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

The Health Insurance Rate Review Grant Program

Grants to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing,
Cycle III

Announcement
Invitation to Apply for 2013

Funding Opportunity Number: PR-PRP-13-001
CFDA: 93.511

Date: May 8, 2013

Cycle III Applicable Dates:

Mandatory Letter of Intent to Apply:	June 17, 2013
Application Due Date:	August 1, 2013
Anticipated Notice of Award:	Prior to September 30, 2013

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OVERVIEW INFORMATION

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

Funding Opportunity Title: Grants to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing, Cycle III

Announcement Type: Funding Opportunity Announcement

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Catalog of Federal Domestic Assistance (CFDA) Number: 93.511

Key Dates:

Date of Issue: **May 8, 2013**

Mandatory Letter of Intent to Apply:	June 17, 2013
Application Due Date:	August 1, 2013
Anticipated Notice of Award:	Prior to September 30, 2013

Anticipated Notice of Award: Approximately 60 days after the Application Due Date

Period of Performance: The period of performance will be 18 months, unless sufficient funding is available for 24 months. Applicants will be notified of the period of performance following the submission of mandatory Letters of Intent.

I. FUNDING OPPORTUNITY DESCRIPTION

1. Background and Purpose

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

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

Section 1003 of the Affordable Care Act adds a new section 2794 to the Public Health Service Act (PHS Act) entitled, "Ensuring That Consumers Get Value for Their Dollars." Specifically, section 2794(a) requires the Secretary of the Department of Health and Human Services (the Secretary) (HHS), in conjunction with the states, to establish a process for the annual review of health insurance premiums[1] to protect consumers from unreasonable rate increases. Section 2794(b) specifies that the process established by the Secretary "shall require health insurance issuers to submit to the Secretary and the relevant State a justification for unreasonable premium increases prior to the implementation of the increase," and that "such issuers shall prominently post such information on their Internet websites." The Secretary is directed to "ensure public disclosure of information on such increases and justifications for all health insurance issuers."

In addition, section 2794(c) directs the Secretary to carry out a program to award grants to states.[2] Section 2794(c) indicates that this program includes the following purposes: (1) establish or enhance rate review programs; (2) help states to provide data to the Secretary regarding trends in rate increases as well as recommendations regarding plan participation in the Exchange; and (3) establish "Data Centers" that collect, analyze, and disseminate health care pricing data to the public. Congress has appropriated $250 million to be awarded in federal fiscal years (FFYs) 2010 through 2014.

By publishing medical claims reimbursement data, Data Centers enhance health pricing transparency for consumers, businesses, and other stakeholders. Their publications help the public to better understand the comparative price of procedures in a given region or for a specific hospital, insurer, or provider. Businesses and consumers alike can use this data to drive decision-making and reward cost-effective provision of care. In addition, claims data can be used to better understand cost drivers, evaluate quality improvement initiatives, and better understand utilization of services.

Effective rate review serves a similar purpose: to increase transparency and save money for consumers. Preliminary results indicate that effective rate review is helping states to slow down premium growth. As part of the Rate Review Grant Program, HHS collects data from states about all rate increases. Based on this information, the estimated national average rate increase implemented in the individual market in 2011 was approximately 1.4 percentage points lower

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

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

than the increase originally requested by insurance companies. Based on 2011 individual market premium data, this difference would equate to nearly $425 million in savings to consumers.[3] In the small group market, the estimated rate increases implemented were approximately 0.8 percentage points lower than the increases originally requested by insurance companies. Based on 2011 small group market premium data, this difference would equate to over $600 million in savings to consumers. Taken together, rate review helped to lower premiums in the individual and small group markets by an estimated $1 billion compared to the amount initially requested.[4]

A recent research brief by the Assistant Secretary of Planning and Evaluation provided further evidence that rate review is restraining premium increases. The research brief noted, "The proportion of rate filings in which the requested increase was 10 percent or more declined from 75 percent in 2010 to 34 percent in 2012, consistent with the increased scrutiny that such requests now receive. Available data for 2013 suggest that this pattern of slower premium growth has been maintained so far in 2013, with only 14 percent of requested rates at 10 percent or more. In addition, the average premium increase in 2012 was 30 percent below that in 2010."[5]

b. Cycle I Rate Review Grants

The Cycle I Funding Opportunity Announcement (FOA) for the Rate Review Grant program was released on June 7, 2010, with the first grant awards made to states on August 9, 2010. During Cycle I, forty-five states and the District of Columbia applied for grants, and each was awarded $1 million in grant funds. A second Cycle I FOA was released on September 1, 2010, to enable the U.S. Territories to apply. On March 27, 2011, $5 million was awarded to five territories, with each territory receiving $1 million.

Grant recipients used Cycle I grant funding in a number of ways, including seeking authority to review health insurance rate increases, expanding the scope of rate review, improving the rate review process, making information on health insurance rates publicly available through transparency initiatives, developing and upgrading technology, and analyzing medical claims reimbursement data.

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[3] "2012 Annual Rate Review Report: Rate Review Saves Estimated $1 Billion for Consumers," U.S. Department of Health and Human Services, September 11, 2012, available at: http://www.healthcare.gov/law/resources/reports/rate-review09112012a.html (2012 Annual Rate Review Report).

[4] See 2012 Annual Rate Review Report.

[5] "Health Insurance Premium Increases in the Individual Market Since the Passage of the Affordable Care Act," U.S. Department of Health and Human Services, February 22, 2013, available at: http://aspe.hhs.gov/health/reports/2013/rateIncreaseIndvMkt/rb.cfm.

A few examples from states illustrate the range of strategies used to expand and improve rate review and to engage consumers and small businesses in the process. North Carolina, for instance, gained prior approval authority over all small employer group premium rates. To provide rigorous analysis of rates, North Carolina also hired an actuary, an attorney, and three insurance regulatory analysts. Ohio has established a website to display rate filings and enable the public to provide online comments on rate increases. In addition, Ohio has integrated rate review processes with form and benefit review processes, which allows the state to evaluate the correlation of product benefit and pricing components. Another example is Arkansas, which has created an active consumer-driven advisory committee, trained staff, launched a new website, and established a new rate review media center for public meetings and hearings.

In addition, a few states used Cycle I funds to enhance or expand Data Centers providing health pricing data to the public. As part of a Data Center project, New Hampshire enhanced the pricing information available on its "HealthCost" website. The "HealthCost" website allows commercially insured and uninsured residents to look up the cost of a specific service (an ankle x-ray, for instance) in a given zip code and determine how the cost varies according to plan type and insurance status. This new public data will help consumers and businesses to understand, and potentially negotiate, better prices for themselves and their employees.

c. Final Rule

On May 23, 2011, HHS published a final rule on "Rate Increase Disclosure and Review," (76 F.R. 29964) (Final Rule). This Final Rule, codified in 45 CFR Part 154, describes how to implement the rate review process described in Section 2794 of the PHS Act. The regulation requires that any rate increase of 10 percent or more be "subject to review." The regulation further requires insurers to report certain health insurance rate information to both the Secretary and the States in which they operate, including:

- Preliminary data justifying any rate increase that is "subject to review"; and
- Final justifications prior to implementation for rate increases determined by a State or HHS to be unreasonable.

Under the Final Rule, whether it is HHS or the State that makes the determination that a rate increase is unreasonable will depend on whether the State has an "Effective Rate Review Program."

d. Cycle II: Rate Review Grants

The Cycle II Rate Review Grant Program was designed to further assist states in improving and enhancing their health insurance rate review and reporting processes. Specifically, the funds

were designated for states to meet the requirements for an "Effective Rate Review Program" as set forth in the Final Rule.

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

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

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

The Cycle II grant funding opportunity provided States with multiple opportunities to apply for funding during several phases, depending on the status of their progress toward meeting the criteria for an Effective Rate Review Program.

In order to be eligible for and receive Cycle II funding, a State needed to demonstrate that, as of the Cycle II application due date, it either: (i) already met the effective rate review criteria described in the final regulation; or (ii) as a result of receiving Cycle II grant funds, it would have the resources to meet those criteria within the twelve month period following the receipt of the Notice of Award. Further, a state has to demonstrate in its quarterly reports that it is meeting the milestones in its application that support the development or enhancement of an Effective Rate Review Program.

Cycle II awards consisted of three components: 1) Baseline Grant awards; 2) "*Performance*" funds; and 3) "*Workload*" funds. Baseline Grant awards were awarded to all grantees, and consisted of $1 million per grant year. In addition to Baseline Grant Awards, two additional segments of funds were available under the Cycle II grants. "*Workload*" funds were available to states based on population and the number of health insurance issuers in the state. While the rate review regulation does not require that states have the authority or ability to disapprove rates in order to be considered a state with an Effective Rate Review Program, the "*Performance*" funds were available only to those states that have the authority to disapprove unreasonable rate increases. States with such authority likely have larger workloads and therefore have higher resource needs.

e. Current Status of Cycle II Rate Review Grant Funds

Cycle II of the Rate Review Grant Program was initiated on September 22, 2011, with Phase I awards. In Phase I, HHS awarded $109 million to 29 states. In Phase II of Cycle II, a total of $8 million was awarded to one state and three territories on September 21, 2012. In Phase III of Cycle II, $2 million was awarded to one state on March 15, 2013. The Cycle II awards are multi-

year grants, with periods of performance continuing through Federal Fiscal Year 2014 for Phases I and II, and with a period of performance for Phase III ending in Federal Fiscal Year 2015.

States are using Cycle II funds to implement extensive enhancements to their rate review programs, ultimately to save money for consumers and small businesses. Rhode Island, for example, is using Cycle II funds to expand rate review oversight to address the underlying factors driving rate increases. By issuing and implementing "Affordability Standards" as part of its rate review process, Rhode Island is engaging health plans in delivery system transformation. In Oregon, two new actuaries have helped the state to provide greater scrutiny of proposed rate hikes. In addition, Oregon has contracted with a consumer advocacy organization to represent consumers in the rate review process, participate in hearings, and develop long-term strategies to increase consumer input.

f. Amendments to the Final Rate Review Regulation

Following the release of the Cycle II FOA, HHS issued two amendments to the final rate review regulation.

On September 6, 2011, HHS published an amendment to the Final Rule (Amended Final Rule).[6] Among other things, the Amended Final Rule clarified that coverage sold through an association is subject to rate review as small group market coverage if it otherwise falls under the requirements of small group market coverage.

On February 27, 2013, HHS published a final rule that amends the standards under the rate review program in 45 CFR part 154.[7] The amendments revise the timeline for states to propose state-specific thresholds for review and approval by CMS. The amendments also direct health insurance issuers to submit data relating to proposed rate increases in a standardized format, and modify the criteria and factors for states to establish and maintain an effective rate review program. These changes are necessary to reflect the new market reform provisions established in 45 CFR parts 144, 147, 150, and 156, and to fulfill the statutory requirement beginning in 2014 that the Secretary, in conjunction with the states, monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange. The provisions are designed to streamline data collection for issuers, states, Exchanges, and HHS.

g. Cycle III Rate Review Grants: *Grants to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing*

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[6] See 76 F.R. 54969 (September 6, 2011).

[7] See 78 F.R. 13406 (February 27, 2013).

The purpose of Cycle III of the Rate Review Grant program is to continue the rate review successes of Cycle I and II as well as to provide greater support to Data Centers. By increasing support to Data Centers through the Cycle III FOA, HHS hopes to increase transparency in health care pricing, thereby helping consumers and employers make better health care decisions.

