



EHB-Benchmark Plan Modernization Grant for States with a Federally Facilitated Exchange

Opportunity number: CMS-2U2-25-001



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Before you begin

If you believe you are a good candidate for this funding opportunity, secure your [SAM.gov](#) and [Grants.gov](#) registrations now. If you are already registered, make sure your registrations are active and up-to-date.

SAM.gov registration (this can take several weeks)

You must have an active account with SAM.gov. This includes having a Unique Entity Identifier (UEI).

[See Step 2: Get Ready to Apply](#)

Grants.gov registration (this can take several days)

You must have an active Grants.gov registration. Doing so requires a Login.gov registration as well.

[See Step 2: Get Ready to Apply](#)

Apply by the application due date

Applications are due by 11:59 p.m. Eastern Time on January 15, 2025.



To help you find what you need, this NOFO uses internal links. In Adobe Reader, you can go back to where you were by pressing Alt + Left Arrow (Windows) or Command + Left Arrow (Mac) on your keyboard.



Step 1:

Review the Opportunity

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Basic information

Centers for Medicare and Medicaid Services (CMS)

Center for Consumer Information and Insurance Oversight

Helping states improve their essential health benefits.

Summary

We know it can be challenging for states to fund the work necessary to improve the Essential Health Benefits (EHB). Improving EHB typically involves:

- Comprehensively reviewing EHB-benchmark plans.
- Seeking public feedback on the coverage of EHB in the state.
- Submitting an application to CMS to change the EHB in the state.

We understand that, due in part to these challenges, that there are many states that have not considered updating their EHB-benchmark plans. These states include 24 of the 28 states expected to have a Federally Facilitated Exchange (FFE) as of January 1, 2026.

As a result, the covered benefits in the Qualified Health Plans (QHPs) offered through the Exchanges in these states may not reflect recent changes in medical evidence, scientific advancement, and clinical care guidelines. Additionally, people enrolled in these QHPs may have trouble accessing EHB because of cost, claims denials, utilization management, discriminatory benefit design, or other factors.

We want to lessen these challenges through the EHB-Benchmark Plan Modernization Grant for States with a Federally Facilitated Exchange (FFE EHB Mod Grant). This new grant program will fund states with an FFE for a variety of activities related to the review of EHB-benchmark plans. The goal is to help applicants modernize and change their EHB-benchmark plans under [45 CFR 156.111](#).



Have questions?
See [Contacts and Support](#).

Key facts

Opportunity name: EHB-Benchmark Plan Modernization Grant for States with a Federally Facilitated Exchange

Opportunity number: CMS-2U2-25-001

Announcement version: New

Federal assistance listing: 93.679

Key dates

Application deadline: January 15, 2025

Optional letter of intent deadline: December 16, 2024

Expected award date: March 14, 2025

Expected earliest start date: March 14, 2025.

See [other submissions](#) for other time frames that may apply to this NOFO.

Funding details

Type: Grant

Expected total funding for the program: \$10,500,000, subject to availability of funds.

Expected total awards: Up to 28.

Funding range per applicant for the period of performance:

- \$250,000 base award per applicant.
- An additional \$125,000 award for each applicant that decides to establish an advisory board as part of their project.

Total award amounts may increase depending on the number of eligible applications received.

We will provide funding in full for the three-year period of performance.

Eligibility

Eligible applicants

Government organizations

You are eligible for funding under this funding opportunity if you meet all of the following criteria:

- You are a state government's executive branch agency.
- You regulate the non-grandfathered^[1] individual and small group health insurance markets in the state, even if any of the following are true:
 - The state does not have statutory authority to enforce the EHB requirements.
 - The state is not otherwise enforcing the EHB requirements, or CMS has determined that the state is not substantially enforcing the EHB requirements.
- Your state must have an FFE as of January 1, 2026. The states expected to have an FFE as of January 1, 2026 are: AL, AK, AZ, DE, FL, HI, IN, IA, KS, LA, MI, MS, MO, MT, NE, NH, NC, ND, OH, OK, SC, SD, TN, TX, UT, WV, WI, and WY^[2]

Eligibility limitations

You are ineligible for funding under this funding opportunity if your state currently has a State-Based Exchange (SBE), including a State-based Exchange on the Federal Platform (SBE-FP) or an FFE that is anticipated to transition to an SBE as of January 1, 2026.

You may submit only one application under this NOFO.

In your [attachments](#), you must submit eligibility documentation including:

- A letter stating that the state is not receiving other federal grants for the same activities.
- A maintenance of effort certification.

Completeness and responsiveness criteria

We will review your application to make sure it meets the requirements found in [eligibility](#), [applications contents and format](#), and [application submission and deadlines](#).

We won't consider an application that:

- Is from an organization that doesn't meet all [eligibility criteria](#).
- Is submitted after the [deadline](#).
- Is not submitted through [Grants.gov](#).
- Does not address the program requirements.

The Division of Grants Director or Deputy Director may choose to continue the review process for an ineligible application if it is in the best interests of the government to meet the objectives of the program.

Cost sharing

This program has no cost-sharing requirement. If you choose to include cost-sharing funds, we will not consider it during review. However, we will hold you accountable for any funds you add, including requirements for grant reporting.

