and establishment. For these reasons, a

State must ensure robust capacity for providing such assistance for all of its residents and must ensure that the Exchange reinforces and strengthens this assistance capacity. The Exchange should collaborate closely with other entities within the State who are carrying out these activities and develop a plan to facilitate this ongoing collaboration.

11. Business Operations of the Exchange

Exchanges must carry out several functions required by the Affordable Care Act. More detailed information will be provided on the requirements for each function in future guidance. Each of the minimum functions of an Exchange are listed below and explained in greater detail below. These requirements are mainly set forth in Sections 1311(d)(4), 1341, 1343, and 1411-1413.

Minimum functions of an Exchange:

- Certification, recertification, and decertification of qualified health plans
- Call center
- Exchange website
- Premium tax credit and cost-sharing reduction calculator
- Quality rating system
- Navigator program
- Eligibility determinations for Exchange participation, advance payment of premium tax credits, cost-sharing reductions, and Medicaid
- Seamless eligibility and enrollment process with Medicaid and other State health subsidy programs
- Enrollment process
- Applications and notices
- Individual responsibility determinations
- Administration of premium tax credits and cost-sharing reductions
- Adjudication of appeals of eligibility determinations
- Notification and appeals of employer liability
- Information reporting to IRS and enrollees
- Outreach and education
- Free Choice Vouchers
- Risk adjustment and transitional reinsurance
- SHOP Exchange-specific functions

Certification, Recertification, and Decertification of Qualified Health Plans

Each Exchange, whether for the small group or individual market, must have a process in place to certify, recertify, and decertify qualified health plans. States must begin defining their process and approach to these activities with health plans in the early planning and establishment phases of an Exchange. There are many steps in this process, and we have provided milestones as a framework for carrying out these activities. However, States may be on slightly different timelines and we encourage States to develop timeframes for these activities that are achievable yet ensure they can be ready for open enrollment in mid to late

2013. In order to meet this deadline, Exchanges must begin the process of selection and certification of qualified health plans in 2012.

Call Center

As part of its plan to provide meaningful assistance to individuals and small businesses, each Exchange must operate a toll-free hotline to respond to requests for assistance from consumers. HHS will provide future guidance containing more specific information about the requirements for Exchange call centers. Each Exchange should aim to have a call center ready before open enrollment, but States may set up these services earlier to facilitate outreach to consumers and to answer consumer questions about how the Affordable Care Act may affect individual access to health insurance. In addition, a State could explore partnering with its State Consumer Assistance Program or Health Ombudsman program to jointly contract for or to operate a call center as these activities will be very closely related.

Exchange Website and Premium Tax Credit and Cost-sharing Reduction Calculator

Each Exchange will maintain a website through which applicants and enrollees and may obtain standardized comparative information on qualified health plans, apply for coverage, and enroll online. Exchange websites will also need to post required transparency information. Exchanges may choose to provide many more services on their websites. In addition, each Exchange website must provide access to an electronic calculator that allows individuals to view an estimated cost of their coverage once premium tax credits have been applied to their premiums, and the impact of cost-sharing reductions, if they are eligible. HealthCare.gov can be used as a source of content for Exchange websites.

Quality Rating System

Each Exchange will need to assign a quality rating to each plan in accordance with the quality rating system that will be issued by HHS. Also, certification of qualified health plans should include consideration of quality data.

Navigator Program

Each Exchange will establish a Navigator program, as required by Section 1311(i) of the Affordable Care Act, under which it awards grants (funded from the operational funds of the Exchange) to entities that will assist consumers in navigating their choices in the health insurance marketplace. This includes facilitating enrollment in qualified health plans.

Eligibility determinations for Exchange participation, advance payment of premium tax credits, cost-sharing reductions, and Medicaid

Key operations of the Exchange will be verification and determination of eligibility for qualified health plans. The Affordable Care Act includes requirements for these functions that will be spelled out in greater detail in future HHS guidance. Key functions within this functional area include:

- Eligibility determinations for:
    - Advance payment of premium tax credits
    - Cost-sharing reductions

- Other applicable State health subsidy programs, including Medicaid and CHIP , and
- Free Choice Vouchers

- Appeals of eligibility determinations for enrollment in a qualified health plan and premium tax credits and cost-sharing reductions

Seamless eligibility and enrollment process with Medicaid and applicable State health subsidy programs

There are numerous milestones that Exchanges will need to accomplish between now and 2014 to create seamless eligibility and enrollment between the Exchange and other State health subsidy programs. The Exchange must determine an individual's eligibility for Medicaid, CHIP, and other applicable State health subsidy programs and the State must ensure that such individuals are seamlessly enrolled in the program for which they are eligible without need for further determination by the other program. States are encouraged to consider how the Exchange eligibility system can be integrated – in the short or longer term - with other health and human services systems in the State since the eligibility function the Exchange will perform has significant similarities to eligibility determinations in other programs. States are encouraged to consider steps necessary to achieve interoperability with other specific health and human services programs for purposes of coordinating eligibility determinations, referrals, verification, or other functions.

Each State's situation will be different and milestones will need to be tailored to the specific scenarios. In addition, many of the steps needed to achieve streamlined eligibility and enrollment in Exchanges and other applicable State health subsidy programs will be carried out through the development of information technology systems in close partnership with State Medicaid programs. We will work closely to help States with the process. States should refer to *Guidance for Exchange and Medicaid Information Technology (IT) Systems*, Version 1.0 or the most current version, the standards adopted by the Secretary pursuant to the Affordable Care Act, and future guidance for additional guidance related to the effort to bring together eligibility and enrollment processes across these programs.

Enrollment process

The Exchange will need to facilitate plan selection for an individual who is eligible to enroll in a qualified health plan. This includes providing information about available qualified health plans that is customized according to an individual's preferences, receiving an individual's choice of plan, and providing enrollment transactions to qualified health plan issuers using applicable standards that will be set forth in future HHS guidance..

Applications and notices

The Exchange must implement all requirements for applications and notices consistent with Federal requirements, including facilitating the use of a single, streamlined application. Applications and notices include mechanisms for consumers to carry out enrollment steps (screening, enrollment forms, verifications) both in person or online. Applications and notices will facilitate the application, eligibility determination process, and enrollment of

individuals into qualified health plans as well as notices that the Exchange will issue to facilitate program operations and communication with enrollees. For example, the Exchange will have to notify individuals upon determination of eligibility for enrollment in a qualified health plan through the Exchange.