As in Cycle II, the Cycle III grant provides resources to states to achieve or maintain their "Effective Rate Review" Program status. Any state applying for a Cycle III grant to develop or enhance its rate review activities must demonstrate that, as of the Cycle III grant application due date, the state either: (i) already meets the effective rate review criteria described in the final regulation; or (ii) as a result of receiving Cycle III grant funds, it will have the resources to meet those criteria within the twelve month period following the receipt of the Cycle III Notice of Award. In addition, a state must demonstrate in its quarterly reports that it is meeting the milestones in its application that support the development or enhancement of an Effective Rate Review Program. These requirements apply to all states that are using Cycle III grant funds for rate review activities, including those states that are using health pricing data as part of their rate review activities. A state does not need to demonstrate that it has met or will meet the criteria for an effective rate review program if it only applies for Cycle III funds to establish or enhance a Data Center under Section 2794(c)(1)(C) and Section 2794(d).

In addition, the Cycle III FOA differs from the Cycle II FOA in order to provide greater support to Data Centers and ensure greater public access to health pricing data. First, the Cycle III FOA eliminates the funding cap on Data Center-related activities. Second, the FOA permits agencies other than state Departments of Insurance to submit applications. Third, the FOA clarifies conflict of interest requirements established under section 2794(d)(2) of the Public Health Service Act. Fourth, the FOA permits previous recipients of Cycle II funds to reapply for funds if they plan to a) establish or enhance a Data Center under section 2794(c)(1)(C); and/or b) use and disseminate pricing data as part of their rate review activities under section 2794(c)(1)(A).

This section provides an overview of similarities and dissimilarities between Cycles II and III; therefore, it does not provide a complete description of the eligibility criteria or the allowable activities under the three statutory funding clauses. For a detailed description of eligibility, please see Section III, *Eligibility Information*. For a detailed description of allowable activities under specific funding clauses, please see Section I.3, *Program Requirements*.

h. Partnership Opportunities and Resources for States Seeking to Establish Pricing Transparency Initiatives

Significant public and private resources are available to assist states seeking to develop new pricing transparency initiatives. Pricing transparency depends on the availability of medical claims data, technical standards, and evidence-based public reporting software tools. All of these

tools can be obtained at the national level, through initiatives such as the Medicare Data Sharing Program (MDSP), the Healthcare Cost and Utilization Project, the MONAHRQ initiative, and the ASC-X12 State Data Harmonization Project. In addition, local and state-based initiatives have surged in the last decade, providing a roadmap for organizations and agencies seeking to analyze and publish medical claims and other pricing-related data.

Medicare Data Sharing Program (MDSP)
Established by the Affordable Care Act, the Medicare Data Sharing Program provides Medicare claims reimbursement data to CMS-Certified, Qualified Entities.[8] These organizations use medical claims data to calculate and report measures of quality, efficiency, effectiveness, and resource deployment. Specifically, they combine claims data from different payers, calculate quality and/or cost of care measures, design performance reports using those measures, share performance reports with the public, and ensure the privacy and security of data. Currently, six Qualified Entities have been certified at the state level. States may choose to partner with Qualified Entities or establish new ones in order to expand pricing transparency resources.

ASC-X12 State Data Harmonization Effort
The ASC-X12 State Data Harmonization Effort, funded in part by the Agency for Healthcare Research and Quality (AHRQ), also serves as a resource for states performing health pricing and cost analysis. ASC-X12 is a national effort to harmonize data collection by All-Payer Claims Databases (APCDs). APCDs collect data from a wide range of payers, including private insurance, Medicare, Medicaid, third-party administrators, and pharmacy benefit managers. Standard-setting reduces burden on payers, while permitting integration of multiple data sets. To learn more about this standard-setting process, please visit: http://ushik.ahrq.gov/index.jsp?enableAsynchronousLoading=true.

MONAHRQ, "My Own Network, Powered by AHRQ"
"My Own Network, Powered by AHRQ" is a free downloadable software that permits a state or local entity to design a state-of-the-art public report on quality. While it does not yet include cost or price information, the template was developed through extensive consumer testing; MONARHQ may be used to identify ways to publicly report data in a user-friendly way. In addition, it can be a useful tool for states interested in integrating quality and pricing data.

Healthcare Cost and Utilization Project (HCUP)
The Healthcare Cost and Utilization Project is a family of health care databases and related software tools and products developed through a Federal-State-Industry partnership and

[8] The Medicare Data Sharing Program was established by Section 10332 of the Affordable Care Act. This section amended section 1874 of the Social Security Act by adding a new subsection (e), creating the Medicare Data Sharing Program.

sponsored by the Agency for Healthcare Research and Quality (AHRQ). HCUP databases bring together the data collection efforts of 47 state partners (State data organizations, hospital associations, private data organizations), and the Federal government to create a national information resource of patient-level health care data (HCUP Partners). HCUP includes the largest collection of longitudinal hospital care data in the United States, with all-payer, encounter-level information beginning in 1988. These databases enable research on a broad range of health policy issues, including cost and quality of health services, medical practice patterns, access to health care programs, and outcomes of treatments at the national, state, and local market levels. The data include hospital charges, along with cost to charge methodologies for converting charges to costs. With six national databases, HCUP provides data for all payers compiled in a uniform format with privacy protections in place. In addition, HCUP provides multiple tools and software to assist in the analysis of related data. While HCUP data use agreements do not permit the data to be reported at the hospital level, hospital-level analyses can yield useful regional and national analyses.

Initiatives at the State and Local Level

At the state level, government agencies and non-profit organizations are using a wealth of data to provide more transparency about health care costs and pricing. The 47 state-based entities that contribute to the national Healthcare Cost and Utilization Project (HCUP) database, make their data available at the state level. These hospital datasets generally include self-pay patients as well as patients covered by Medicare, Medicaid, and private insurance. As such, they provide an in-depth view of the variation in costs in the health care industry. They serve as important research tools to better understand cost drivers. For more on these hospital cost databases, please see: http://www.hcup-us.ahrq.gov/databases.jsp.

In addition to hospital pricing databases, the past decade has seen an increase in the number of All-Payer Claims Databases (APCD). By collecting payer data across all medical facilities, APCDs provide a window into health care pricing beyond the hospital setting. According to *Bloomberg BNA*, All-Payer Claims Databases are well-established in nine states and in implementation phases in another seven states.[9] The National Association of All-Payer Claims Databases (APCD) Council provides an interactive map of APCD initiatives across the nation, available online at: http://www.apcdcouncil.org/state/map.

All-Payer Claims databases are being used extensively to increase health pricing transparency, empower consumers, and educate employers. According to a research brief published by the Kaiser Foundation, states have used APCD data to:

[9] Patrick Miller, "Why All-Payer Claims Databases Matter to Employers", Pension & Benefits Daily, 12 PBD 114, 06/14/2012. Available online at: http://apcdcouncil.org/sites/apcdcouncil.org/files/Why%20State%20APCDs%20Matter%20to%20Employers_Miller_062012.pdf

- "Provide cost information to support consumer-driven health care choices, providing information about the varying cost of procedures in different medical facilities (Massachusetts, New Hampshire, Maine);
- "Help employers understand variations in the cost and utilization of services by geographic area and in different provider settings (Maine, New Hampshire);
- "Explore the value equation (cost and quality) for services provided (New Hampshire);
- "Inform the design and evaluation plan of payment reform models including the medical home model and accountable care organizations (Vermont, New Hampshire)".[10]

As the research brief further notes, "States with APCDs are providing a roadmap for implementation that other states can apply, making it feasible for almost every state to establish an APCD reporting program in the future."[11]

2. Authority

The Cycle III Rate Review and Health Pricing Transparency grant program is being administered by HHS under the authority of section 2794 of the Public Health Service Act entitled, "Ensuring That Consumers Get Value for Their Dollars."

3. Program Requirements

a. Overview

States may apply for a Cycle III grant to perform one or more of the following purposes:

(1) Establish or enhance an Effective Rate Review (ERR) Program under section 2794(c)(1)(A). For the purposes of this FOA, this provision will be referred to as "Rate Review" activities.

(2) Perform required reporting to the Secretary and to the Exchanges under section 2794(c)(1)(B). For the purposes of this FOA, this provision will be referred to as "Required Rate Reporting" activities.

(3) Establish or enhance a Data Center under Section 2794(c)(1)(C). For the purposes of this FOA, this provision will be referred to as "Data Center" activities.

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[10] Patrick B. Miller, Denise Love, Emily Sullivan, Jo Porter, and Amy Costello, "All-Payer Claims Databases, An Overview for Policymakers", May, 2010: Academy Health and the Roger Wood. Available at: http://apcdcouncil.org/sites/apcdcouncil.org/files/2010_sci-all-payer-claims-report_1.pdf.

[11] Patrick B. Miller, Denise Love, Emily Sullivan, Jo Porter, and Amy Costello, "All-Payer Claims Databases".

All states must comply with the reporting requirements under section 2794(c)(1)(B), which include reporting rate information to the Secretary and to the relevant Exchange. However, states may choose to use other funds to pay for these reporting activities.

States that choose to apply for funds to establish or enhance Rate Review Activities under Section 2794(c)(1)(A) and/or Required Rate Reporting under section 2794(c)(1)(B) must commit to establish and maintain an ERR Program. A state is excluded from the requirement to establish and maintain an ERR Program only if it solely requests funds to establish or enhance a Data Center.

As the Cycle II grants are currently ongoing, previous recipients of Cycle II funds must meet additional eligibility requirements prior to applying for Cycle III funds. Detailed eligibility criteria are described in Section III, *Eligibility*.

b. Rate Review Activities, Section 2794(c)(1)(A)

Overview
States can choose to apply for funds for "Rate Review activities", under section 2794(c)(1)(A). States may use such grant funds to develop or enhance their current capacity to review and, to the extent permitted by state law, approve or deny rate increases in the individual and group markets through an Effective Rate Review Program. In addition, states **can** use section 2794(c)(1)(A) funds to collect and analyze health care pricing data, as part of their Rate Review activities.

Pricing data employed as part of "Rate Review" activities, under section 2794(c)(1)(A)
States using funds under section 2794(c)(1)(A) for the analysis of pricing data will need to clearly explain the connection between their work and Rate Review. Examples of pricing data-related activities allowable under section 2794(c)(1)(A), include: procuring pricing data from an external data source; integrating pricing data with rate filings in order to better evaluate rate submissions; analyzing and publishing pricing data in coordination with premium and rate filing information; and enhancing the transparency of pricing, cost, and rate information through web-based transparency initiatives.

Maryland serves as an example of a state that used pricing data as part of their Rate Review activities. During Cycle II of the Rate Review Grant Program, the Maryland Insurance Administration (MIA) contracted with the Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) to identify opportunities to incorporate data and information available from both organizations into the rate review process. The MHCC collects claims information for all service categories from carriers and Medicare and the HSCRC regulates all hospital rates in Maryland. The MIA is using data from MHCC and HSCRC to

develop appropriate benchmarks for use in reviewing a carrier's premium pricing. These purposes are allowable under the Rate Review activities category.

Eligibility requirements applying to states seeking to pursue Rate Review Activities with Cycle III funds

To be eligible for an award under Cycle III to fund Rate Review activities, a State must be able to demonstrate at the time of the application either that it already meets the criteria for an Effective Rate Review Program, or that with the funding resources from the grant it can achieve an Effective Rate Review Program.