Program description

Purpose

The purpose of this funding opportunity is to provide funding to eligible states with an FFE to review and potentially change their EHB-benchmark plans because of:

- Enrollees experiencing difficulties in accessing needed services.
- Changes in medical evidence or scientific advancement
- Changes in the health needs of their populations.
- Other clinical considerations as authorized by the Affordable Care Act (ACA).

Background

Section 1301(a)(1)(B) of the ACA directs all QHP issuers to cover the EHB package described in section 1302(a) of the ACA.

The EHB package includes:

- Coverage of the services described in section 1302(b) of the ACA.
- Adherence to the cost-sharing limits described in section 1302(c) of the ACA
- Meeting the actuarial value levels established in section 1302(d) of the ACA.

[Section 2707\(a\) of the PHS Act](#), which is effective for plan or policy years beginning on or after January 1, 2014, extends the requirement to cover the EHB package to non-grandfathered individual and small group health insurance coverage, whether that coverage is offered through an Exchange.

[Section 1302\(b\) of the ACA](#) requires the Secretary of HHS to define the EHB and make sure that the EHB:

- Includes at least the following general categories and the items and services covered within the categories:
 - Ambulatory patient services.
 - Emergency services.
 - Hospitalization.
 - Maternity and newborn care.
 - Mental health and substance use disorder services.

- Including behavioral health treatment.
 - Prescription drugs.
 - Rehabilitative and habilitative services and devices.
 - Laboratory services.
 - Preventive and wellness services and chronic disease management.
 - Pediatric services, including oral and vision care.
- Is equal in scope to the benefits provided under a typical employer plan.
 - Reflect an appropriate balance among the categories, so that benefits are not unduly weighted toward any category.
 - Does not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life.
 - Takes into account the health care needs of diverse populations, including women, children, persons with disabilities, and other groups.
 - Makes sure that individuals are not denied essential health benefits on the basis of their age, expected length of life, present or predicted disability, degree of medical dependency, or quality of life.
 - Is periodically reviewed and updated to address any gaps in access to coverage, changes in medical evidence, or scientific advancement.

CMS defined the EHB using a benchmark-based approach in the February 25, 2013 [Federal Register \(78 FR 12834\) \(EHB Rule\)](#).

Under this approach, a health plan provides the EHB if it provides, among other things:

- Benefits that are substantially equal to the EHB-benchmark plan including covered benefits.
- Limitations on coverage (including coverage of benefit amount, duration, and scope) that are substantially equal to the EHB-benchmark plan.
- Prescription drug benefits that meet the requirements of [45 CFR 156.122](#).

Thus, a state's EHB-benchmark plan serves as a reference plan for benefits defined as EHB in the state.

States play an integral role in determining what benefits are included in EHB-benchmark plans. For plan years beginning on or after January 1, 2020, states select or change an EHB-benchmark plan by meeting the requirements at [45 CFR 156.111](#), which include certain actuarial analysis and confirmations that

the state's selected EHB-benchmark plan meets the scope of benefits requirements at § 156.111(b)(2).

CMS recently revised the requirements at [§ 156.111](#) in the April 15, 2024 [Federal Register \(89 FR 26218\) \(2025 Payment Notice\)](#), to make this process easier to understand and to undertake, with the ultimate goal of promoting more frequent EHB-benchmark plan changes to expand coverage. Twelve states, including only four states with an FFE (Alaska, Michigan, North Dakota, and South Dakota), have used [156.111](#) to add or expand coverage for certain benefits to EHB-benchmark plans since 2020.^[3]

Program requirements and expectations

At a minimum, you must use grant funds to perform the following activities. You may engage contractors such as actuarial, health policy, or clinical firms to help with all or some of these activities, under your guidance and direction.

You must do all of the following:

1. Undertake a comprehensive review of the state's current EHB-benchmark plan and consider potential changes based on your review.

At a minimum, you must:

- Identify whether enrollees are having trouble accessing the benefits in the state's EHB-benchmark plan for reasons of cost, claims denials, utilization management, discriminatory benefit design, or other factors. You may fulfill this analysis through statistically valid consumer surveys, engaging in outreach with interested parties such as consumer groups, and reviewing data on issuer claim denials, utilization management, or consumer complaints related to consumers enrolled in the FFE.
- Ensure health equity. To ensure that EHB-benchmark plans are designed to further health equity^[4] initiatives and address health care disparities, your analysis must address how the state's EHB-benchmark plan could be updated to better meet the needs of people:
 - With lower incomes.
 - Of all ages, including children and older adults.
 - With disabilities or who have a greater risk of developing serious health issues.
 - Of color.
 - Who identify as LGBTQIA+.