Individual responsibility determinations
The Exchange must have in place a process to receive and adjudicate requests from individuals for exemptions from the individual responsibility requirements of the Affordable Care Act, and to communicate information on such requests to HHS for transmission to IRS. This is a required function of Exchanges under the Affordable Care Act.

Administration of advance premium tax credits and cost-sharing reductions
The Exchange must perform administrative activities related to premium tax credits and cost-sharing reductions. For example, an Exchange will need to communicate with HHS in situations when a person would like to report a change in income level, which will trigger redetermination of eligibility for advance payment of the credits. Exchanges are the first point of contact for prospective enrollees who will be interested in learning more about premium tax credits and for seeking assistance when needed.

Adjudication of appeals of eligibility determinations
Individuals may seek to contest the eligibility determinations made by the Exchange for premium subsidies and Exchange participation, and therefore the Exchange will need to implement a process for processing appeals, and this process will coordinate with Medicaid and CHIP.

Notification and appeals of employer liability
The Exchange must notify employers when one or more of their employees is determined to be eligible for advance payment of a premium tax credit because the employer does not offer minimum essential coverage or the coverage is not affordable or does not meet the minimum value requirement. Further, the Exchange must offer the employer an opportunity to appeal.

Information reporting to IRS and enrollees
The Exchange must report to the IRS and enrollees each year certain information regarding the enrollee's coverage provided through the Exchange.

Outreach and education
Each State will need to have in place a robust education and outreach program to inform health care consumers about the Exchange and the new coverage options available to them. The Exchanges must also educate consumers about the benefits of purchasing health insurance coverage through the Exchange, including access to health plans that meet State and Federal certification standards and access to assistance with paying their premiums and cost-sharing. Each Exchange may determine a unique strategy for conducting outreach and education activities and timelines may vary depending on the investment Exchanges choose

to make in these activities as well as the size and diversity of the populations each Exchange serves.

Free Choice Vouchers

Individuals who have access to employer sponsored coverage that is not affordable according to the affordability standards set forth in the Affordable Care Act, may be eligible to receive Free Choice Vouchers from their employers. These vouchers will be used to offset the cost of health insurance premiums for these individuals. The Exchange will need to conduct eligibility determinations for Free Choice Vouchers and will need to implement a process to notify an employer regarding an individual's eligibility for a Free Choice Voucher, collect funds from an employer, apply funds to an individual's purchase of a qualified health plan, and refund excess funds to an individual, consistent with Federal standards.

Risk adjustment and Transitional Reinsurance

Pursuant to the Affordable Care Act, each State must implement a risk adjustment program and a transitional reinsurance program in accordance with Federal standards. Funding under the Establishment grants may be used to support risk adjustment and transitional reinsurance. States will need to plan for necessary data collection to support risk adjustment, including demographic, diagnostic, and prescription drug data. Qualified health plans may be required to submit encounter data, and therefore, States need to develop data and other systems to support risk adjustment. HHS is working with insurance plans and experts so that each State does not have to develop a risk adjustment model independently. We will release more guidance in the future, including information on a risk adjustment model that States may use and the Federal standards for data collection and operations.

SHOP Exchange-specific functions

The Affordable Care Act requires each State that elects to operate an Exchange to establish a Small Business Health Options Program (SHOP) Exchange. States may choose to merge the operations of their SHOP Exchange with their individual market Exchange. The SHOP Exchange will facilitate the purchase of coverage in qualified health plans for the employees of small businesses that choose to purchase coverage through the Exchange. Starting on January 1, 2014, small employers can only qualify for Small Business Health Care Tax Credits if they purchase coverage for their employees inside the Exchange or SHOP Exchange. For purposes of this funding opportunity, we have identified SHOP Exchange-specific functions to aid States in their operational planning efforts related to the SHOP Exchange.

B. Appendix B: Example Milestones for Exchange Establishment

This appendix provides a series of example milestones in each Core Area that will lead States through establishment of an Exchange. Each Exchange should include milestones drawn from these examples in its Work Plan to be submitted with its application, according to the project period of the grant for which the State applies. A State applying for a *Level One Establishment* award will need to provide milestones for the duration of the project period, which is up to one year from the date of award. A State applying for a *Level Two Establishment* award will need to provide a Work Plan with milestones from the date of award up through calendar year 2014.

Each State's progress throughout the grant project period will be evaluated against its Work Plan. Certain milestones in the table below are in **BOLD** and preceded by two asterisks (**) which indicates that these tasks are required and should be completed in the timeframe provided. We consider these milestones to be critical to Exchange success. Many of these critical milestones are related to the building and testing of Exchange IT systems, which impacts the successful establishment of Exchanges. HHS may restrict funds for activities if certain milestones are not met. States should work with their Project Officers on these issues and alert the PROJECT Officer so technical assistance may be provided early. We may also determine that additional milestones are considered comparable to those provided in **BOLD** and preceded by two asterisks (**) below and will communicate this to States.

The State should also draw from the milestones in the table that are not bold and preceded by two asterisks (**) in the development of its Work Plan, but the timeframes provided are suggested and not required. We suggest States use these targeted timeframes in their Work Plans, but we will not condition the release of additional grant funds on meeting these milestones in the timeframes provided. We have provided milestones below that we believe are important to the establishment of Exchanges. States will likely need to include numerous additional milestones that are tailored to their specific needs and the progress they have already made toward Exchange establishment. If a State is already ahead of these timeframes, we encourage the State to continue making progress on an accelerated schedule. The timeframes in the table are structured according to the calendar year. For example, Quarter One of 2011 is from January 2011 through March 2011.