An Effective Rate Review Program meets the following criteria:

1. The State receives data and documentation sufficient to determine whether a rate increase is unreasonable;
2. The State has adequate resources to effectively review that data and documentation in a timely manner;
3. The State's review examines the reasonableness of the assumptions used by the issuer in developing its rate proposal and the validity of the historical data underlying those assumptions, in accordance with specific areas of analysis set forth in the regulation; and
4. The State's determination of whether a rate increase is unreasonable is based on a standard set forth in State statute or regulation.

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

Each state seeking to establish or enhance their rate review program must include in its Project Narrative and Work Plan a proposal for program activities that enhance its current Effective Rate Review Program or how it would lead to the development of an Effective Rate Review Program.

c. Required Rate Reporting Activities, Section 2794(c)(1)(B)

As established by section 2794(b)(1), all states are required to submit certain rate filing data to HHS and to the relevant Exchange as a condition of participating in the Cycle III Rate Review Grant Program. First, section 2794(b)(1) of the PHS Act requires **all** grant participants to make recommendations, as appropriate, to the applicable Exchange about whether particular health insurers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified rate increases. The applicant should discuss plans to provide such recommendations to the relevant Exchange serving its state. Second, section 2794(b)(1) requires

all grant participants to report rate and premium information to the Secretary. See Section IV, *Application and Submission Information*, for additional information.

States can choose to apply for Cycle III funding for this purpose or use their existing resources for these reporting functions.

To be eligible for an award under Cycle III to fund "Required Rate Reporting activities," a State must be able to demonstrate at the time of the application either that it already meets the criteria for an Effective Rate Review Program, or that with the funding resources from the grant it can achieve an Effective Rate Review Program.

An Effective Rate Review Program meets the following criteria:

1. The State receives data and documentation sufficient to determine whether a rate increase is unreasonable;
2. The State has adequate resources to effectively review that data and documentation in a timely manner;
3. The State's review examines the reasonableness of the assumptions used by the issuer in developing its rate proposal and the validity of the historical data underlying those assumptions, in accordance with specific areas of analysis set forth in the regulation; and
4. The State's determination of whether a rate increase is unreasonable is based on a standard set forth in State statute or regulation.

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

d. Data Centers, section 2794(c)(1)(C)

States may use all or part of their Cycle III funds to establish or enhance Data Centers that compile and publish fee schedule and other health pricing data. Data Centers must be located at academic or other non-profit institutions. States may contract with existing non-profit organizations. Such non-profit organizations can be located in the applicant's state or in another state and serve as a Data Center for multiple states, as long as the non-profit organization possesses or will expeditiously obtain pricing data sets that satisfy two criteria. First, the data sets must include fair and accurate pricing and reimbursement data from providers or issuers in the applicant state. Second, the dataset must include a sufficiently representative subset of claims from the applicant state in order to be useful to consumers, employers, researchers, and the general public when comparing prices.

In addition, Data Centers must adopt by-laws that comply with the conflict of interest requirements established by section 2794 of the PHS Act. Appendix F contains new guidance in order to assist states seeking to comply with the requirements established by section 2794.

A Data Center, established under subsection (c)(1)(C) of section 2794, must: (A) develop fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates; (B) use the best available statistical methods and data processing technology to develop such fee schedules and other database tools; (C) regularly update such fee schedules and other database tools to reflect changes in charges for medical services; (D) make health care cost information readily available to the public through an Internet website that allows consumers to understand the amounts that health care providers in their area charge for particular medical services; and (E) regularly publish information concerning the statistical methodologies used by the center to analyze health charge data and make such data available to researchers and policy makers.

Additional information is provided on Data Centers in Section IV (*Application and Submission Information*).

Please note, that even if a state chooses to apply for funds solely to establish a Data Center, the state must meet reporting requirements established by section 2794(b)(1), regarding providing premium and rate data to the Secretary as well as providing rate-specific data to the Exchange.

e. Work Plan

Each State applying for Cycle III funding will be required to develop and submit a Work Plan that outlines specific milestones for successful development and enhancement of its rate review program and/or Data Center. For example, a state seeking to establish an Effective Rate Review Program by using grant funds to hire actuaries should include as a milestone the anticipated number of new actuaries on staff or under contract at the end of the first grant year. These milestones must be articulated clearly, be measureable, and be appropriate for the award time period. Section IV (*Application and Submission Information*) provides additional information and examples of milestones. **Following the submission of letters of intent, states will be informed as to whether to prepare a Work Plan covering a project period of 18 months or two years.** Section II, *Award Information*, provides additional information regarding the process that will be used to inform states of the project period length and funding availability.

f. Demonstrating Progress toward Milestones

Progress toward the milestones outlined in the Work Plan will be reported during the quarterly programmatic progress reports and in the required programmatic annual reports. States will have the opportunity to update and amend their Work Plans on a quarterly basis throughout the Cycle III grant program. Any state receiving funds to enhance rate review, cannot alter its Work Plan

to defer the objective of establishing an Effective Rate Review Program. Any state that is applying for Cycle III funding to focus on planned health pricing transparency activities cannot alter its Work Plan to defer the objective of establishing or enhancing health pricing transparency. Other than these two exclusions, HHS will work closely with a state in the event that a state updates its Work Plan as their plans evolve, and HHS will make technical assistance available to facilitate and support state progress throughout the grant program.

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

g. Commitment to Mentor States (Optional)

States that currently meet the proposed Effective Rate Review Program requirements may agree to mentor states that are in the process of developing Effective Rate Review Programs. States that have established data centers may agree to mentor states that are in the process of establishing or enhancing Data Centers.

II. AWARD INFORMATION

1. Total Funding:

Under Section 2794 of the PHS Act, funds are available to support grants as necessary to fulfill the purpose of this funding opportunity to the fifty states, the District of Columbia and the U.S. territories. A total of approximately $87 million is available for the Cycle III grants.

The project period and funding awarded to each recipient will be conditional upon funding availability. As a result, all applicants must submit the mandatory Letter of Intent by the deadline given. HHS will use this information to determine the amount of funding available to each recipient. The amount of funding available will determine the overall project period. The project period is expected to be 18 months unless there is sufficient funding to issue awards for a two-year project period (see Section II. 2. *Award Amount* for more information). HHS will provide applicants with information on the project period and their funding allocation prior to July 1, 2013 or at least 30 days prior to the application deadline date of August 1, 2013.

Baseline funding consists of one million per grant year. If there are sufficient funds, states may also receive supplemental awards, called "*Workload*" and "*Performance*" funds. "*Workload*" funds are determined based on the population and number of health insurance carriers. "*Performance*" funds are determined based on the ability to disapprove unreasonable rate increases in at least one market (i.e. individual or small group). HHS will inform states of funding allocations following submission of the mandatory Letters of Intent. The funding

formula will be consistent, regardless of whether or not the applicant plans to spend funding for section 2794(C)(1)(a), Rate Review activities; section 2794(C)(1)(b), Required Rate Reporting requirements; and/or section 2794(C)(1)(c), Data Center activities.

2. Award Amount:

Section 2794(c)(2)(C)(ii) of the PHS Act states that "no state qualifying for a grant shall receive less than $1,000,000 or more than $5,000,000 for a grant year." Accordingly, states must budget for at least $1,000,000 in each grant year, with one exception. A state can budget for $500,000 in a grant year if it already received rate review grant funding under Cycle II and that funding in combination with the Cycle III funding totals at least $1 million during a grant year. For example, Cycle II grantees can request a funding allocation of $500,000 for Cycle III during fiscal year 2014 (October 1, 2013 to September 30, 2014).

Award amounts will consist of Baseline, Workload, and/or Performance awards, as follows:

- Baseline Award Amount: Each state will be awarded a $1.5 million baseline award for 18 months unless there is sufficient funding to award a $2 million baseline award for 24 months. This funding allocation has one exception. A state can budget for $500,000 in a grant year if the state already received rate review grant funding under Cycle II and that funding, in combination with the Cycle III funding totals at least $1 million during a grant year. Cycle II grantees can request a funding allocation of $500,000 for Cycle III during fiscal year 2014 (October 1, 2013 to September 30, 2014). Cycle II Phase III grantees can also request a funding allocation of $500,000 during fiscal year 2015 (October 1, 2014 to September 30, 2015).
- "*Workload*" and "*Performance*" Awards: Workload and Performance funds will only be available if there are sufficient funds, after providing for two-year project periods for all eligible applicants.

  Funding Formula for "Workload" and "Performance" Awards: Certain States may be eligible to receive additional grant funds based on:

  1. "*Workload":* the State population size and the number of issuers with 5 percent or more market share (combined individual and small group market) within the State; and
  2. "*Performance":* the ability to disapprove unreasonable rate increases in at least one market.

If funding is available for "*Workload*" and "*Performance*" awards, the "*Workload"* funds will be awarded along with the Baseline Award in the Notice of Award. The "*Performance*" funds may also be awarded along with the Baseline Award for eligible States. States that are not initially eligible to receive the "*Performance"* funds at the time they receive their Baseline Award in their Notice of Award may have the opportunity to later receive "*Performance"* funds after

meeting the eligibility requirements. Such States must provide written documentation to HHS regarding their eligibility for the "*Performance*" funds and officially request such funds from HHS. HHS will inform states whether sufficient funds are available for "*Workload*" funds and/or "*Performance*" funds following submission of the mandatory Letters of Intent.

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

3. Anticipated Award Date:

The anticipated award date for the Cycle III grant awards is approximately 60 days after the application due date.

4. The Period of Performance:

The project and budget period for the grant will be determined by funding availability. Cycle III will have a project period of 18 months from award date, unless sufficient funds are available to provide for two years for all applicants. HHS will inform states of the length of the project period following submission of the mandatory Letters of Intent.

18-month project and budget period: October 1, 2013 to March 31, 2015
24-month project and budget period: October 1, 2013 to September 30, 2015

5. Milestones and Funding:

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

6. Number of Awards:

In Cycle III, there will be no more than fifty-seven initial Baseline Awards, for each of the 50 states, the District of Columbia and the five U.S. territories. Only one state will be eligible for two separate awards.[12] All awards are subject to funding availability.

7. Type of Award:

These awards will be issued and structured as grants. HHS will work closely with each state to evaluate its progress against its Work Plan and may condition the availability of funding on a

[12] This provision applies to the State of California, which has two regulatory agencies that are each primarily responsible for regulating a portion of the private health insurance market.

State's demonstrated progress toward the proposed grant plan. HHS Project Officers will track each state's progress and provide technical assistance when needed.

III. ELIGIBILITY INFORMATION

1. Eligible Applicants:

This FOA is open to all 50 states, the District of Columbia and the five U.S. territories to develop or enhance their respective rate review programs and/or establish Data Centers. Only one application per State is permitted, except in a state in which there are two regulating entities, each with a primary responsibility over the regulation of a portion of the private health insurance market.