- In rural communities.
- Who have limited English proficiency.
- Who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality.
- Identify areas where the state's EHB-benchmark plan could be updated to account for changes in medical evidence, scientific advancement, and clinical care guidelines. This may involve consulting or contracting with one or more clinical experts to analyze the state's EHB-benchmark plan. For example, states could do one or more of the following:
 - Consider whether benefit visit and other limits are clinically based and meet the needs of a diverse population, or whether they are arbitrary.
 - Look at current EHB-benchmark coverage for particular conditions or scenarios, such as HIV, diabetes, infertility, chronic kidney disease, or developmental disabilities, and compare that coverage to generally accepted clinical guidelines.
 - Examine whether coverage prevents access to medical advancements such as new radiology and laboratory methods, cost-effective yet newer advancements such as silver diamine fluoride, or newer treatment modalities such as doula care and peer recovery support services.
- Identify areas where the state's EHB-benchmark plan could be updated to account for national and/or state healthcare concerns.
 - You must examine your EHB-benchmark plan for how it may account for nationwide health care concerns (such as the opioid epidemic or addressing mental health concerns).
 - You must also examine your EHB-benchmark plan for how it accounts for concerns that may be specific to the state (such as diabetes, obesity, or maternal health outcomes).
 - You must identify at least five areas where your EHB-benchmark plan may need to be modified or updated to account for a national healthcare concern, a state healthcare concern, or both.
- Perform a regional comparison analysis. You must assess how the state's EHB-benchmark plan's benefits compare to at least three other state EHB-benchmark plans in a nearby geographic region. This assessment must include whether there are differences in the scope of EHB (such as maternity and newborn care), benefits not covered as EHB for which there

is a public health need or expectation of coverage (such as durable medical equipment), or other deficiencies.

- Ensure the state's EHB-benchmark plan is clear and unambiguous. You must perform a comprehensive review of its EHB-benchmark plan to determine whether it is sufficiently clear which benefits are covered and the scope of benefits. If the plan is ambiguous in any way, you must consider how to make it clearer.

2. Submit a Section 508-compliant report to CMS for publication and publish the same report on a public state website.

The report must reflect the findings of your comprehensive review of your current EHB-benchmark plan, as described in the previous requirements.

3. For applicants that decide to submit pursuant to the process at 156.111(b)(2)(ii) before the end of the period of performance: Submit such an application to CMS by May 6, 2026, for effectiveness in plan year 2028, or by May 5, 2027, for effectiveness in plan year 2029.

We encourage you to submit an application to update your EHB-benchmark plan after the end of the award period, but the grant will not be extended to provide you with support. We urge you to apply to update your EHB-benchmark plans as a result of completing the requirements of this grant, but this application is not required.

States that decide to submit an EHB-benchmark plan submission before the end of the period of performance may use grant funds to conduct the required actuarial analysis to demonstrate that the state's new EHB-benchmark plan complies with the typicality regulatory requirements at 156.111(b)(2).[\[5\]](#)

You do not have to include your EHB-benchmark plan application in the report described in program requirement #2.

4. For applicants that decide to seek additional grant funds for an advisory board to advise the state: Applicants that create advisory boards may not require the advisory board to be responsible for completing other program requirements. At a minimum, a state's advisory board must:

- Include patients and patient representatives on the advisory board.
- Ensure the participation or perspective of persons:
 - With lower incomes.
 - Of all ages, including children and older adults.
 - With disabilities or who have a greater risk of developing serious health issues.

- Of color.
 - Who identify as LGBTQIA+.
 - In rural communities.
 - Who have limited English proficiency.
 - Who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality.
 - Be subject to a public notice and comment process to address updates and full public transparency on advisory board proceedings and materials.
- Be subject to disclosure and conflict of interest protocols.

Funding policies and limitations

Limitations

We do not allow the following costs:

- Pre-award costs.
- Meeting matching requirements for any other federal funds or local entities.
- Services, equipment, or supports that are the legal responsibility of another party under federal, state, or tribal law, such as vocational rehabilitation or education services, or under any civil rights laws, such as modifying a workplace or providing accommodations that are obligations under law.
- Goods or services not allocable to the project.
- Supplanting existing state, local, tribal, or private funding of infrastructure or services, such as staff salaries, etc.
- Construction.
- Capital expenditures for improvements to land, buildings, or equipment that materially increase their value or useful life as a direct cost, except with our prior written approval.
- The cost of independent research and development, including their proportionate share of indirect costs (see [45 CFR 75.476](#)).
- Funds related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order.
- Certain telecommunications and video surveillance equipment (see [2 CFR 200.216](#)).

- Meals, unless in limited circumstances such as:
 - Subjects and patients under study.
 - Where specifically approved as part of the project or program activity, such as in programs providing children's services.
 - As part of a per diem or subsistence allowance provided in conjunction with allowable travel.
- Costs that supplant funds for any other Notice of Funding Opportunity or Financial Assistance Program. You cannot use grant funds for the same grant activities for which you receive other federal grant dollars (for example, grant activities performed under the Expanding Access to Women's Health Grant). If you receive other federal grant dollars for these grant activities, you must explain in your budget narrative how other federal grant dollars are not used to perform grant activities performed under this grant.
- 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, funding awarded under this NOFO may **not** be used for:
 - Paying 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.
 - Lobbying, but awardees can lobby *at their own expense* if they can segregate federal funds from other financial resources used for lobbying.