Core Area	2011	2012	2013	2014
Background Research	Conduct analysis of State insurance market and develop recommendations for Exchange structure based on this analysis. Analysis must include: ▪ Number of uninsured in the State ▪ Size of the current individual and small group markets ▪ Number of carriers in each market and market shares for the ten largest carriers			
Stakeholder Consultation	▪ Establish a stakeholder advisory committee with the support of the Governor and State legislature to solicit input on Exchange design and function by stakeholder groups. ▪ Complete stakeholder meetings that cover all regions of the State. ▪ ****In addition to general stakeholder consultation, establish, implement, and document a process for consultation with federally recognized Indian Tribal governments to solicit their input on the establishment and ongoing operation of the Exchange.**	▪ Provide to HHS publicly-available minutes from completed open stakeholder meetings. ▪ ****In addition to stakeholder consultation, continue to implement and document its Tribal consultations to solicit Tribal input on the ongoing operation of the Exchange.**	▪ Complete stakeholder meetings and provide publically-available minutes related to the open enrollment process and outreach materials. ▪ ****In addition to stakeholder consultation, continue to implement and document its Tribal consultations to solicit Tribal input on the ongoing operation of the Exchange.**	▪ Post evidence of regular consultation with required stakeholders and other groups and holds regular public meetings to solicit public input on the Exchange website. ▪ ****In addition to stakeholder consultation, continue to implement and document its Tribal consultations to solicit Tribal input on the ongoing operation of the Exchange.**

Core Area	2011	2012	2013	2014
Legislative/ Regulatory Action	▪ Draft enabling legislation, implementing regulations, or other mechanism that provides the legal authority to establish and operate an Exchange that complies with Federal requirements. ▪ Introduce Exchange enabling legislation. ▪ Hold public hearings on Exchange enabling legislation.	Q2: Has The necessary legal authority to establish and operate an Exchange that complies with Federal requirements and provides for establishment of governance and Exchange structure		

Governance	▪ ****Develop a governance model by working with stakeholders to answer key questions about the governance structure of the Exchange:**
	  ▪ **Will the State pursue a Regional Exchange?**
	  ▪ **Will the Exchange be housed in a State agency, quasi-governmental agency, or non-profit?**
	  ▪ **How will the governing body be structured?**
	▪ Determine standards for the Exchange governing body that will ensure:
	  ▪ Public accountability
	  ▪ Transparency
	  ▪ Prevention of conflict of interest
		▪ **Q2: **Establish governance structure.**
		▪ Appoint a governing board (if applicable) and a management team sufficient to oversee the operations of the Exchange.
		▪ Develop a formal operating charter or by-laws that are consistent with State and Federal requirements including public accountability, transparency, and conflicts of interest.		

Core Area	2011	2012	2013	2014
Exchange IT Systems (Note: Use iterative system development process to capture updates and changes to business and system requirements, development, testing, and implementation of Exchange IT Systems)	Q1: **Conduct a gap analysis of its existing systems and the end goal for systems development by 2014. Q1: **Complete the review of product feasibility, viability, and alignment with Exchange program goals and objectives. Q2: **Complete Preliminary business requirements and develop an IT architectural and integration framework. Q2: **Complete Systems Development Life Cycle (SDLC) implementation plan. Q3: **Complete security risk assessment and release plan. Q3: ** Complete Preliminary detailed design and system requirements documentation (e.g. technical, design, etc.). Q4: **Finalize IT and integration architecture. Complete Final business requirements and Interim detailed design and system requirements documentations (e.g. technical, design, etc.).	Q1: **Complete Final requirements documentation (including System Design, Interface Control, Data Management, & Database Design). Q1/Q2: **Complete Preliminary and Interim development of baseline system and review and ensure compliance with business and design requirements. Q3: **Complete Final development of baseline system including software, hardware, interfaces, code reviews, and unit-level testing. Q4: **Complete testing of all system components including data, interfaces, performance, security, and infrastructure.	Q3: **Complete final user testing – including testing of all interfaces. Q3 or pre-open enrollment: ** Complete pre-operational readiness review to validate readiness of all system components. Complete end-to-end testing and security control validations. As early as mid-2013: **Prepare and deploy all system components to production environment. Obtain security accreditation.	**Support business operations and maintenance of all systems components.

Core Area	2011	2012	2013	2014
Program Integration	▪ **Q2**Perform detailed business process documentation to reflect current State business processes, and include future State process changes to support proposed Exchange operational requirements** ▪ **Initiate communication with the State HIT Coordinators, State Department of Insurance and the State Medicaid agency, and the State Human Services agency as appropriate, and hold regular collaborative meetings to develop work plans for collaboration.** ▪ **Execute an agreement with the State Department of Insurance that includes:	Collaborate on procurement and development of Exchange and Medicaid IT systems needed to facilitate "no wrong door" for eligibility determinations.	▪ Collaborate on testing of Exchange and other applicable State health subsidy programs (OASHSPs) systems. ▪ Coordinate launch of Exchange open enrollment period with eligibility determinations for Medicaid and OASHSPs	

Core Area	2011	2012	2013	2014
	▪ Determination of the roles and responsibilities of the Exchange and the State DOI as they relate to qualified health plans offered inside and outside the Exchange. ▪ Devise a strategy for limiting adverse selection between the Exchange and the outside market, possibly including legislative changes to level the playing field. ▪ **Execute an agreement with the State Medicaid agency, any other applicable State health subsidy program, and other specific health and human services programs as appropriate, that includes: ▪ Determination of the roles and responsibilities related to eligibility determination, verification, and enrollment ▪ Identification of challenges in the program integration process, strategies for mitigating those issues, and timelines for completion. ▪ Strategies for compliance with the "no wrong door" policy. ▪ Standard operating procedures for interactions between the Exchange and OASHSPs. Cost allocation between the Exchange grants, Medicaid Federal Financial Participation (FFP), and other fund streams as appropriate.			