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

- Each application must include a letter from the Governor officially endorsing the grant application and the proposed program plan, except in two situations. In the case of the District of Columbia, a letter from the Mayor will be accepted. In the case of an independently elected Insurance Commissioner, a letter from the Insurance commissioner will substitute for the letter from the Governor.
- If the applicant entity is not the same entity that has received or currently receives Rate Review Grant funding on behalf of the State, a letter, memorandum of understanding, or an agreement must be submitted that delineates the different entities receiving funds, the coordination of timelines and the entity responsible for each of the activities. All of the identified entities must demonstrate that they are coordinating so that they do not duplicate activities or supplant funds.
- If the applicant entity is not the state entity with the primary statutory and regulatory authority for the regulation of private health insurance, the applicant must include a letter from the Department of Insurance or the relevant state entity with primary statutory authority for the regulation of private health insurance. This letter must indicate that the Department of Insurance or relevant state entity will comply with the requirements of section 2794(b)(1), specifically that the entity will (1) provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State; and (2) make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified rate increases.
- Each applicant must submit a state certification of Maintenance of Effort verifying that the grant funds will not supplant existing State expenditures for Rate Review or Data Center activities.

Additional eligibility criteria are specific to:

1) previous recipients of Cycle II funding; and

2) states applying for funds to enhance or establish Rate Review activities under section 2794(c)(1)(A), states applying for funds to complete Required Rate Reporting activities under section 2794(c)(1)(B), or both.

2. Previous recipients of Cycle II funding

A previous recipient of Cycle II funds is eligible for Cycle III if:

i. The state plans to establish, enhance, or contract with a Data Center and provide medical pricing data in a transparent, accessible way to consumers, employers, researchers, and the general public. In addition, all Data Center applicants must make pricing data available to the relevant state-based authority that performs rate review; or
ii. The state provides a comprehensive plan to invest $500,000 or greater to expand the health care pricing data collected, analyzed, and displayed as part of its Rate Review activities under section 2794(c)(1)(A). That plan must (a) include detailed documentation of how the medical pricing data will be analyzed and presented to the public in an easily accessible manner and useable format; and (b) clearly document the connection between the use of pricing data and the state's rate review activities. For more information about pricing initiatives eligible under section 2794(c)(1)(A), please see Section I.3.c., *Rate Review Activities*; or
iii. The state received Cycle II funding and drew down fifty-five (55) percent of Cycle II funds through the Payment Management System (PMS) by July 15, 2013. Such states can elect to expend their funds on Rate Review Activities, Required Rate Reporting, and/or Data Centers.

3. Eligibility Criteria for States Applying for funds to enhance Rate Review under section 2794(c)(1)(A) and/or complete Required Rate Reporting under section 2794(c)(1)(B)

The following eligibility requirement applies to all applicants applying for funds to enhance or establish Rate Review activities under section 2794(c)(1)(A) and/or complete Required Rate Reporting activities under 2794(c)(1)(B). In other words, this requirement applies to all applicants except those applying for funds only for section 2794(c)(1)(C) "Data Center"-related activities.

For states applying to enhance or establish Effective Rate Review Programs (including those applying for funds to complete Required Rate Reporting activities), the State must meet one of the following criteria to be eligible to apply for the Cycle III grant program:

- The state currently meets the Effective Rate Review Program requirements under the final rate review regulation in both the individual and small group markets and commits to using Cycle III grant funds to enhance its rate review; or

- The state currently has an Effective Rate Review Program in either the individual or small group market and commits to using Cycle III grant funds to meet these requirements in the remaining market within twelve months of receiving a Cycle III Notice of Award; or

- The state currently lacks an Effective Rate Review Program in either the individual or small group market, and commits to using Cycle III funds to meet these requirements in both markets within twelve months of receiving a Cycle III Notice of Award.

4. Continued Eligibility

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

5. Legal Status

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

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

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

7. System for Award Management (SAM):

All applicants must register in the System for Award Management (SAM)* database in order to be able to submit an application (https://www.sam.gov/). In order to register, applicants must provide their DUNS and EIN numbers. Additional information about SAM is available at https://www.sam.gov/portal/public/SAM/. Applicants must successfully register with SAM prior to submitting an application or registering in the Federal Funding Accountability and Transparency Act Subaward Reporting System (FSRS) as a prime awardee user. See Section IV, *Application and Submission Information*, for more guidance on SAM registration. Primary awardees must maintain a current registration with the SAM database, and **may make subawards only to entities that have DUNS numbers**. Organizations must report executive compensation as part of the registration profile at https://www.sam.gov/ by the end of the month following the month in which this award is made, and annually thereafter (based on the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109-282), as amended by Section 6202 of Public Law 110-252 and implemented by 2 CFR Part 170)). See Section VI, *Award Administration Information*, for more information on

FFATA. The Grants Management Specialist assigned to monitor the subaward and executive compensation reporting requirements is Iris Grady, who can be reached at divisionofgrantsmanagement@cms.hhs.gov.

*Applicants were previously required to register with the Central Contractor Registration. The CCR was a government-wide registry for organizations that sought to do business with the federal government. CCR collected, validated, stored, and disseminated data to support a variety of federal initiatives. This function is now fulfilled by SAM. SAM has integrated the CCR and will also incorporate 7 other Federal procurement systems into a new, streamlined system. If an applicant has an active record in CCR, there will be an active record in SAM. Nothing more is needed unless a change in the business circumstances requires updates to the Entity record(s) in order for the applicant to be paid, receive an award, or to renew the Entity prior to expiration in SAM. Please consult the SAM website listed above for additional information.

8. Cost Sharing/Matching

Awardees are not required to provide matching contributions.

9. Maintenance of Effort

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

10. One Application Requirement with Certain Exceptions:

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

11. Pre-Application Conference Call:

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

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

IV. APPLICATION AND SUBMISSION INFORMATION

1. Address to Request Application Package:

This FOA contains instructions to apply for the Cycle III Rate Review Grant Program. The application should be written primarily as a narrative with the addition of standard forms required by the Federal government for all grants.

A Letter of Intent is **required** for Cycle III funding. A Letter of Intent should include a brief explanation of a state's intent to apply for the Cycle III Grant Program. The purpose of the Letter of Intent is to determine the number of applications for planning purposes. Following the review of the Letters of Intent, eligible applicants will be notified of the project period length and their funding eligibility. Please note that submitting a letter of intent to apply is not binding on an applicant.

The Letter of Intent must be submitted by 4:00 pm Eastern Daylight Time on June 17, 2013. The Letter of Intent must be submitted electronically in PDF format to Sarah.Norman@cms.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 http://www.grants.gov website. This FOA can also be viewed on HHS's website at http://cciio.cms.gov/resources/fundingopportunities/index.html#rir.

Specific Instructions for Applications Submitted via http://www.grants.gov:

- You can access the electronic application for this project at http://www.grants.gov. You must search the downloadable application page by the CFDA number **93.511.**
- At the http://www.grants.gov website, you will find information about submitting an application electronically through the site, including the hours of operation. HHS strongly recommends that you do not wait until the application due date to begin the application process through http://www.grants.gov because of the time needed to complete the required registration steps.
- All applicants under this announcement must have an Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN), to apply. Applicants should begin the process of obtaining an EIN/TIN immediately upon posting of this FOA to ensure this information is received in advance of application deadlines.

- All applicants, as well as sub-recipients, must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number at the time of application in order to be considered for a grant or cooperative agreement. A DUNS number is required whether an application is submitting a paper application (only applicable if a waiver is granted) or using the Government-wide electronic portal, www.Grants.gov. 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. Applicants should obtain this DUNS number as soon as possible after the announcement is posted to ensure all registration steps are completed in time.
- The applicant must also register in the System for Award Management (SAM) database in order to be able to submit the application. Applicants are encouraged to register early, and must have their DUNS and EIN/TIN numbers in order to do so. Information about SAM is available at https://www.sam.gov/portal/public/SAM/. The SAM registration process is a separate process from submitting an application. **Therefore, applicants should begin the SAM registration process as soon as possible after the announcement is posted to ensure that it does not impair your ability to meet required submission deadlines.**
- Authorized Organizational Representative: The Authorized Organizational Representative (AOR) who will officially submit an application on behalf of the organization must register with Grants.gov for a username and password. AORs must complete a profile with Grants.gov using their organization's DUNS Number to obtain their username and password at http://grants.gov/applicants/get_registered.jsp. AORs must wait one business day after registration before entering their profiles in Grants.gov. Applicants should complete this process as soon as possible after successful registration to ensure this step is completed in time to apply before application deadlines.
- When an AOR registers with Grants.gov to submit applications on behalf of an organization that organization's E-Biz POC will receive an email notification. The email address provided in the profile will be the email used to send the notification from Grants.gov to the E-Biz POC with the AOR copied on the correspondence.
- The E-Biz POC must then login to Grants.gov (using the organization's DUNS number for the username and the special password called "M-PIN") and approve the AOR, thereby providing permission to submit applications.
- **Any files uploaded or attached to the Grants.Gov application must be PDF file format and must contain a valid file format extension in the filename. Even though Grants.gov allows applicants to attach any file format as part of their application, CMS restricts this practice and only accepts PDF file formats. Any file submitted as part of the Grants.gov application that is not in a PDF file format, or contains password protection, will not be accepted for processing and will be excluded from the application during the review process. In addition, the use of compressed file formats such as ZIP, RAR, or Adobe Portfolio will not be accepted. The application must be submitted in a file format that can easily be copied and read by reviewers. It is recommended that**

scanned copies not be submitted through Grants.gov unless the applicant confirms the clarity of the documents. Pages cannot be reduced in size, resulting in multiple pages on a single sheet, to avoid exceeding the page limitation. All documents that do not conform to the above constraints will be excluded from the application materials during the review process.

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

Each year organizations and entities registered to apply for Federal grants through http://www.grants.gov must renew their registration with the System for Award Management (SAM). You can register with SAM online; registration will take about 30 minutes to complete (https://www.sam.gov/). **Failure to renew SAM registration prior to application submission will prevent an applicant from successfully applying via Grants.gov. Similarly, failure to maintain an active SAM registration during the application review process can prevent HHS from issuing your agency an award under this program.**

Applications cannot be accepted through any email address. Full applications can only be accepted through http://www.grants.gov. Full applications cannot be received via paper mail, courier, or delivery service, unless a waiver is granted per the instructions below.

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

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

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

In order to be considered for a waiver application, an applicant must have adhered to the timelines for obtaining a DUNS number, registering with the System for Award Management (SAM), registering as an Authorized Organizational Representative (AOR), obtaining an Employer/Taxpayer Identification Number (EIN/TIN), completing Grants.gov registration, as

well as requested timely assistance with technical problems. Applicants that do not adhere to timelines and/or do not demonstrate timely action with regards to these steps will not be considered for waivers based on the inability to receive this information in advance of application deadlines.

Please be aware of the following:

- Search for the application package in Grants.gov by entering the CFDA number 93.511.
- 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@cms.hhs.gov with a clear justification for the need to deviate from our standard electronic submission process.
- If the waiver is approved, the application should be received by the Division of Grants Management Division by the application due date.

To be considered timely, applications must be received on or before the published deadline date. However, a general extension of a published application deadline that affects all applicants or only those applicants in a defined geographical area may be authorized by circumstances that affect the public at large, such as natural disasters (e.g., floods or hurricanes) or disruptions of electronic (e.g., application receipt services) or other services, such as a prolonged blackout.

2. Content and Form of Application Submission:

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

The application Project Narrative must not exceed 20 pages in length; the Budget Narrative must not exceed 10 pages; and the Work Plan must not exceed 15 pages for all Work Plans combined. The Standard Forms and additional supporting documentation listed below are excluded from the page limitation.