Program-specific limitations

You must also follow these program-specific funding limitations:

- Funds requested in your budget must be derived from the approximate enrollment size of the off-Exchange market relative to the on-Exchange market in the states eligible to apply for this grant.
- You cannot use grant funds to account for a percentage of program requirements that impact enrollees in off-Exchange plans in the non-grandfathered individual and small group markets.

- On average, total enrollment in the FFEs accounts for approximately 80% of total enrollment in non-grandfathered individual and small group health insurance coverage in states with an FFE.
 - You are responsible for the remaining percentage of costs to perform program requirements. You must explain in your budget narrative how you plan to account for this proportion of costs to ensure that user fees funds are not used to impact non-grandfathered individual and small group health insurance coverage in the off-Exchange market in your state.
 - Specifically address how these costs will not be funded by user fees.
 - State employee salary hours (such as an actuary) may be used as non-federal share if grants funds are not supplanted.
 - Include the date of your most recently approved cost allocation plan.

Indirect costs

Indirect costs are those for a common or joint purpose across more than one project and that cannot be easily separated by project.

To charge indirect costs you can select one of two methods:

Method 1 – Approved rate. You currently have an indirect cost rate or cost allocation plan approved by your cognizant federal agency.

Method 2 – *De minimis* rate. Per [2 CFR 200.414\(f\)](#), if you have never received a negotiated indirect cost rate, you may elect to charge a *de minimis* rate. If you are awaiting approval of an indirect cost proposal you may also use the *de minimis* rate. If you choose this method, costs included in the indirect cost pool must not be charged as direct costs.

This rate is 15% of modified total direct costs (MTDC). See [2 CFR 200.1](#) for the definition of MTDC. You can use this rate indefinitely.

Salary rate limitation

The salary rate limitation in the current appropriations act applies to this program. As of January 2024, the salary rate limitation is \$221,900. We will update this limitation in future years.

Program income

Program income is money earned as a result of your award-supported project activities. You must use any program income you generate from awarded funds for approved project-related activities. Find more about program income at [45 CFR 75.307](#).

Statutory authority

Section 1311(d)(5)(A) of the ACA allows an Exchange to charge user fees to issuers of QHPs, “to support [the Exchange’s] operations.” CMS, as operator of the FFE in 28 states that have not elected to establish their own State-based Exchange, assesses user fees to issuers that offer QHPs on an FFE. In addition, section 1311(e)(1)(B) of the ACA also requires an Exchange to ensure that health plans available through the Exchange are in the interests of qualified individuals and qualified employers in the state.



Step 2:

Get Ready to Apply

In this step

Get registered

Get registered

SAM.gov

You must have an active account with SAM.gov. This includes having a Unique Entity Identifier. SAM.gov registration can take several weeks. Begin that process today.

To register, go to [SAM.gov Entity Registration](#) and select Get Started. From the same page, you can also select the Entity Registration Checklist for the information you will need to register.

When you register or update your SAM.gov registration, you must agree to the [financial assistance general certifications and representations](#). You must agree to those for grants specifically, as opposed to contracts, because the two sets of agreements are different. You will have to maintain your registration throughout the life of any award.

Grants.gov

You must also have an active account with [Grants.gov](#).

You can see step-by-step instructions at the Grants.gov [Quick Start Guide for Applicants](#).

Need help? See [Contacts and Support](#).

Find the application package

The application package has all the forms you need to apply. You can find it online. Go to [Grants Search at Grants.gov](#) and search for opportunity number CMS-2U2-25-001.



Step 3:

Prepare Your Application

In this step

Application contents and format

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Application contents and format

Applications include five main components. The following sections include guidance and instructions on the required format for each.

You can find all referenced forms within the funding opportunity's [application package on Grants.gov](#).

Make sure you include each of these:

Component	Submission format
Project abstract	Use the Project Abstract Summary form.
Project narrative	Use the Project Narrative Attachment form.
Budget narrative	Use the Budget Narrative Attachment form.
Attachments	Insert each in the Other Attachments form.
Other required forms	Upload using each required form.

See requirements for [other submissions](#).

Your organization's authorized organizational representative (AOR) must certify and submit your application.

We will provide instructions on document formats in the following sections.

See [completeness and responsiveness criteria](#) to understand what may disqualify your application from consideration.

Project abstract

Limit to one page. May be single spaced but follow other formatting requirements listed for the [project narrative](#).

Write a one-page summary of your proposed project including the purpose and outcomes. Do not include any proprietary or confidential information. We will use this document for information sharing and public information requests if you get an award.

Include:

- The name of your state.
- Project goals.
- Total budget amount.
- A description of how you will use the funds.

Project narrative

Required format for project narrative

Page limit: 15, excluding attachments

File name: Project Narrative

Format: PDF (Do not compress or encrypt)

Size: 12-point font or bigger

Footnotes and text in graphics may be 10-point.

Spacing for project abstract, tables, and footnotes: Single-spaced

Spacing for main content: Double-spaced

Margins: 1-inch

Page size: 8.5 x 11

Include consecutive page numbers throughout.

The project narrative is the most important part of your application and should clearly describe your proposed project. You must address the proposed goals, measurable objectives, and milestones in accordance with the instructions in the following sections.

See the [merit review criteria](#) to understand how reviewers will assess and score your project narrative.