Core Area	2011	2012	2013	2014
Financial Management	▪ ****Adhere to HHS financial monitoring activities carried out for the Planning Grant and under the Establishment Cooperative Agreement.** ▪ Begin defining financial management structure and the scope of activities required to comply with requirements. ▪ ****Establish a financial management structure and commit to hiring experienced accountants to support financial management activities of the Exchange, which include responding to audit requests and inquiries of the Secretary and the Government Accountability Office as needed.**	▪ Develop a plan to ensure sufficient resources to support ongoing operations and determine if legislation is necessary to assess user fees. ▪ Assess adequacy of accounting and financial reporting systems. ▪ Conduct a third party objective review of all systems of internal control.	Demonstrate capability to manage the finances of the Exchange soundly, including the ability to publish all expenses, receivables, and expenditures consistent with Federal requirements.	▪ Post information related to Exchange financial management on its website and has identified other means to make financial activities associated with the management of the Exchange transparent. ▪ Submit the required annual accounting report to HHS.
Oversight & Program Integrity	▪ ****Ensure the prevention of waste, fraud, and abuse related to the expenditure of Exchange Planning and Exchange Establishment grants.** ▪ Continue planning process and hire staff for oversight and program integrity functions.	Establish procedures for external audit by a qualified auditing entity to perform an independent external financial audit of the Exchange.	▪ Establish fraud detection procedures. ▪ Develop procedures for reporting to HHS on efforts to prevent fraud, waste, and abuse.	Comply with HHS reporting requirements related to auditing and prevention of fraud, waste, and abuse.

Core Area	2011	2012	2013	2014
Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints	▪ Coordinate with existing organizations in the State if applicable; and assure that the following services are available and sufficient to meet State residents' need for assistance: (i) help individuals determine eligibility for private and public coverage and enroll in such coverage; (ii) help file grievances and appeals; (iii) provide information about consumer protections; and (iv) collect data on inquiries and problems and how they are resolved. ▪ ****Analyze data collected by consumer assistance programs and report on plans for use of information to strengthen qualified health plan accountability and functioning of Exchanges.**	▪ ****If the State chooses to operate these functions within the Exchange, establish protocols for appeals of coverage determinations including review standards and timelines and provision of help to consumers during the appeals process.** ▪ ****Draft scope of work for building capacity to handle coverage appeals functions.** ▪ ****Analyze data collected by consumer assistance programs and report on plans for use of information to strengthen qualified health plan accountability and functioning of Exchanges.**	▪ Establish a process for reviewing consumer complaint information collected by the State Consumer Assistance program when certifying qualified health plans. ▪ Establish process for referrals to consumer assistance programs if available in another entity.	Ensure the any consumer complaints or coverage appeal requests are referred directly to the State program that is designated to process these calls.

Core Area	2011	2012	2013	2014
Certification of Qualified Health Plans	Q3: Begin developing standards that will be required for certification of a qualified health plan. Q4: Develop a clear certification policy including a timeline for application submission, evaluation, and selection of qualified health plans. Q4: Actively engage stakeholders in the development of the solicitation for proposals, through meeting, conferences, webinars, and other forums designed to gather stakeholder input.	Q1: Develop a strategy and timeline for the integration of staff and IT systems needed to receive applications, evaluate data from insurers, and notify insurers of the result of the solicitations for applications for qualified health plans. Q2: Make significant progress on the development of an RFP for certification of a qualified health plan. Q2: Draft applicable certification documents (notices/solicitations, applications, agreements, etc.) that will be used in connection with the certification of qualified health plans. Such documents must address Exchange policies relating to the minimum qualifications of a qualified	Q1: Collect submissions from the solicitation and begin evaluating proposals. Q1: Solicit premium quotes from health plan issuers who responded to the solicitation. **Q1: **Launch plan management and bid evaluation system to allow upload of qualified health plan bids and other required information.** Q2: Complete the certification of qualified health plans, complete any negotiations and execute contracts to health plan issuers who applied for qualified health plan issuer status. Q2: Issue an announcement on the selection of qualified health plans to the public.	Q1: Begin collecting user fees if the Exchange is utilizing this funding mechanism. Q1: Demonstrate capability for the Exchange and/or for the State insurance regulatory body to monitor the practices and conduct, as well as the pricing and benefits, of health insurers offering products in the Exchange with regard to their products inside and outside the Exchange.

Core Area	2011	2012	2013	2014
		health plan including any user fees, the length of the initial certification, recertification, and terms that may lead to decertification. Q2: Complete a solicitation for proposals for qualified health plans. Q3: Provide evidence of staff resources (or contracts) to support the plan certification evaluation. Q3: Release the solicitation for the certification of a qualified health plans, conduct bidders conference, respond to bidder questions on solicitation. Q4: Begin training health plan issuers to become qualified health plans.	2013 Q3 or before open enrollment: Conduct plan readiness reviews/activities (e.g., test enrollment interfaces with plans, reviews member materials, test financial reconciliation, cross-functional implementation sessions with plans, etc).	
Call Center	Collaborate with the State Consumer Assistance Program or Health Ombudsman program if applicable, to determine if call center functionalities can be shared.		Q2: Complete call center procurement process and select a vendor to operate the call center. Q2: Develop call center customer service representative protocols and scripts to respond to likely requests from health care consumers in the State. Q2: Develop protocols for accommodating the hearing impaired and those with other disabilities and foreign language and translation services. Q2: Train call center representatives on eligibility verification and enrollment process, and other	

Core Area	2011	2012	2013	2014
			applicable areas, so they can facilitate enrollment of individuals over the phone. Q3: **Launch call center functionality and publicize 1-800 number. Prominently post information on the Exchange website related to contacting the call center for assistance.	
Exchange Website and Calculator	Q1: **Begin developing requirements for systems and program operations, including: ▪ Requirements related to online comparison of qualified health plans. ▪ Requirements related to online application and selection of qualified health plans. ▪ Premium tax credit and cost-sharing reduction calculator functionality. ▪ Requests for assistance. ▪ Linkages to other State health subsidy programs. and other health and human services programs as appropriate.	Q1: **Begin systems development. Q3: **Submit content for informational website to HHS for comment. Q4: **Complete systems development and final user testing of informational website.	Q1: **Launch information website. Q1: **Collect and verify plan data for comparison tool. Q3: **Test comparison tool with consumers and stakeholders. Before open enrollment: **Launch comparison tool with pricing information but without online enrollment function. As early as mid-2013: **Launch fully functioning comparison tool with pricing information and online enrollment functionality on the first day of open enrollment.	
Quality Rating System	Utilize the Federal quality rating system developed by HHS in development of draft contract for qualified health plans.	▪ Include quality rating functionality in system business requirements for the Exchange website. ▪ Complete system development of quality rating functionality. ▪ Complete testing and validation of quality rating functionality.	Before open enrollment: Post quality rating system information on the Exchange website.	Continually update quality rating information on the Exchange website and for call center representatives so they have the most up to date information on qualified health plans.