The following documents are required for a complete application:

A. Standard Forms

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

- SF 424: Official Application for Federal Assistance (see note below)
- SF 424A: Budget Information Non-Construction
- SF 424B: Assurances-Non-Construction Programs
- SF LLL: Disclosure of Lobbying Activities
- Project Site Location Form(s)

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

- Item 15 "Descriptive Title of Applicant's Project." Please indicate in this section the name of this grant: Grants to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing**, Cycle III**

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

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

B. Applicant's Application Cover Letter or Cover Page

A letter from the applicant must identify the:

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

C. Project Abstract

A one-page abstract should serve as a succinct description of the proposed project and must include the goals of the project, the total budget, and a description of how the grant will be used to enhance health insurance rate review and/or establish a data center.

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

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

D. Project Narrative

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

Both the required and optional sections of the Project Narrative are described below. States applying for funds for Rate Review and/or Required Rate Reporting activities must address sections (b), "Description of Current Rate Review Processes," and (c), "Plans to Develop or Enhance Rate Review." States applying for Data Center related activities must address sections (f), "Description of current status of data centers in the State," and (g), "Proposed Data Center Activities." **All** states must provide the following sections: Section (a), "Eligibility"; Section (d), "Reporting to the Secretary on Rate Increase Patterns"; Section (e), "Recommendations to the Applicable Exchange on Issuer Participation"; and Section (i), "Evaluation Plan." Section (h), "Commitment to Mentor States", is optional. However, states interested in mentoring other states must address this section.

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

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

1. Activity specific requirements

All states applying for funds for Rate Review Activities or Required Rate Reporting must select one below:

- ☐ State has an Effective Rate Review Program and has already implemented rate review processes consistent with the amendments to 45 CFR part 154 issued on February 27, 2013; or
- ☐ State has an Effective Rate Review Program and plans to maintain that status by implementing new rate review processes consistent with amendments to 45 CFR part 154 issued on February 27, 2013; or
- ☐ State plans to become an Effective Rate Review Program within one year of receiving Cycle III funding, including implementing processes consistent with the amendments to 45 CFR part 154 issued on February 27, 2013.

States only applying for Data Center related activities must indicate as follows:

- ☐ State is planning to use Cycle III funds only for Data Center related activities. Such a state will be required to produce pricing data for rate review purposes; in addition, the state must satisfy the reporting requirements established under section 2794(b)(1).

2. Cycle II funding status

States can select one or more of the following eligibility criteria:

- ☐ State did not apply for Cycle II funding; or
- ☐ State received Cycle II funding and drew down fifty-five (55) percent of Cycle II funds through the Payment Management System (PMS) by July 15, 2013; or
- ☐ State received Cycle II funding and plans to establish or enhance an existing Data Center in Cycle III; or
- ☐ State provides a comprehensive plan to invest $500,000 or greater to expand the health care pricing data collected, analyzed, and displayed as part of its Rate Review activities under section 2794(c)(1)(A). That plan must (a) include detailed documentation of how the medical pricing data will be analyzed and presented to the public in an easily accessible manner and useable format; and (b) clearly document the connection between the use of pricing data and the state's rate review activities. For more information about pricing initiatives eligible under section 2794(c)(1)(A), please see Section I.3.c., *Rate Review Activities*.

Section (b), Description of Current Rate Review Processes
(Mandatory for all states requesting funding to establish or enhance Rate Review or Required Rate Reporting)

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

In addition, states that are eligible to apply for Cycle III because they have drawn down and expended 55% of their Cycle II funds, must report their expenditure figures, as of July 15, 2013. In other words, states must indicate the total Cycle II grant funds drawn down from the Payment Management System (PMS) and expended, as of July 15, 2013, if the state meets the following criteria: 1) the state previously received Cycle II funding; and 2) the state is not requesting funds **solely** to establish or enhance a Data Center with Cycle III funding; or 3) the state is not requesting funds to spend at least $500,000 to establish or enhance health pricing data analysis and transparency initiatives as part of their Rate Review activities. A review of PMS reports and previously submitted Federal Financial Reports (FFR) will be used to verify funding outlays.

Applicants must also provide:

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

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

3. Consumer protections:
    a. Please describe the state's rate review processes, regulations, and statutes, as they relate to the final rule entitled, "Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review," 45 CFR part 154, as amended on February 27, 2013.
    b. Are rate filings publicly disclosed? If so, what is the mechanism for public access to rates and rate filings? Describe the state laws and regulations that govern disclosure and public access to rate filings and public access to the Insurance Department documents in general.
    c. Are summaries of rate changes offered in plain language for consumers? Please provide an example.
    d. Discuss staff expertise that involves the ability to provide assistance and develop materials that are culturally and linguistically appropriate. In discussing this topic, please refer to the Office of Minority Health's website for the national standards on culturally and linguistically appropriate services (http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15).
    e. How much advanced notice is given to consumers prior to proposed rate changes? Are consumers provided with official comment periods to review and comment on proposed rate changes?
    f. What processes exist for public meetings and/or hearings on rate filings?

g. What rate review related information is available on the Insurance Department's website?
    i. How has the Insurance Department organized and displayed the information in order to make it easily accessible to consumers and small businesses?
    ii. Has the Insurance Department utilized usability testing to enhance the accessibility of these online resources? For more information regarding usability testing, please see: http://www.usability.gov/methods/test_refine/learnusa/index.html.
h. Provide the number and summarize the nature of consumer inquiries and complaints related to health insurance rates that have been received for the past two plan years.

4. Examination and Oversight:
    a. Describe actions taken against insurance companies during the past years regarding health insurance rates. Include in the description a discussion of the market share and the number of affected policyholders for the cited insurance company.
    b. Describe formal agency (e.g., Department of Insurance) hearings held during the past year regarding health insurance rates.

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

States that plan to invest funds in health pricing data collection, analysis and dissemination ***as part of their Rate Review activities under section 2794(c)(1)(A)*** *must describe the state's current collection and/or use of health care pricing data. If the state plans to contract with one or more non-profit organizations in order to perform health pricing data collection and analysis, please describe the resources available through the relevant non-profit entity or entities. Required information on the state and contractual entities are as follows:*

1. Existing statutory authority to collect medical claims reimbursement data from issuers. If the data is collected through voluntary means, please describe the system of voluntary data collection.
2. A description of the current collection, analysis, and publication of pricing data:
    - *Sources of data*:
        - Please describe the types of payers that submit to pricing/claims data (private and/or public). In addition, please describe the collection threshold (e.g.,

insurance providers with greater than 10,000 lives). If data regarding self-pay is collected, please indicate.

- *Type of data collected*:
    - Please describe the data collected, including: 1) types of claims files (e.g. eligibility files, provider files, pharmacy files); 2) data elements collected (e.g. diagnosis codes, types of care, insurance product type, facility type, cost type, provider information).
- *Analysis, aggregation, and integration of data*
    - Please describe how pricing data is used currently to inform rate review. If rate review will be a new use for this data, please indicate so.
    - If applicable, please describe how the state has developed tools to reflect market rates for medical services and the geographic differences in those rates. If applicable, please describe how the contractual entity has developed such tools.
    - Please describe how the state uses available statistical methods and data processing technology to develop medical claims reimbursement reports, analytics, and data base tools.
    - Please describe any efforts to harmonize the applicant's data collection and analytics with other data sources. In this description, please describe any efforts to support the standard-setting process called "the ASC-X12 State Data Harmonization Effort". The ASC-X12 State Data Harmonization Effort, funded in part by the Agency for Healthcare Research and Quality (AHRQ), is a national effort to harmonize data collection by All-Payer Claims Databases. To learn more about this standard-setting process, please visit: http://ushik.ahrq.gov/index.jsp?enableAsynchronousLoading=true
- *Privacy and Data Security*
    - Please describe privacy and security practices and procedures designed to protect the data managed by the state, or if relevant, contractual entity.
- *Transparency and data dissemination*:
    - Please describe how the agency or partner organization makes health care cost information available to the public through a website. Please explain if the website allows consumers to understand the amounts that health care providers in their area charge for particular medical services.
    - Please describe the data release standards, including: (1) which entities are considered eligible to receive data; and (2) how the data transfer process is overseen.
    - Please describe how the collected data has been used by researchers, employers, consumers, and other stakeholders.

Section (c), Plans to Develop or Enhance Rate Review

(Mandatory for all states requesting funding to establish or enhance rate review programs)

All states planning to use section 2794 funding to enhance rate review must indicate their plans to implement rate review changes that comply with the standards for Effective Rate Review as described in the final rule entitled, "Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review," 45 CFR part 154, as amended on February 27, 2013.[13]

For states that meet the Effective Rate Review Program requirements in both the individual and small group markets at the time of application, milestones may include, but are not limited to:

- Improving rate-filing requirements: States may use grant funds to develop and implement more rigorous rate filing requirements that better document the underlying factors that influence proposed rate increases. For example, states may require more comprehensive supporting documentation and actuarial attestations, such as exhibits that describe the underlying assumptions and factors used to derive medical trend estimates, require companies to separately report and justify administrative expenses (salaries, advertising, broker commissions, etc.) and take into consideration an insurance company's overall finances (profits/investment income) when making rate change determinations.
- Improving rate review through the intake, analysis, and publication of health pricing data: States may use funds to improve rate review through the review, analysis, and publication of health pricing data. Health pricing data includes medical reimbursement data, generally provided by insurance companies. Allowable activities include the integration of pricing, premium, and benefit information in order to better evaluate requested rates.
- Enhancing consumer protection standards: States may enhance transparency of the rate filing process, for example, by posting to a public website information about: (a) rate filings and the issuer's justification for increases in easy to understand language for the public; (b) improving the quality of online material through usability testing; (c) requiring insurers to post rate increase information, including all accompanying documentation, on their websites; (d) implementing a public hearings process for proposed rate increases; and (e) providing consumers with advanced notice of rate increases before rate changes become effective.
  Enhancing rate review process - Staffing: Permitted use of funds includes additional staffing and consultant expertise through qualified actuaries familiar with the Actuarial Standards of Practice (ASOPs) and Guidelines for Professional Conduct.
  Enhancing rate review process - IT capacity: States may develop new analytic capacities to assess the validity of rate increases and improve the IT infrastructure that supports health insurance rate review functions, including more robust data analysis and data exchange capabilities both within the state as well as with the Federal government. For example, states may request funding to plan, develop and implement enhanced electronic filing and approval processes for rates and policy forms, and implement electronic reporting of financial data used by insurance regulators.

[13] See 78 F.R. 13406 (February 27, 2013).

For States that meet the Effective Rate Review Program requirements in only one market (or for only some products) at the time of application, but that commit to use Cycle III funds to meet these requirements in both markets, milestones may include, but are not limited to:

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

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

  - Secure needed authority to receive from issuers data and documentation in connection with rate increases that are sufficient to conduct rate reviews; report required rate trend data to the Secretary; and base a determination that a rate increase is unreasonable on a standard set forth in a state statute or regulation.

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

For states whose rate review processes do not meet the Effective Rate Review Program requirements in either market at the time of application, but that commit to using Cycle III funds to meet these requirements in both markets.

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

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

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

Section (d), Reporting to the Secretary on Rate Increase Patterns

Mandatory: This section is mandatory for all applicants.