Your project narrative should include the following four sections:

- Capabilities
- Proposed activities
- Project goals
- Work plan and timeline

1. Capabilities

Why are you qualified to review and assess the items and services covered or not covered as EHB in your state?

To demonstrate your eligibility, describe how you meet both of the following criteria:

- Be an executive branch agency of a state government that regulates the non-grandfathered individual and small group health insurance market in the state.
- Plan to have a Federally Facilitated Exchange for years beginning on or after January 1, 2026.
- To demonstrate your capability, describe your procedural requirements to review and update EHBs, which may include coordination with your state legislature as well as certain public engagement requirements.

2. Proposed activities

What are you going to do?

Describe your proposed project and how you will carry out all the program requirements. Explain how you will do all of the following:

- Identify whether enrollees are having trouble accessing the benefits in your EHB-benchmark plan for reasons of cost, claims denials, utilization management, discriminatory benefit design, or other factors.
- Identify areas where your EHB-benchmark plan could be updated to account for changes in medical evidence, scientific advancement, and clinical care guidelines.
- Identify areas where your EHB-benchmark plan could be updated to account for national and/or state healthcare concerns.
- Perform a regional comparison analysis.
- Ensure the state's EHB-benchmark plan is clear and unambiguous.
- Submit a Section 508-compliant report to CMS for publication and publish the same report on a public state website. The report should reflect your findings in undertaking a comprehensive review of the state's current EHB-benchmark plan within three years of the grant award.
- For applicants that decide to submit an EHB-benchmark plan application before the end of the period of performance: Submit such an application to CMS by May 6, 2026, for effectiveness in plan year 2028 or by May 5, 2027, for effectiveness in plan year 2029.

- For applicants that decide to seek additional grant funds: Create an advisory board to advise the state in completing program requirements.

3. Project goals

What do you expect to achieve?

The goal of the grant opportunity is to fund state review of EHB-benchmark plans for states with an FFE to:

- Describe what barriers you anticipate enrollees may be facing accessing the benefits in its EHB-benchmark plan for reasons of cost, claims denials, utilization management, discriminatory benefit design, or other factors. Take into account medical evidence, scientific advancement, and clinical care guidelines.
- Identify barriers inhibiting enrollees from accessing care.
- Ensure that EHB-benchmark plans account for medical and scientific advancements in care.
- Identify areas where the state's EHB-benchmark plan may warrant modification or updates to account for national and/or state healthcare concerns. You must examine your EHB-benchmark plan for how it may account for nationwide health care concerns (such as the opioid epidemic or addressing mental health concerns) and for how it accounts for concerns that may be specific to their state (such as diabetes, obesity, or maternal health outcomes). identify at least five areas (distributed between the following at the state's discretion) where your EHB-benchmark plan may need to be modified or updated to account for both of the following:
 - Any national healthcare concerns.
 - Any healthcare concerns unique to the state. Conduct a review of its EHB-benchmark plan to ensure it is sufficiently clear which benefits are covered and the scope of benefits, and if ambiguity exists, how it may be revised.
- Create and submit a section 508 compliant report to CMS for publication as well as your public state website. This report will include your findings in undertaking a comprehensive review of your current EHB-benchmark plan, as described.

4. Work plan and timeline

What is your action plan to meet the project goals and carry out the program requirements?

Your work plan must outline specific milestones for your proposed project and state how you will, at a minimum, carry out all the program requirements. These milestones must be articulated clearly, measurable, and appropriate for the period of performance. The milestones should include all of the following:

- When you anticipate you will be able to contract with or hire new staff or consultants such as actuaries, clinicians, and health policy experts, if applicable.
- When you expect to conduct research in line with the program requirements.
- **If applicable:** Which EHB-benchmark application period, you expect to update the EHB-benchmark plan during.
- **If applicable:** When you would create an advisory board and how often the advisory board would meet.

You will need to procure contractor assistance as soon as practicable after the grant award. The three-year period of performance is such that you should be able to procure support and complete all activities without the need for extending the period.

Budget narrative

The budget narrative supports the information you provide in Standard Form 424-A. See [other required forms](#). It includes added detail and justifies the costs you ask for. As you develop your budget, consider:

- If the costs are reasonable and consistent with your project's purpose and activities.
- The restrictions on spending funds. See [funding policies and limitations](#).
- HHS now uses the definitions for [equipment](#) and [supplies](#) in 2 CFR 200.1. The new definitions change the threshold for equipment to the lesser of the recipient's capitalization level or \$10,000 and the threshold for supplies to below that amount.

To create your budget narrative, see [detailed instructions and a template](#) on our website.

In your budget narrative, you will:

- Identify a PI/PD who will dedicate sufficient time and effort to manage and provide oversight of the grant program.
- Include a yearly breakdown of costs for each line item in your SF-424A.
- Describe the proposed costs for each activity or cost within the line item.
- Define the proportion of the requested funding designated for each activity.
- Justify the costs, including how you calculated them.
- Provide an overall estimated budget for the entire three-year period of performance, that is, the total costs across all three years.
- Explain how you separate costs and funding administered directly by you as the lead agency, from funding you subaward to other consortium members.
- Be clear about how costs link to each activity and the goals of this program.
- Explain in your budget narrative how you plan to account for this proportion of costs to ensure that user fees funds are not used to impact non-grandfathered individual and small group health insurance coverage in the off-Exchange market in your state. Applicants that seek additional funding to create an advisory board may not utilize the board to complete other program requirements. However, at a minimum, a state's advisory board must:

To create your SF-424A and budget narrative, see detailed instructions in [CMS Guidance for Preparing a Budget Request and Narrative](#) on our website.