Core Area	2011	2012	2013	2014
Navigator Program	Conduct preliminary planning activities related to the Navigator program including developing high level milestones and timeframes for establishment of the program.	Determine targeted organizations in the State who would qualify to function as Navigators.	▪ **Q2: **Determine Navigator grantee organizations and award contracts or grants** (funded from the operational funds of the Exchange) ▪ Q2: Train Navigators ▪ 1 quarter before open enrollment: Begin operations of Navigators.	

Core Area	2011	2012	2013	2014
Eligibility Determinations	Q1: Begin coordination with agencies administering other Applicable State Health Subsidy Programs (OASHSPs), including Medicaid and CHIP agencies and other health and human services agencies as appropriate, and create institutional structure to support future work. Q1: Begin coordination with the State Department of Insurance on Exchange planning efforts. **Q1: **Begin developing requirements, including requirements on the Exchange side and in OASHSPs, (and other program agencies as appropriate), including:** ▪ **Integrating or interfacing with OASHSPs to support enrollment transactions and eligibility referrals** ▪ **Coordinating appeals** ▪ **Coordinating applications and notices** ▪ **Managing transitions** ▪ **Communicating the enrollment status of individuals**	**Q1: **Begin system development, including any systems development needed by OASHSPs. (and other programs as appropriate)..** **Q4: **Complete system development and prepare for final user testing, including testing of any systems within OASHSPs. (and other programs as appropriate)..**	**Q1: **Begin final user testing, including testing of all interfaces.** **2013 Q3 or before open enrollment: **Complete user testing, including full end-to-end integration testing with all other components.** **As early as mid-2013: **Begin conducting eligibility determinations for OASHSPs, coordinating all relevant business functions, and receiving referrals from OASHSPs for eligibility determination.**	

Core Area	2011	2012	2013	2014
Enrollment Process	Q1: **Begin developing requirements for systems and program operations, including: ▪ Providing customized plan information to individuals based on eligibility and QHP data. ▪ Submitting enrollment transactions to QHP issuers. ▪ Receiving acknowledgements of enrollment transactions from QHP issuers. ▪ Submitting relevant data to HHS.	Q1: **Begin systems development. Q4: **Complete systems development and prepare for final user testing.	Q1: **Begin final user testing, including testing of all interfaces. 2013 Q3 or before open enrollment: **Complete user testing, including full end-to-end integration testing with all other components. As early as mid-2013: **Begin enrollment into qualified health plans.	
Applications and Notices	Review Federal requirements for applications and notices, begin customizing Federal applications and notices as allowable and begin developing requirements for Exchange-created applications and notices.		2013 Q3 or before open enrollment: Finalize all applications and notices including stakeholder review, testing, translation of content, etc. prior to open enrollment. As early as mid-2013: **Begin utilizing applications and notices to support eligibility and enrollment process.	
Exemptions from Individual Responsibility Requirement and Payment	Q1: **Begin developing requirements for systems and program operations, including: ▪ Accepting requests for exemptions. ▪ Reviewing and adjudicating requests. ▪ Exchanging relevant information with HHS.	Q1: **Begin systems development. Q4: **Complete systems development and prepare for final user testing.	Q1: **Begin final user testing, including testing all interfaces. 2013 Q3 or before open enrollment: **Complete user testing, including full end-to-end integration testing with other components. As early as mid-2013: **Begin processing exemptions from individual responsibility	

Core Area	2011	2012	2013	2014
			requirements and payment and reporting to HHS on outcome of determinations.	
Premium Tax Credit and Cost-sharing Reduction Administration	Q1: **Begin developing requirements for systems and program operations, including providing relevant information to QHP issuers and HHS to start, stop, or change the level of premium tax credits and cost-sharing reductions.	Q2: **Begin systems development. Q4: **Complete systems development and prepare for final user testing.	Q1: **Begin final user testing, including testing all interfaces. 2013 Q3 or before open enrollment: **Complete user testing, including full end-to-end integration testing with other components. As early as mid-2013: **Begin submitting tax credit and cost-sharing reduction information to QHP issuers and HHS.	
Adjudication of Appeals of Eligibility Determinations		Q2: Begin developing business processes and operational plan for appeals functions. Q4: Establish resources to handle appeals of eligibility determinations including training on eligibility requirements.	2013 Q3 or before open enrollment: Initiate communication with HHS on process for referring appeals to the Federal appeals process.	As early as mid-2013: **Begin receiving and adjudicating requests.
Notification and appeals of employer liability for the employer responsibility payment	Q1 ** Begin developing requirements for systems and program operations including: ▪ Coordination of employer appeals with appeals of individual eligibility. ▪ Submission of relevant data to HHS.	▪ Q1 ** Begin systems development. ▪ Q3 ** Complete systems development and prepare for final user testing.	▪ Q1 ** Begin final user testing including testing all interfaces. ▪ Q3 ** Complete user testing, including full end-to-end intergration testing with all other components. ▪ As early as mid-2013 ** Begin notifying employers in coordination with eligibility determinations.	

Core Area	2011	2012	2013	2014
Information reporting to IRS and enrollee	Q1** Begin developing requirements for systems and program operations, including: ▪ Capturing data used in enrollment process. ▪ Submitting relevant data to HHS for later use in information reporting. ▪ Capacity to generate information reports to enrollees.	▪ Q1 ** Begin systems development. ▪ Q3 ** Complete systems development and prepare for final user testing.	▪ Q1 ** Begin final user testing including testing all interfaces. ▪ Q3 ** Complete user testing, including full end-to-end intergration testing with all other components.	Confirm that systems are prepared to generate information reports to enrollees.