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

For Cycle III, each grantee is required to provide certain rate filing data to the Secretary for the individual and small group market segments for which the State Insurance Commissioner has jurisdiction or review and approval authority. During Cycle I, HHS, the States and the National Association of Insurance Commissioners (NAIC) collaborated on a set of data indicators (Tables A-D and the Rate Review Health Insurance Data Elements). As a result of the new Uniform Rate Review Template, established through the final rule published at 45 CFR part 154[14], HHS now collects health insurance rate information on all rate increases. As the Rate Review Grant data collects unique data that is not captured by the Uniform Rate Review Template, it remains relevant. However, CMS is proposing to reduce data collected through the Rate Review Grant Program in order to eliminate redundant data fields. This streamlined data submission will be required on a quarterly basis throughout Cycle III and is outlined in the Standard and Special Terms and Conditions (STCs) provided to all states who have been awarded a grant. Data submission requirements may be revised in the future to reflect regulations or guidance.

Section (e), Recommendations to the Applicable Exchange on Insurer Participation

Mandatory: This section is mandatory for all applicants

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

Section (f), Current status of Data Center activities

[14] See 78 F.R. 13406 (February 27, 2013).

This section is mandatory only for applicants seeking to enhance or establish a Data Center, under section 2794(c)(1)(C).

Applicants must *describe the state's current collection and/or use of health care pricing data. If the state plans to contract with one or more non-profit organizations in order to expand health pricing transparency, please describe the resources available through these non-profit entities. Required information on the state and contractual entities are as follows:*

1. Overview of existing data centers
    a. Please provide an overview of data centers that collect and analyze health charges, costs, pricing, and/or quality using medical claims data from payers or providers in the applicant's state. Please address all health care cost reimbursement databases, such as All-Payer Claims (APC) databases, in the applicant's state, as well as state data organizations that collect and analyze encounter-level data from hospitals, emergency departments, ambulatory surgery centers, and/or other provider sites. If multiple data centers exist, please indicate how the state prevents duplication and redundancy of efforts. Further, please describe state-wide and regional efforts to integrate the data contained by different data centers. Finally, if a state plans to contract with an academic or other non-profit organization that is not located in the applicant's state, please provide a description of the relevant data center.
    b. If applicable, please describe any data centers established as "Qualified Entities" through the Medicare Data Sharing Program in the applicant's state. The CMS-Certified, Qualified Entities serve as important partners to the health pricing transparency work funded by the Cycle III FOA. These organizations use medical claims data to calculate and report measures of quality, efficiency, effectiveness, and resource deployment. Specifically, they combine claims data from different payers, calculate quality and/or cost of care measures, design performance reports using those measures, share performance reports with the public, and ensure the privacy and security of data. Please visit www.cms.gov/QEMedicareData for more information.
    c. If applicable, please describe any State-specific Health Cost and Utilization Project (HCUP) databases in the applicant's state. HCUP databases provide longitudinal hospital care data, with some collecting all-payer, encounter-level information beginning in 1988. These databases enable research on a broad range of health policy issues, including cost and quality of health services, medical practice patterns, access to health care programs, and outcomes of treatments at the national, State, and local market levels. Please visit http://www.hcup-us.ahrq.gov/partners.jsp for more information.
2. Please describe existing statutory authority to collect medical claims reimbursement data from issuers. If data is collected on a voluntary basis, please describe this mechanism. In

addition, please describe any relevant statutory restrictions on proprietary or confidential data that may impact the dissemination of aggregated or disaggregated pricing data.

3. If the applicant is seeking to enhance an existing Data Center, please provide the following description of that specific Data Center:
    a. *Data sources and collection threshold*:
        - Please describe the types of payers or providers that submit to the relevant data center (private and/or public). In addition, please describe the collection threshold (e.g., insurance providers with greater than 10,000 lives), and which payers (e.g. private payers, Medicare, Medicaid, uninsured) contribute to the dataset. If self-pay data is collected, please indicate. Also, please indicate if data is collected from self-funded health plans.
    b. *Type of data collected*:
        - Please describe the types of claims files collected (e.g. eligibility files, provider files, pharmacy files).
        - Please describe the data elements collected (e.g. diagnosis codes, types of care, insurance product type, facility type, cost type, provider information).
        - Please indicate if non-claims based financial transactions are collected. Non-claims based financial transactions include pay for performance, capitation fees, among others.
        - Please indicate whether or not direct or indirect patient identifiers are collected for linkage purposes. If direct patient identifiers are collected, please indicate relevant confidentiality and data security protections, such as encryption.
        - Please describe any efforts to harmonize the applicant's data with other data sources. In this description, please describe any efforts to support the standard-setting process called "the ASC-X12 State Data Harmonization Effort". The ASC-X12 State Data Harmonization Effort, funded in part by the Agency for Healthcare Research and Quality (AHRQ), is a national effort to harmonize data collection by All-Payer Claims Databases. To learn more about this standard-setting process, please visit: http://ushik.ahrq.gov/index.jsp?enableAsynchronousLoading=true
    c. *Analysis of data and integration with other data sources*
        - Please describe integration with other data sources, such as premium, rate, benefit, and quality data.
        - Please describe how the Data Center develops tools to reflect market rates for medical services and the geographic differences in those rates.
        - Please describe how the data center uses available statistical methods and data processing technology to develop medical claims reimbursement reports, analytics, and data base tools.
        - Please describe how the data has been disseminated to and used by researchers, employers, consumers, entrepreneurs, and other government

agencies. For example, please detail if data from the data center has been used to evaluate the effectiveness of cost reduction and quality improvement initiatives, such as medical homes pilots or other care coordination initiatives.

d. *Data security and privacy*
   - Please describe privacy and security practices and procedures designed to protect the data managed by the Data Center. As noted previously, entities must demonstrate that they have rigorous security and privacy practices in place to protect the data released to them and have programs in place to enforce and monitor data security practices.

e. *Dissemination of data and transparency*:
   - Please describe how the data center makes health care cost information available to the public through a website, web-based applications, and other vehicles.
   - Please detail if the website allows consumers to look up the prices that health care providers in their area charge for particular medical services. If available, please describe how the website permits individuals to access, analyze, and display the data.
   - If available, please describe mapping, data download, sorting, and other database tools.
   - Please describe the experience and expertise of the data center in creating and mounting websites for use by consumers. Further, please describe experience conducting consumer testing of measures and display modalities.
   - Please describe any analyses that have been conducted on the website's use by and impact on consumers.
   - Please describe current data release policies, as they apply to other government agencies, researchers, and other external parties.

4. Conflict of interest protections
   - Please describe current conflict of interest protections.
   - Please provide a copy of the data center's by-laws.
   - Please provide a list of the governing data center's board and their affiliations.

5. Explanation of the current level of resources and capacity supporting current data center activities: *Budget and Staffing*
   - Please provide a description of the annual overall total budget and revenue for data center activities from the most recent fiscal year.
   - Please provide a budgetary breakdown for resources allocated to the data center.
   - Please provide a description of the qualifications (education and professional background) of each of the staff members responsible for collecting, analyzing, and publishing medical claims reimbursement data. To the extent that IT,data analysis, or data collection services are contracted, please provide

the name of the company and description of the nature and scope of the contract service.

Section (g), Proposed Data Center Activities

This section is only mandatory for applicants seeking to enhance or establish a Data Center.

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

- *Institution requirements*: A Data Center must be an academic or other nonprofit institution. To establish or enhance a Data Center, a state may contract with academic or non-profit institutions located in the applicant's state or in another state, as long as the contractual entity possesses or will acquire expeditiously fair and accurate health pricing and reimbursement data specific to the applicant state. In addition, a Data Center shall adopt by-laws that comply with the conflict of interest requirements established by section 2794 of the PHS Act. **Appendix F contains new guidance in order to assist states seeking to comply with the requirements established by section 2794.**
- *Research functions of Data Centers*: Data Centers must collect and analyze medical reimbursement data. As part of their research, the centers must develop and update fee schedule databases that contain health pricing data. Applicants must **ensure** that Data Centers demonstrate use of appropriate analytic methods and describe how the proposed research will add to the existing body of available fee schedule research (i.e., ensuring that Data Center efforts are not duplicative).
- *Public disclosure requirements*: Data Centers must make data and research findings (and statistical methodologies) publically available to issuers, health care providers, health researchers, health policymakers and the public. Additionally, the centers must make cost information available so that consumers can evaluate service costs in their area.
- *Privacy and data security:* Entities must demonstrate that they have rigorous security and privacy practices in place to protect the data released to them and have programs in place to enforce and monitor data security practices. Stringent security and privacy standards must be enforced throughout all phases of the program, including data receipt or transmission, performance measure calculation, the provider review and corrections process, and performance reporting (including all public reporting as well as any other types of more limited reporting).
- *Provide pricing data to regulatory agency:* All states must provide pricing data for rate review purposes to the relevant agency or sub-agency that oversees rate review.
- *Conflict of Interest requirements:* If the current conflict of interest protections established by the Data Center do not comply with the requirements established by section 2794d, please describe the Data Center's plan to revise current by-laws in order to come into

compliance. Please see Appendix F, *Conflict of Interest Requirements*, for additional information.

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

Applicants are encouraged to consult "*Digital Government, Building a 21st Century Platform for the American Public*" for ideas about how to build a Data Center that serves consumers, entrepreneurs, and employers in a consumer-centric, information-centric way. As elaborated in this strategy and applied to health pricing transparency, we recommend that applicants seek to:

- *Enable the public to access high-quality digital health pricing information and services anywhere, anytime, on any device.*

  Modern tools and technologies such as responsive web design and search engine optimization help to deliver services to any device, anytime, anywhere. Similarly, optimizing content for modern platforms, rather than just translating content from paper-based documents to the Web, will help ensure that consumers, employees, and entrepreneurs can access content regardless of platform.

- *Provide data in an open format that is easily accessible to entrepreneurs, employers, and consumers.*

  In order to permit entrepreneurs and the public to access, use, and transform health pricing data for new purposes and analyses, we recommend that newly developed IT systems be architected for openness. If possible, Data Centers should expose high-value data and content as web Application Programming Interfaces (APIs) at a discrete and digestible level of granularity with metadata tags. In addition, data should be posted in a machine-readable format.

For more, please see the following website:
http://www.whitehouse.gov/sites/default/files/omb/egov/digital-government/digital-government.html

States may pursue a wide range of activities to establish or enhance Data Centers. Below is a list of permissible activities; however, states are not limited to the activities described below.

States may:

- <u>Establish or improve data collection and quality</u>: States may seek to expand the completeness of the data collected by, for instance, establishing mandatory submission of

data or adjusting the collection threshold to include a more comprehensive set of issuers. In addition, states may establish or enhance data collection standards. Furthermore, states may improve the quality of data through the development of pre- and post- data collection quality standards and protocols.

- Perform or enhance data analysis: States may perform time series, geographic, provider-specific, or setting-specific analyses of pricing patterns. In addition, states may pursue a wide range of data analysis projects that use pricing and claims data to evaluate health care cost, quality, and outcomes.

- Establish or improve data dissemination and transparency: States may enhance the health care cost and pricing information readily available to the public through websites and web-based applications. States are encouraged to consider strategies that increase the accessibility of data to consumers so that the public can access data anywhere, any time on any device. As part of this website, states can develop a range of online tools, including mapping, search, and data analysis tools, to help consumers and their families make health care choices informed by this data. Furthermore, states can establish or enhance new data release guidelines that provide more data to researchers, employers, and other relevant stakeholders. In addition, states can integrate pricing and quality information in order to present the value equation to consumers and employers.