See [merit review criteria](#) to understand how reviewers will assess and score your budget narrative.

Required format for budget narrative

Page limit: 10

File name: Budget Narrative

File format: PDF (Do not compress or encrypt.)

Font size: 12-point or larger

Spacing: Single-spaced

Margins: 1-inch

Page size: 8.5 x 11

Include consecutive page numbers throughout.

Attachments

You will upload attachments in [Grants.gov](https://www.grants.gov) using the Other Attachments Form. Attachments do not count against application page limits.

Do not include additional attachments not requested in the NOFO. Reviewers will not review any attachments that are not listed here.

Indirect cost agreement

If you include indirect costs in your budget using an approved rate or cost allocation plan, include a copy of your current agreement approved by your [cognizant agency for indirect costs](#). If you use the *de minimis* rate, you do not need to submit this attachment. See [CMS Guidance for Preparing a Budget Request and Narrative](#).

Resume and job descriptions for key personnel

For key personnel, such as the authorized organizational representative (AOR) and principal investigator/project director (PI/PD), attach resumes for positions that are filled. If a position isn't filled, attach the job description with qualifications you plan to use for recruitment.

Business assessment of applicant organization

Maximum 12 pages, single spaced.

CMS must assess your organization's risk before we can make an award. This analysis includes your organization's:

- Financial stability.

- Quality of management systems.
- Internal controls.
- Ability to meet the management standards prescribed in [45 CFR Part 75](#).

For us to complete your assessment, you must review, answer, and attach the completed business assessment questions found on our website at [Business Assessment of Applicant Organization](#).

Organizational chart

Submit an organizational chart clearly identifying the reporting relationships of key personnel assigned to implementing the grant.

Eligibility documentation

You must submit both of the following:

- A letter attesting that the State is not receiving other federal grant dollars for the same activities for which it will receive (if awarded) EHB-Benchmark Plan Modernization Grant for States with a Federally Facilitated Exchange funds, signed by the head of the applicable State regulatory agency.
- A State certification of Maintenance of Effort verifying that the grant funds will not supplant existing State expenditures for related EHB-Benchmark Plan Modernization, or related activities, signed by the head of the applicable State regulatory agency.

Other required forms

You will need to complete four other required forms. Submit the following required forms through Grants.gov. You can find the forms in the [NOFO application package](#) or review them and their instructions at [Grants.gov Forms](#).

Forms	Submission Requirement
Application for Federal Assistance (SF-424)	With the application. See extra instructions .
Budget Information for Non-Construction Programs (SF-424A)	With the application.
Disclosure of Lobbying Activities (SF-LLL)	With the application.
Project/Performance Site Location(s) Form	With the application.

Extra instructions for SF-424: Official Application for Federal Assistance

Special instructions include:

- To write your Descriptive Title of Applicant's Project in Item 15, see [Writing a Strong Descriptive Title](#) on our website.
- Check No to item 19c. State review under [Executive Order 12372](#) does not apply .
- Your [authorized organizational representative \(AOR\)](#) must electronically sign this form. The AOR is the person who can make legally binding commitments for your organization. When the AOR authorizes an application, they agree to assume all award obligations.



Step 4:

Learn About Review and Award

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Application review

Initial review

We review each application to make sure it meets basic requirements.

We will review your application to make sure that it meets both the [completeness and responsiveness criteria](#). If your application does not meet these criteria, we will not move it to the merit review phase.

We will not review any pages that exceed the page limit.

Criterion	Total number of points = 100
Project narrative sections 1, 2, and 3	60 points
Project narrative section 4	30 points
Budget narrative	10 points

Merit review

A merit review panel reviews all applications that pass the initial completeness and responsiveness review. The members use the following criteria. For more information, see [Review and Selection Process](#) on our website.

Criteria

Project narrative section 1 Capabilities: Why are you qualified to review and assess the items and services covered or not covered as EHB in your state?	Maximum points: 20
Describe the executive branch agency that will perform the activities under this funding opportunity.	4 points
Demonstrate how you will regulate the non-grandfathered individual and small group health insurance market in the state.	4 points
Describe your procedural requirements to review and update EHBs in your state, which may include coordination with your state legislature as well as certain public engagement requirements.	4 points
Describe your plan to have a Federally Facilitated Exchange for years beginning on or after January 1, 2026.	2 points
In your attachments , include an organizational chart clearly identifying the reporting relationships of key personnel assigned to implementing the grant.	4 points
In your attachments , include a resume or curriculum vitae for each individual identified as key personnel in the organizational chart. If key personnel have not yet been hired, provide a hiring strategy and job descriptions.	2 points