Core Area	2011	2012	2013	2014
Outreach and Education	▪ Perform market analysis/environmental scan to assess outreach/education needs to determine geographic and demographic-based target areas and vulnerable populations for outreach efforts. ▪ Develop outreach and education plan to include key milestones and contracting strategy. ▪ Distribute outreach and education plan to stakeholders and HHS for input and refinement.	▪ Develop a "toolkit" for outreach to include educational materials and information. ▪ Develop performance metrics and evaluation plan. ▪ Design a media strategy and other information dissemination tools. ▪ Submit final outreach and education plan (to include performance metrics and evaluation plan) to HHS. ▪ Focus test materials with key stakeholders and consumers and make refinements based on input.	▪ Q1: Launch outreach and education strategy and continue to refine messaging based on response and feedback from consumers.	
Free Choice Vouchers	**Q1: **Begin developing requirements for systems and program operations, including reporting to employers and managing financial components of Free Choice Vouchers.**	**Q1: **Begin systems development.** **Q4: **Complete systems development and prepare for final user testing.**	**Q1: **Begin final user testing, including testing all interfaces.** **2013 Q3 or before open enrollment: **Complete user testing, including full end-to-end integration testing with other components.** **As early as mid-2013: **Have in place a process to notify an employer regarding an individual's eligibility for a Free Choice Voucher, collect funds from an employer, apply funds to an individual's purchase of a qualified health plan, and refund excess funds to an individual, consistent with Federal standards.**	

Core Area	2011	2012	2013	2014
SHOP-specific Functions	▪ Research the design and approach of the SHOP Exchange and whether it will be merged with the individual market Exchange. ▪ Q1: **Begin developing requirements for systems and program operations.	Q1: **Begin systems development. Q4: **Complete systems development and prepare for final user testing.	Q1: **Begin final user testing, including testing all interfaces. 2013 Q3 or before open enrollment: **Complete user testing, including full end-to-end integration testing with other components. As early as mid-2013: **Begin enrolling employees of small employers into qualified health plans.	

C. Appendix C: IT Gap Analysis for Project Narrative

The applicant is required to perform an IT Gap Analysis on the following criteria and provide a summary of this analysis in its Project Narrative in this application. **Please critically evaluate your state of readiness to implement Exchange IT systems for each criterion**. The following set of topics shall be addressed as the applicant conducts the analysis. In addition, provide a summary of conclusions regarding your readiness.

1. Technical Architecture
    - The applicant shall provide specific details regarding its current systems and how it expects the Exchange environment to differ from the As-Is environment.
        - Identify all current/legacy software
        - Identify all current/legacy hardware
        - Identify all target system software
        - Identify all target system hardware
        - Provide a mapping of the "as is" environment with proposed "to be" solution option(s) so that you demonstrate that the proposed solution(s) meets the Exchange IT system requirements
    - For those applicants that are participating in the "Cooperative Agreement to Support Innovative Exchange IT Systems," provide details regarding their progress from the Readiness Review Assessment that was completed as part of their application and validate previously identified target system software and hardware.

2. Applicable Standards (The following standards do not represent an exhaustive list by which a State must consider in planning the target environment in which to maximize the use of standards.)
    - Affordable Care Act Section 1561 Recommendations
        - Per statutory requirement, ONC has developed a set of specific recommendations that pertain to standards and protocols that facilitate enrollment of individuals in Health and Human Services programs. For details on Section 1561, see: http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3161. Recommendation 1.1 recommends that States collaborate by using the NIEM (National Information Exchange Model) framework. This framework will allow for use of common data between multiple users and facilitate many aspects of enrollment.
            - How is the applicant incorporating NIEM into its processes?
            - What implications will this have from a data management standpoint?
            - Recommendation 3.1 recommends that States express business rules using a consistent, technology-neutral standard format separate from core programming or transactional systems.
            - How will the Applicant ensure consistent expression of business rules outside core programming or transactional systems?

- Recommendation 4.1 recommends using existing HIPAA standards to facilitate transfer of consumer eligibility, enrollment, and disenrollment information between programs.
- How will the applicant use x12n HIPAA 834 enrollment and 270/271 eligibility transactions.

- HIPAA
  - The HIPAA Privacy and Security Rules provide Federal protections for personal health information held by covered entities and give patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.
    - How will the administrative, physical and technical requirements of HIPAA relate to future Exchange operations?
    - Is the applicant prepared to adhere to these rules as it develops new Exchange interfaces?
- Accessibility for individuals with disabilities
    - Enrollment and eligibility systems should be designed to meet the diverse needs of users (e.g., consumers, State personnel, other third party assisters) without barriers or diminished function or quality, using legal requirements under Section 508 (for the Federal government), Section 504 (for recipients of Federal financial assistance), and Title II of the Americans with Disabilities Act (for State and local governments). Therefore, electronic eligibility and enrollment systems shall include usability features or functions that accommodate the needs of persons with disabilities, including those who use assistive technology. To meet these standards and to meet the needs of diverse users, applications should address how they will comply with the latest 508 guidelines issues by the US Access Board or standards that provide greater accessibility for individuals with disabilities.
    - How is the applicant poised to adapt to these standards?
- Security
  - The applicant shall address Fair Information Practices (FIP) in new and existing eligibility and enrollment systems to safeguard consumer information. The following are best practices the applicant can consider for implementing FIPs in the State systems:
    - **Collection Limitation:** State systems shall be designed to collect the minimum data necessary for an eligibility and enrollment determination. This shall be balanced with the desire to reuse information for multiple eligibility decisions.
    - **Data Integrity & Quality:** States shall establish a minimum threshold level for data matches, adopting a glide-path towards achieving advanced probabilistic matching.

- **Openness & Transparency**: Clear, transparent policies about authorizing access and use of data shall be provided to the applicant in the Privacy Notice.
- **Purpose Specification**
- **Use Limitation**
- **Security Safeguards and Controls**
- **Individual Participation and Control**
- **Accountability and Oversight**

▪ The applicant shall address Taxpayer Privacy and Safeguard standards which apply to any tax return information that the exchanges may handle as part of the eligibility determination process. For more information, see IRS Publication 1075 - Tax Information Security Guidelines For Federal, State and Local Agencies (http://www.irs.gov/pub/irs-pdf/p1075.pdf)

o Federal Information Processing Standards (FIPS)

▪ Under the Information Technology Management Reform Act (ITMRA), Division E, National Defense Authorization Act for FY 1996 (P. L. 104-106), the Secretary of Commerce approves standards and guidelines that are developed by the National Institute of Standards and Technology (NIST) for Federal computer systems. These standards and guidelines are issued by NIST as Federal Information Processing Standards (FIPS) for use government-wide. NIST develops FIPS when there are compelling Federal government requirements such as for security and interoperability and there are no acceptable industry standards or solutions. See Recommendation 5.3 in Section 1561 recommendations for more details: http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3161.