- Improve integration of data and harmonization with other data sources: Individual states may investigate harmonization of data with other claims data from other states. For instance, states may standardize data submission processes and templates in order to permit regional and cross-state analytics. The ASC-X12 "State Data Harmonization Effort" is one example of such a data standardization effort. States may also integrate datasets from various sources in order to provide a more comprehensive, powerful overview of the health care industry. In addition, states can invest in the infrastructure necessary to link claims data with premium and benefit data.

- Improve IT infrastructure and improving data security: To improve the quality, comprehensiveness, and accessibility of pricing data, states may need to invest and improve their IT infrastructure. This may include increased storage capacity and data security enhancements, among other investments.

- Enhance staff and contracting capacity: Permitted use of funds includes additional staffing and consultant expertise, including national experts in data, analytics, and IT.

Section (h), Commitment to Mentor States

This section is optional for all grant applicants.

States that currently meet the Effective Rate Review Program requirements may agree to mentor states that are in the process of developing Effective Rate Review Programs. States with existing Data Centers may agree to mentor states that are in the process of developing Data Centers.

Section (i), Evaluation Plan

This section is required for all grantees.

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

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

Examples may include:

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

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

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

- Improvements in the transparency, accessibility, quality, and comprehensiveness of health care pricing data—collection of new data (changes in collection threshold, comprehensiveness of data), improvements in data quality, harmonization of data with other APCDs nationwide, development and enhancement of publicly available data sets (data release policy changes), and web-based tools (# of website hits, # of reports published, usability of website tools).

- Impact of Data Center on health care costs and quality – development of publicly available research reports and statistical analyses that indicate cost drivers and measure performance (# of publications; impact indicators for publications); use of

publicly available datasets in cost effectiveness/quality research performed by external researchers.

E. Work Plan

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

The reasonableness and completeness of the specific tasks to be conducted throughout the project period will be reviewed as well as the adequacy of the projected timeframes. The Work Plan must indicate which milestones the Program plans to meet within the associated timeframes. The incremental steps to achieving these milestones should also be identified by the months and years in which they start, are carried out, and completed. States are permitted to do a separate Work Plan for different aspects of their grant application, such as one devoted exclusively to becoming an effective rate review state in a market in which it is currently not. There is not a specified template for the Work Plan.

F. Budget and Budget Narrative

i. SF-424A

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

<u>Section A – Budget Summary</u>

- *Grant Program Function or Activity* (column a) = Enter "The Health Insurance Rate Review Grant Program, Cycle III" in row 1.

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

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

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

Section B – Budget Categories

- Enter the total costs requested for each Object Class Category (Section B, number 6) for each year of the project period. Under Section B, there are 5 columns (immediately below Grant Program, Function, or Activity). Rate Review Cycle III applicants should complete columns (1), (2), and (5).
- Column (1) = Enter Year 1 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all year 1 line items should be entered in column 1, row k (sum of row i and j).
- Column (2) = Enter Year 2 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all year 2 line items should be entered in column 2, row k (sum of row i and j). *If funding is only available to support an 18-month project period, then Year 2 should show the amount of funding requested for a six-month period.
- Column 5 = Enter total costs for the project period for each line item (rows a-h), direct total costs (row i), and indirect costs (row j). The total costs for all line items for the three years should be entered in row k (sum of row i and j). The total in column 5, row k should match the total provided in Section A – Budget Summary, New or Revised Budget, column g, row 5.

ii. Budget Narrative

Applicants must supplement Form SF-424A with a Budget Narrative. The Budget Narrative must include a yearly breakdown of costs according to an 18-month or 24-month project period (based upon information provided by HHS to states which submit the mandatory letter of intent). See Section II. *Award Information* for more information on the performance period. Applicants must include a clear description of the proposed set of services that will be covered with Rate Review funds. The Budget Narrative should provide a detailed cost breakdown for each line item outlined in the SF-424A by grant year, including a breakdown of costs for each activity/cost within the line item. The proportion of the requested funding designated for each activity should be clearly defined and should justify the applicant's readiness to receive funding. The budget must separate out funding that is administered directly by the lead agency from funding that will be subcontracted to other partners.

States may apply for and receive multiple awards under the Rate Review Grant program. As part of each application for funding, states must request funding only for activities not already funded/supported by a previous award. Each award made under this funding opportunity should support different activities and new funding should not be used for activities funded by prior awards. In the budget request, states should distinguish between activities that will be funded under this specific application and activities funded with other sources, including Cycle I and Cycle II Rate Review Grant awards.

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

- Estimated Budget Total.
- Current state funding for health insurance rate review and Data Center efforts, if the State currently devotes funding to such activities. The amount that was spent in the preceding fiscal year on rate review activities and/or Data Center activities for the Maintenance of Effort requirement (MOE).
- Total estimated funding requirements for each of the following line items, and a break down for each line item by grant year:
    - Personnel
    - Fringe benefits
    - Contractual costs, including subcontract contracts
    - Equipment
    - Supplies
    - Travel
    - Indirect charges, in compliance with the appropriate OMB Circulars. If requesting indirect costs in the budget, a copy of the indirect cost rate agreement is required.
    - Other costs
    - Completion of the Budget Form 424A remains a requirement for consideration of your application. This Estimated Budget Presentation is an important part of your proposal and will be reviewed carefully by HHS staff.
    - Provide budget notes for major expenditures and notes on personnel costs and major contractual costs.

G. Required Supporting Documentation:

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

a) Applicants must submit the following letters:

- Each application must include a letter from the Governor officially endorsing the grant application and the proposed program plan, except in two situations. In the case of the District of Columbia, a letter from the Mayor will be accepted. In the case of an independently elected Insurance Commissioner, a letter from the Insurance Commissioner will substitute for the letter from the Governor.
- If the applicant entity is not the same entity that has received or currently receives Rate Review Grant funding on behalf of the State, a letter, memorandum of understanding, or an agreement must be provided that delineates the different entities receiving funds, the coordination of timelines and the entity responsible for each of the activities must be submitted. All of the identified entities must demonstrate that they are coordinating so that they do not duplicate activities or supplant funds.
- If the applicant entity is not the state entity with the primary statutory and regulatory authority for the regulation of private health insurance, the applicant must include a letter from the Department of Insurance or the relevant state entity with primary statutory authority for the regulation of private health insurance. This letter must indicate that the Department of Insurance or relevant state entity will comply with the requirements of section 2794(b)(1), specifically that the entity will (A) provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State; and (B) make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified rate increases.
- State certification of Maintenance of Effort verifying that the grant funds will not supplant existing State expenditures for Rate Review or Data Center activities.

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

3. Submission Dates and Times:

All grant applications must be submitted electronically and be received through http://www.grants.gov by 4:00 pm **Eastern Daylight** Time on **August 1, 2013.**

4. Intergovernmental Review:

Applications for these grants are not subject to review by States under Executive Order 12372,

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

5. Funding Restrictions:

A. Indirect Costs and Cost Allocation Plans

If requesting indirect costs, a currently effective Indirect Cost Rate Agreement will be required. Applicants are required to use the rate agreed to in the Indirect Cost Rate Agreement. However, if there is not an agreed upon rate, the award (if the applicant is selected) may not include an amount for indirect costs unless the organization has never established an indirect cost rate (usually a new recipient) and intends to establish one. In such cases, the award shall include a provisional amount equaling one-half of the amount of indirect costs requested by the applicant, up to a maximum of 10 percent of direct salaries and wages (exclusive of fringe benefits). If the recipient fails to provide a timely proposal, indirect costs paid in anticipation of establishment of a rate will be disallowed. See the Health and Human Services Grants Policy Statement at http://www.hhs.gov/grantsnet/adminis/gpd/ for more information.

The provisions of 2 CFR Part 225 (previously OMB Circular A-87) govern reimbursement of indirect costs under this solicitation; and also include information about Cost Allocation Plans.

B. Reimbursement of Pre-Award Costs

As permitted by the cost principles under 2 CFR Part 225 (previously OMB Circular A-87) and further clarified by the Health and Human Services Grants Policy Statement, funds awarded under this FOA may be used to reimburse pre-award costs that are allowable and incurred up to 90 days before grant award that cannot be covered under existing funding from Rate Review Grants. The applicant must seek prior approval in writing before incurring pre-award costs. If a state does not receive a grant award, HHS is not liable for costs incurred by the applicant.

C. Prohibited Uses of Grant Funds

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

V. APPLICATION REVIEW INFORMATION

1. Criteria:

The Cycle III FOA provides states with the opportunity to (1) establish or enhance Rate Review activities; (2) complete Required Rate Reporting activities; and (3) establish or enhance health pricing transparency through Data Centers. Applicants will be evaluated according to the type of activities proposed and based on the information outlined in Sections III. *Eligibility Information* and IV. 2. *Content and Form of Application* Submission.

An objective of the Cycle III grants is that each state awarded a grant to fund Rate Review activities or Required Rate Reporting activities will, ***at a minimum***, ensure that its rate review process meets the requirements of an Effective Rate Review Program under the final rule and will be, or will begin to be, comprehensively reviewing rates pursuant to the proposed Effective Rate Review Program requirements at the start of or by the end of the first grant year of their Cycle III award period. This requirement has one exception: those states only applying for Data Center related activities will not be required to submit information related to their Effective Rate Review Program status. Such states, however, will be required to provide pricing data to the relevant agency or sub-agency that performs rate review activities.

To receive Cycle III funding for Rate Review Activities and/or Required Rate Reporting Activities, a state must demonstrate that as a result of receiving grant funds, the state will either: 1) have the needed resources to meet the Effective Rate Review Program requirements during Cycle III, or 2) continue to meet the Effective Rate Review Program requirements and build upon its current rate review process. A state that has received Cycle I or Cycle II grant funds but whose rate review process does not yet meet the effective review program requirements will need to explain why it has not yet met these requirements and demonstrate how, with Cycle III funding (and other changes if necessary), it will meet them. The State's Project Narrative and Work Plan will have to demonstrate how it will meet the criteria it does not already meet, and the milestones will have to specifically address the elements of the Effective Rate Review Program that the state does not currently meet. Further, the Project Narrative must include plans for disclosing rates to the public and to the Secretary as described in this section.

In order to receive a grant award for Cycle III of the Rate Review Grant Program, states must submit an application, in the required format, no later than the deadline date. If an applicant does not submit all of the required documents and does not address each of the topics described below, the applicant risks not being awarded a Cycle III grant.

Additional eligibility requirements apply to previous recipients of Cycle II funding, as described in Section III, 2. *Previous recipients of Cycle II funding*.

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

1. Standard Forms
2. Applicant's Cover Letter
3. Project Abstract

4. Project Narrative
5. Work Plan
6. Budget and Budget Narrative
7. Required Supporting Documentation

2. Review and Selection Process

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

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

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

3. Final award decisions will be made by an HHS program official. In making these decisions, the HHS program official will take into consideration the following: recommendations of the review panel; reviews for programmatic and grants management compliance; the reasonableness of the estimated cost to the government and anticipated results; and the likelihood that the proposed project will result in the benefits expected.

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

VI. Award Administration Information

1. <u>Award Notices</u>

Successful applicants will receive a Notice of Award signed and dated by an HHS Grants Management Officer. The Notice of Award is the document authorizing the grant award and it will be sent through electronic mail to the state as listed on the SF 424. Any communication between HHS and applicants prior to issuance of the Notice of 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 Act (FFATA) subaward Reporting Requirement: Awards issued under this FOA are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109–282), as amended

by section 6202 of Public Law 110–252 and implemented by 2 CFR Part 170. Grant recipients must report information for each 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. 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 cost principles and administrative requirements, as outlined in 2 CFR Part 225 (previously OMB Circular A-87) as well as 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, and
   iv. Title II Subtitle A of the Americans with Disabilities Act of 1990.