Project narrative section 2 Proposed activities: What are you going to do?	Maximum points: 20
Identify whether enrollees are having trouble accessing the benefits in your EHB-benchmark plan for reasons of cost, claims denials, utilization management, discriminatory benefit design, or other factors.	4 points
Identify areas where your EHB-benchmark plan could be updated to account for changes in medical evidence, scientific advancement, and clinical care guidelines.	4 points
Identify areas where your EHB-benchmark plan could be updated to account for national and/or state healthcare concerns.	4 points
Perform a regional comparison analysis.	2 points
Ensure the state's EHB-benchmark plan is clear and unambiguous.	2 points
Submit a Section 508-compliant report to CMS for publication and publish the same report on a public state website. The report should reflect your findings in undertaking a comprehensive review of the state's current EHB-benchmark plan within three years of the grant award.	2 points
For applicants that decide to submit an EHB-benchmark plan application before the end of the period of performance: Submit such an application to CMS by May 6, 2026, for effectiveness in plan year 2028, or by May 5, 2027, for effectiveness in plan year 2029.	2 points

Project narrative section 3	
Project goals: What do you expect to achieve?	Maximum points: 20
Describe your project goals for carrying out the program requirements during the three-year period of performance:	
Describe what barriers you anticipate enrollees may be facing accessing the benefits in its EHB-benchmark plan for reasons of cost, claims denials, utilization management, discriminatory benefit design, or other factors.	4 points
Ensure health equity. Identify populations that may be at-risk of health inequality and how the state's EHB-benchmark plan may warrant modification to better meet the needs of people: • With lower incomes. • Of all ages, including children and older adults. • With disabilities or who have a greater risk of developing serious health issues. • Of color. • Who identify as LGBTQIA+. • In rural communities. • Who have limited English proficiency. • Who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality.	4 points
Identify areas where the state's EHB-benchmark plan may warrant modification or updates to account for changes in medical evidence, scientific advancement, and clinical care guidelines. This may involve consulting or contracting with one or more clinical expert(s) to analyze the state's EHB-benchmark plan, taking into account medical evidence, scientific advancement, and clinical care guidelines.	3 points
Identify areas where the state's EHB-benchmark plan may warrant modification or updates to account for national and/or state healthcare concerns. You must examine your EHB-benchmark plan for how it may account for nationwide health care concerns (such as the opioid epidemic or addressing mental health concerns) and for how it accounts for concerns that may be specific to their state (such as diabetes, obesity, or maternal health outcomes). You must identify at least five areas (distributed between the following at the state's discretion) where a your EHB-benchmark plan may need to be modified or updated to account for both of the following: • Any national healthcare concerns. • Any healthcare concerns unique to the state.	3 points

Project narrative section 3	
Project goals: What do you expect to achieve?	
Conduct a review of its EHB-benchmark plan to ensure it is sufficiently clear which benefits are covered and the scope of benefits, and if ambiguity exists, how it may be revised.	3 points
Create a Section 508-compliant report to CMS for publication and on a public state website that reflects your findings in undertaking a comprehensive review of your current EHB-benchmark plan, described above.	3 points
Project narrative section 4	
Work plan and timeline: What is your action plan to meet the project goals and carry out the program requirements?	
Maximum points: 30	
Address all the components of your project goals. Your work plan must outline specific milestones for your proposed project and how you will, at a minimum, carry out each of the program requirements. These milestones must be articulated clearly, be measurable, and be appropriate for the period of performance.	14 points
Include a timeline of milestones for your proposed project and how you will, at a minimum, carry out all the program requirements. These milestones must be articulated clearly, be measurable, and be appropriate for the period of performance. The milestones should include:	
When you anticipate you will be able to contract or hire with new staff or actuaries.	6 points
When you expect to conduct research, and which projects you plan to take on in line with the six program requirements.	10 points
Budget narrative	
Maximum points: 10	
Provide a detailed budget that follows the instructions in the budget section for the period of performance.	6 points
Request funds that are reasonable based on the total available funding and that link each activity to the goals of this program.	2 points
Request funds that are reasonable based on proposed project goals. Identify any non-CMS funding sources and the value of such funding and describe how the funding will be integrated into the project.	2 points

Risk review

Before making an award, we review the risk that you will not prudently manage federal funds. We need to make sure you've handled any past federal awards well and demonstrated sound business practices. We use SAM.gov [Responsibility/Qualification](#) to check this history for all awards likely to be over \$250,000. You can comment on your organization's information in SAM.gov. We'll consider your comments before making a decision about your level of risk.

If we find a significant risk, we may choose not to fund your application or to place specific conditions on the award.

For more details, see [45 CFR 75.205](#).

Selection process

CMS selects recipients at our sole discretion unless the authorizing statute says otherwise. Our selections are not subject to administrative or judicial review, per Section 1115A(d)(2)(B) of the Social Security Act.

When making funding decisions, we consider:

- Merit review results. These are key in making decisions but are not the only factor.
- Program office technical recommendations.
- Advice from other federal officials, advisory bodies, consultants, or others as documented in the NOFO.
- The larger portfolio of agency-funded projects, including the diversity of project types and geographic distribution.
- The past performance of the applicant. We may choose not to fund applicants with management or financial problems. See [risk review](#).