- How is the applicant poised to adapt to these standards?

D. Appendix D: Exchange Information Technology

Key Principles of Exchange IT capabilities

- The organization governing the design, development, and implementation of the core capabilities must follow standard industry Systems Development Life Cycle (SDLC) frameworks including the use of iterative and incremental development methodologies. The governing body must also be able to produce requirement specifications, analysis, design, code, and testing that can be easily shared with other interested and authorized stakeholders (i.e., other States, consortia of States, or any entity that is responsible for establishing an Exchange).
- The design must take advantage of a Web Services Architecture (using XML, SOAP and WSDL or REST) and Service Oriented Architecture approach for design and development leveraging the concepts of a shared pool of configurable computing resources (e.g., Cloud Computing).
- The services description/definition, services interfaces, policies and business rules must be published in a web services registry to support both internal and external service requests that are public and private, and be able to manage role-based access to underlying data.
- Per Section 1561 of the Affordable Care Act, all designs must follow the standards that are currently outlined in the recommendations published by the Office of the National Coordinator (ONC). For details on Section 1561 Standards, see: http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3161.
- Per National Institute of Standards and Technology (NIST) publications, the design and implementation must take into account security standards and controls. (For details on NIST publications, see: http://csrc.nist.gov/publications/PubsSPs.html)

HHS will closely monitor, assess, and guide grantees to ensure the highest quality results are attained. Grantees will be required to complete certain planning tasks that are pursuant to Systems Development Life Cycle (SDLC) practices. The applicant shall follow the SDLC framework for its planning activities (an example of an SDLC framework can be found here: http://www.cms.gov/ILCPhases/01_Overview.asp#TopOfPage.) The list of required activities and due dates are as follows:

Core Exchange Functions supported by IT

To ensure the Exchange IT systems are comprehensive and reusable by other States, the key modules shall include, but not be limited to:

1) Eligibility
2) Enrollment
3) Premium tax credits administration
4) Cost-sharing assistance administration
5) Health plan management to support Qualified Health Plan certification

6) Payment management system for Free Choice Vouchers

Systems must also be interoperable and integrated with State Medicaid/Children's Health Insurance Program (CHIP) programs and be able to interface with HHS and other data sources in order to verify and acquire data as needed. States are encouraged to achieve interoperability with other health and human services programs for purposes of coordinating eligibility determinations, referrals, verification or other functions. Examples of additional core Exchange functions that could be added, initially or eventually, include Exchange administration, and qualified health plan administration (including data and certification management).

To meet milestones and assure alignment with other critical State and Federal programs, it will be desirable for Exchanges to leverage and re-use services or capabilities available in the State, including those offered by the State health information exchange program such as for provider and patient identity services (eMPI, ID resolution and authentication).

Exchange IT SDLC Reviews

Listed below are the suggested lifecycle reviews, products that will accompany each stage and a table containing delivery dates for each review (some of these steps will include HHS consultation with CMS and other Federal agencies as warranted):

Project Startup Review (PSR)
Deliverables: Acquisition Strategy, Concept of Operations, Risk Analysis, Alternatives Analysis, Scope Definition, Performance Measures, briefings/presentations to HHS

Architecture Review (AR)
Products: Business Process Models, Requirements Document, Architectural diagrams, briefings/presentations to HHS

Project Baseline Review (PBR)
Products: Project Process Agreement (Charter), Information Security Risk Assessment, Information Security Risk Assessment, Project Management Plan, Project Schedule, Release Plan, briefings/presentations to HHS

Preliminary Design Review (PDR)
Products: System Security Plan, Test Plan(s) and Traceability Matrix, Logical Data Model, Data Use Agreement(s), Technical Architecture Diagrams (Software/Hardware Architectures, Network, Overall Infrastructure, Security, etc.), briefings/presentations to HHS

Detailed Design Review (DDR)
Products: System Design Document, Interface Control Document, Database Design Document(s), Physical Data Model, Data Management Plan, Data Conversion Plan, Automated Code Review Results briefings/presentations to HHS

Final Detailed Design Review (FDDR)
Products: See DDR products

Pre-Operational Readiness Review (PORR)
Products: Contingency Plan, Inter/Intra-agency Agreement(s) (IAs), Test Case Specification, Implementation Plan, User Manuals, Operations & Maintenance Manual, Training Plan, Integration Testing, End-to-End Testing, Test Summary Report, Defect Reports, Security Testing Results, briefings/presentations to HHS

Operational Readiness Review (ORR)
Products: See PORR products

For an explanation of each product, please reference the following CMS ILC framework: https://www.cms.gov/ILCReviews/01_Overview.asp

For examples of product templates, please refer to the following: http://www3.cms.gov/SystemLifecycleFramework/Tmpl/list.asp#TopOfPage

Exchange IT SDLC Review Timeline (dates are approximate)

Architecture Review	Project Startup Review	Project Baseline Review	Preliminary design Review	Detailed Design Review	Final Detailed Design Review	Pre-Operational Readiness Review	Operational Readiness Review	IT Project Dashboard Reports
Beginning of Q3 2011	TBD	Q3 2011	Q4 2011	Q1 2012	Q2 2012	Q4 2012	Q2 2013	TBD

The Project Startup Review (PSR) may be combined with Architecture Review (AR) to kick-off the project, but PSRs may also be required depending on how many "phases" there are in the overall project. Products coming out of the SDLC process will be available to States that partner with each other either as consortia or are sharing designs, code, etc.

E. Appendix E: 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 Exchange Establishment Cooperative Agreements. Any other grant funding provided by HHS, including the Exchange planning grants and other grant funds, should not be supplanted by Exchange Establishment funding.** 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.