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

3. Terms and Conditions

Grants issued under this FOA are subject to the *Health and Human Services Grants Policy Statement (HHS GPS)* at http://www.hhs.gov/grantsnet/adminis/gpd/. Standard terms and special terms of award will accompany the Notice of 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 Award).

4. Intellectual Property

As a term and condition of a grant award, under 45 CFR 92.34, the Federal awarding agency reserves a royalty-free, nonexclusive, and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, for Federal Government purposes:(a) The copyright in any work developed under a grant, subgrant, or contract under a grant or subgrant; and (b) Any rights of copyright to which a grantee, subgrantee or a contractor purchases ownership with grant support.

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. HHS reserves the right to restrict funds for activities related to unmet milestones. More details of the quarterly report will be outlined in the Notice of Award. The report must include, but will not be limited to:

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

B. Annual Report

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

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

C. Final Report

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

D. Work Plan Updates

Each State will be required to submit an updated Work Plan along with the quarterly reports in order to exhibit progress toward identified milestones contained in the Work Plan. HHS Project Officers will track state progress using these updated Work Plans and progress made towards milestones.

E. Performance Review

HHS is interested in enhancing the performance of its funded programs within communities and states. As part of this agency-wide effort, grantees will be required to participate, where appropriate, in an on-site performance review of their HHS-funded

project(s) by a review team. The timing of the performance review is at the discretion of HHS.

F. Federal Financial Report (FFR)

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

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

In addition to submitting the quarterly FFR to PMS, Grantees must also provide, on an annual basis (and in the final report of the award), a completed SF 425 to CMS which includes their expenditures and any program income generated. The form is available at:

http://www.whitehouse.gov/sites/default/files/omb/assets/grants_forms/SF-425.pdf

More details will be outlined in the Notice of Award.

executives as outlined in Appendix A to 2 CFR Part 170 (available online at www.fsrs.gov).

G. Audit Requirements

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

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

Programmatic Contact

Programmatic questions about the "Grants to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing" can be directed to:

Sarah Norman
The Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
(301) 492-4185
Sarah.Norman@cms.hhs.gov

Grants Management Official/Business Administration

Michelle Feagins
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
(301) 492-4312
Michelle.Feagins@cms.hhs.gov

VIII. APPENDICES

APPENDIX A

Prohibited Uses of Grant Funds

The Department of Health and Human Services Grants for Rate Review Cycle III funds may not be used for any of the following:

1. To cover the costs to provide direct services to individuals.

2. To match any other Federal funds.

3. To provide services, equipment, or supports that are the legal responsibility of another party under Federal or State law (e.g.; vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.

4. To supplant existing State, local, or private funding of infrastructure or services such as staff salaries, etc.

Other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government, Grants for Rate Review Cycle III funds may not be used to pay the salary or expenses of any grant recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body. Grant recipients may lobby at their own expense if they can segregate federal funds from other financial resources used for that purpose.

APPENDIX B

Definitions

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

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

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

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

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

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

Group health insurance coverage offered in connection with a group health plan.

Group health plan — An employee welfare benefit plan (as defined in section 3(I) of ERISA [29 U.S.C. 10002(1)] to the extent that the plan provides medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

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

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

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

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

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

Health insurance issuer — An insurance company, insurance services, or insurance organization (including a health maintenance organization that is licensed to engage in the business of insurance in a State and which is subject to State law insurance regulations and statutes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX C

Application Check-Off List

REQUIRED CONTENTS

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

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

- ☐ Applicant's Application Cover Letter

- ☐ Project Abstract

- ☐ Project Narrative

- ☐ Rate Review Work Plan

- ☐ Budget Narrative

- ☐ Required Supporting Documentation
  - ☐ State Certification of Maintenance of Effort
  - ☐ Required Letters of Support (Governor, independently elected Insurance Commissioner, or Mayor of D.C.)
  - ☐ Descriptions of Key Personnel & Organizational Chart

- ☐ Coordination of funds letter, memorandum of understanding or other agreement (Only required if the applicant entity is not the same entity that has received or currently receives Rate Review Grant funding on behalf of the State)
- ☐ Satisfaction of required rate review reporting letter, as required by section 2794(b)(1) (Only required if the applicant entity is not the state entity with the primary statutory and regulatory authority for the regulation of private health insurance)

APPENDIX D

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

INTRODUCTION

This guidance is offered for the preparation of a budget request. Following this guidance will facilitate the review and approval of a requested budget by insuring that the required or needed information is provided. This is to be for done for each 12 month period of the grant project period. Applicants should be careful to only request funding for activities that will be funded by the Rate Review Cycle III Grant Program**.** In the budget request, States should distinguish between activities that will be funded under this grant and activities funded with other sources, including previous Rate Review Cycle I and II grant awards. Other funding sources also include other HHS grant programs and other funding sources as applicable.

A. Salaries and Wages

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

Sample budget

Personnel

Total $_____

Rate Review Grant $_____

Funding other than Rate Review Grant $_____

Sources of Funding_____

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

John Johnson

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

(Vacant)*

Sample Justification

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

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

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

B. Fringe Benefits

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

Sample Budget

Fringe Benefits

Total $_____

Rate Review Grant $_____

Funding other than Rate Review Grant $_____

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 $_____

Rate Review Grant $_____

Funding other than Rate Review Grant $_____

Sources of Funding_____

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

Sample Justification

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

E. Supplies

Individually list each item requested. Show the unit cost of each item, number needed, and total amount. Provide justification for each item and relate it to specific program objectives. If appropriate, General Office Supplies may be shown by an estimated amount per month times the number of months in the budget category.

Sample Budget

Supplies

Total $_____

Rate Review Grant $_____

Funding other than Rate Review Grant $_____

Sources of Funding_____

General office supplies (pens, pencils, paper, etc.)

12 months x $240/year x 10 staff	=	*$2,400*
Educational Pamphlets (3,000 copies @) $1 each)	=	*$3,000*
Educational Videos (10 copies @ $150 each)	=	*$1,500*
Word Processing Software (@ $400—specify type)	=	*$ 400*

Sample Justification

General office supplies will be used by staff members to carry out daily activities of the program. The education pamphlets and videos will be purchased from XXX and used to illustrate and promote safe and healthy activities. Word Processing Software will be used to document program activities, process progress reports, etc.

F. Travel

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

In-State Travel—Provide a narrative justification describing the travel staff members will perform. List where travel will be undertaken, number of trips planned, who will be making the trip, and approximate dates. If mileage is to be paid, provide the number of miles and the cost per mile. If travel is by air, provide the estimated cost of airfare. If per diem/lodging is to be paid, indicate the number of days and amount of daily per diem as well as the number of nights and estimated cost of lodging. Include the cost of ground transportation when applicable.

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

Sample Budget

Travel (in-State and out-of-State)

Total $_____

Rate Review Grant $_____

Rate Review Grant $_____

Sources of Funding_____

In-State Travel:

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

Sample Justification

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

Sample Budget

Out-of-State Travel:

1 trip x 1 person x $500 r/t airfare	=	*$500*
3 days per diem x $45/day x 1 person	=	*135*
1 night's lodging x $88/night x 1 person	=	*88*

Ground transportation 1 person = *50*

_____

Total *$773*

Sample Justification

The Project Coordinator will travel to HHS, in Atlanta, GA, to attend the HHS Conference.

G. Other

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

Sample Budget

Other

Total $_____

Rate Review Grant $_____

Funding other than the Rate Review Grant $_____

Sources of Funding_____

Telephone

($ ___ per month x ___ months x #staff) = *$ Subtotal*

Postage

($ ___ per month x ___ months x #staff) = *$ Subtotal*

Printing

($ ___ per x ___ documents) = *$ Subtotal*

Equipment Rental (describe)

($ ___ per month x ___ months) = *$ Subtotal*

Internet Provider Service

($___ per month x ___ months) = *$ Subtotal*

Sample Justification

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

Grant 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.

APPENDIX E

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

The "*Workload*" Funds:

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

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

Example: State **X**

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

State Population: 10,000,000

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

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

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

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

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

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

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

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

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

The "*Performance"* funds are to be allocated to those States that have authority to disapprove a rate, either at the time of the Cycle III award or, upon submission of proof that authority has been secured after the initial award date, on the date the authority becomes effective. If sufficient funds are available, "*Performance*" funds will be divided evenly among all eligible applicants.

APPENDIX F

Conflict of Interest Requirements

Section 2794(d)(2) of the Affordable Care Act states that a center "established under Section 2794(c)(1)(C) shall adopt by-laws that ensure that the center (and all members of the governing board of the center) is independent and free from all conflicts of interest. Such by-laws shall ensure that the center is not controlled or influenced by, and does not have any corporate relation to, any individual or entity that may make or receive payments for health care services based on the center's analysis of health care costs."

HHS interprets Section 2794(d)(2) to establish two conflict of interest requirements, as described below. For a state to be awarded a Cycle III grant for activities related to its Data Center, it must either: 1) meet both of these requirements at time of award; or 2) provide a feasible plan to come into compliance. No expenditures by the Data Center will be permitted until the by-laws comply.

I. Recusal

To ensure that a Data Center is independent and free from conflicts of interests, states must require Data Centers to establish by-laws that prohibit governing board members of the Data Centers from participating, directly or indirectly, in the selection, award or administration of any matter that gives rise to a potential conflict of interest involving the work of the Data Center. This would involve any situation in which a member could benefit, financially or otherwise, from the impact of the Data Center's work on payments for health care services made or received. For example, if a board member shares in the profits of a provider that could benefit by Data Center analysis showing that payments to providers should be higher, or the profits of an issuer that would benefit from analysis showing that payments should be lower, the governing board member must recuse himself or herself from the matter and notify a compliance official, the chairman of the Board, or other official appointed to address conflicts of interest.

II. Relationship between Data Center and individuals or entities that make or receive payments for health care services based on the center's analysis of health care costs

We interpret the provision of section 2794 addressing relationships with entities that make or receive payments that would be "based on" the data center's analysis to have been intended to ensure that those conducting data analysis are not controlled or influenced by, or financially related to, an individual or entity that could be in a position to "base" charges or payments for health care services on the Data Center's analysis. We understand that this provision was developed in response to evidence of collusion in a previous situation in which a Data Center performing analysis was a wholly-owned subsidiary of an entity in the health insurance industry

that would be directly affected by the analysis. To meet the conflict of interest requirements in section 2794(d)(2), the by-laws of the Data Center must include steps to ensure that this does not occur. For example, a Data Center or an individual involved in the activities related to the Data Center could ensure that, if it is related to an entity that either receives payment or makes payment for health care services, the individuals at that entity making decisions on payment amounts would agree not to base payment decisions in whole or in part on the Data Center's analysis. We do not believe that this provision would prevent the Data Center from being related to a provider or issuer that was only indirectly affected by the results of the Data Center's analysis on the marketplace generally. Another possible approach would be to ensure, if possible, that those at the Data Center actually conducting analysis be people who the Data Center would ensure were unaware of the relationship between the Data Center and the provider or issuer. CMS will be flexible in reviewing approaches to compliance with this provision.