Note that OMB Circular A-87 REQUIRES states to allocate all costs to programs that benefit from a particular good or service. In the case of Exchanges, the state Medicaid program is a direct beneficiary of many of the activities of the Exchange, particularly IT systems and related systems and staffing involved with determining an applicant's eligibility for the Medicaid and CHIP programs. Consequently, the costs associated with these activities MUST be paid through a separate funding request to the Centers for Medicare & Medicaid Services. The funding request is in the form of an Advance Planning Document (APD) that specifically requests funding for each of these activities that benefit Medicaid and applies the appropriate Federal Financial Participation (FFP) rate of 50, 75 or 90 percent. OCIIO Grant funds cannot be used to pay for Medicaid and/or CHIP costs, nor can they be used to pay the State share of the Medicaid allocated costs.

The goods and services that are to be allocated to, and paid for by, the state Medicaid program are of two types: direct and indirect and are handled differently. Direct expenses are those that benefit Medicaid and/or CHIP exclusively. These direct expenses are allocated 100%.to the Medicaid and/or CHIP program and matched at the appropriate FFP rate. Indirect expenses are those that benefit Medicaid AND other programs, including the Exchange itself. One such example would be staffing salaries for those individuals who serve both Medicaid's needs as well as the Exchanges'. These indirect expenses are allocated to the benefiting programs in proportion to Medicaid/non-Medicaid anticipated numbers of clients served by the Exchange. Having allocated the Medicaid share, the resultant figures are then matched at the appropriate FFP rate.

For further information on cost allocation relative to Medicaid and CHIP cost allocation, please contact: Richard H. Friedman, Director, Division of State Systems, Centers for Medicare and Medicaid Services, Baltimore, MD 21244, or via e-mail at Richard.Friedman@cms.hhs.gov and put "OCIIO Establishment Grant Cost Allocation Issue" in the subject line. For further information on cost allocation requirements re OMB Circular A-87, please see:

http://www.whitehouse.gov/sites/default/files/omb/circulars/a087/a87_2004.pdf

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 $_____
Exchange Establishment Grant $_____
Funding other than Establishment Grant $_____
Sources of Funding_____

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

Sample Justification

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

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

B. Fringe Benefits

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

Sample Budget

Fringe Benefits

Total $_____
Exchange Establishment Grant $_____
Funding other than Establishment Grant $_____
Sources of Funding_____

25% of Total salaries = Fringe Benefits

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

Example: Project Coordinator — Salary $45,000

Retirement 5% of $45,000	=	*$2,250*
FICA 7.65% of $45,000	=	*3,443*
Insurance	=	*2,000*
Workers' Compensation	=	_____
	Total:	

C. 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 $_____
Exchange Establishment Grant $_____
Funding other than Establishment 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 $_____
Exchange Establishment Grant $_____
Funding other than Establishment 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 $_____
Exchange Establishment Grant $_____
Funding other than Establishment Grant $_____
Sources of Funding_____

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

Sample Justification

The Project Coordinator and the Outreach Supervisor will travel to (location) to attend an eligibility conference. The Project Coordinator will make an estimated 25 trips to local outreach sites to monitor program implementation.

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 $_____
Exchange Establishment Grant $_____
Funding other than Establishment 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.

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.

F. Appendix F: Guidance for Preparing Budget Request By Core Area

INTRODUCTION

Applicants are required to identify cost by Core Area. Following this guidance will facilitate the review and approval of a requested budget by insuring that the required or needed information is provided **Applicants should be careful to only request funding for activities that will be funded by the Exchange Establishment Cooperative Agreements. Any other grant funding provided by HHS, including the Exchange planning grants and other grant funds, should not be supplanted by Exchange Establishment funding.**

The following are the Core Areas and Business Functions that need to be identified by cost, if the applicant wishes to receive funding.

1. Background Research:
2. Stakeholder Involvement:
3. Governance
4. Program Integration
5. Exchange IT Systems:
6. Financial Management

7. Program Integrity
8. Health Insurance Market Reforms
9. Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints
10. Business Operations/ Exchange Functions. This includes:
    - Certification, recertification, and decertification of Qualified Health Plans
    - Call center
    - Exchange website and premium calculator
    - Quality rating system
    - Navigator Program
    - Eligibility determinations for Exchange participation, advance payment of premium tax credits, and cost-sharing reductions
    - Seamless eligibility and enrollment process with Medicaid and other State health subsidy programs
    - Enrollment process
    - Applications and notices
    - Individual responsibility determinations
    - Administration of advance premium tax credits and cost-sharing reductions
    - Appeals of eligibility determinations
    - Outreach and education
    - Free Choice Vouchers
    - Risk adjustment and transitional reinsurance
    - SHOP Exchange-specific functions

For each core area and business function above, please include the following information:

1. Total Cost
2. Percent of cost that is fixed and/or variable (explain)
3. Amount of Cost by Object Class Code (OCC) (Personnel, contractual, equipment, travel, other, etc)-If contractual, include % by OCC of those costs).
4. Amount of costs being requested by Exchange Establishment Grant
5. Amount of cost being requested by another source (indicate that source(s))
6. Assumptions or other narrative

Sample:
Core Area: Stakeholder Involvement
1. Total Cost: $25,000
2. Amount of cost that is fixed and/or variable: 60% fixed; 40% variable (based on numbers of meetings)
3. Amount of Cost by Object Class Code (OCC) (Personnel, contractual, equipment, travel, other, etc)-If contractual, include % by OCC of those costs).
    Dollar amount of personnel
    Dollar amount contractual (90% personnel; 10% space)
    Dollar amount travel
    Dollar amount other (supplies, flyers, etc)

4. Percent of costs being requested by Exchange Establishment Grant; 100%
5. Identify the percentage of costs being requested by another source (indicate that source(s)): 0
6. Assumptions or other narrative; Assume 10 meetings a quarter.

G. Appendix G: Federal 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 that 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 be normally 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.

H. Appendix H: Application Check-Off List

REQUIRED CONTENTS

A complete application consists of the following materials organized in the sequence below. Please ensure that the project narrative is page-numbered. The sequence is:

- ☐ 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 and State Medicaid Director, State Insurance Commissioner)
- ☐ Applicant's Application Cover Letter
- ☐ Project Abstract
- ☐ Project Narrative
- ☐ Work plan and Timeline
- ☐ Budget Narrative
- ☐ Required Appendices
  - ☐ Organizational Chart & Job Descriptions for Key Personnel
  - ☐ Letters of Agreement and/or Description(s) of Proposed/Existing Project