We may:

- Fund applications in whole or in part.
- Fund applications at a lower amount than requested.
- Decide not to allow a prime recipient to subaward if they may not be able to monitor and manage subrecipients properly.
- Choose to fund no applications under this NOFO.

Award notices

If you are successful, your authorized organizational representative (AOR) will receive an email notification from GrantSolutions. You can then retrieve your Notice of Award (NoA). We will email you if your application is incomplete or unresponsive.

The NoA is the only official award document. The NoA tells you about the amount of the award, important dates, and the terms and conditions you need to follow. Until you receive the NoA, you don't have permission to start work.

By drawing down funds, you accept the terms and conditions of the award. The NoA incorporates the requirements of the program and funding authorities, the grant regulations, the [HHS Grants Policy Statement](#), and the NOFO.

If you want to know more about NoA contents, go to [Notice of Award](#) on our website.



Step 5:

Submit Your Application

In this step

Application submission and deadlines

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Application submission and deadlines

See [find the application package](#) to make sure you have everything you need.

Make sure you are current with SAM.gov and UEI requirements. See [get registered](#).

You will have to maintain your registration throughout the life of any award.

Deadlines

Optional letter of intent

Due by December 16, 2024.

See [letter of intent details](#).

Application deadline

Due on January 15, 2025, at 11:59 p.m. ET.

[Grants.gov](#) creates a date and time record when it receives the application. If you submit the same application more than once, we will accept the last on-time submission.

The grants management officer may extend an application due date based on emergency situations such as documented natural disasters or a verifiable widespread disruption of electric or mail service.

Submission methods

Grants.gov

You must submit your application through Grants.gov. See [get registered](#).

For instructions on how to submit in Grants.gov, see the [Quick Start Guide for Applicants](#). Make sure your application passes the Grants.gov validation checks. Do not encrypt, zip, or password protect any files.

Other submissions

Optional letter of intent

We ask that you let us know if you plan to apply for this opportunity. We do this to plan for the number of expert reviewers we will need to evaluate applications. You do not have to submit a letter of intent to apply.

Please email the notice to PMPolicy@cms.hhs.gov.

In your email, include:

- The funding opportunity number and title
- Your organization's name and address
- A contact name, phone number, and email address
- An expression of your interest
- The proposed regions of participation
- A brief description of your organization

See the [deadline](#) for letters of intent.

Intergovernmental Review

This NOFO is not subject to executive order 12372, Intergovernmental Review of Federal Programs. No action is needed other than checking “No” on the [SF-424 box 19c](#).

Assurance of compliance

If you receive an award, you must follow all applicable nondiscrimination laws. You agree to this when you register in [SAM.gov](#).

You and all subrecipients, including contractors, must also submit an [Assurance of Compliance, HHS-690](#). You will find instructions on how to submit it at the bottom of the form.

To learn more, see the [HHS Office for Civil Rights](#) website.

Application checklist

Make sure that you have everything you need to apply:

Component	How to upload	Page limit
☐ Project abstract	Use the Project Abstract Summary Form.	1 page
☐ Project narrative	Use the Project Narrative Attachment form.	15 pages
☐ Budget narrative	Use the Budget Narrative Attachment form.	10
Attachments (5 total)	Insert each in a single Attachments form.	
☐ Indirect cost agreement		None
☐ Resumes and job descriptions for current and prospective key personnel		None
☐ Business assessment of applicant organization		12 pages
☐ Organizational chart		1 page
☐ Eligibility documentation		None
Other required forms (4 total)	Upload using each required form.	
☐ SF-424 (Application for Federal Assistance)		None
☐ SF-424A: Budget Information for Non-Construction Programs		None
☐ Project/Performance Site Locations		None
☐ Disclosure of Lobbying Activities (SF-LLL)		None



Step 6:

Learn What Happens After Award

In this step

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Post-award requirements and administration

Administrative and national policy requirements

There are important rules you need to know if you get an award. You must follow:

- All terms and conditions in the Notice of Award. See [CMS Standard Terms and Conditions](#).
- We incorporate this NOFO by reference.
- The rules listed in [45 CFR part 75](#), Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, or any superseding regulations. Effective October 1, 2024, HHS adopted the following superseding provisions:
 - [2 CFR 200.1](#), Definitions, Modified Total Direct Cost.
 - [2 CFR 200.1](#), Definitions, Equipment.
 - [2 CFR 200.1](#), Definitions, Supplies.
 - [2 CFR 200.313\(e\)](#), Equipment, Disposition.
 - [2 CFR 200.314\(a\)](#), Supplies.
 - [2 CFR 200.320](#), Methods of procurement to be followed.
 - [2 CFR 200.333](#), Fixed amount subawards.
 - [2 CFR 200.344](#), Closeout.
 - [2 CFR 200.414\(f\)](#), Indirect (F&A) costs.
 - [2 CFR 200.501](#), Audit requirements.
- The [HHS Grants Policy Statement \(GPS\)](#). This document has terms and conditions tied to your award. If there are any exceptions to the GPS, they'll be listed in your Notice of Award.
- All federal statutes and regulations relevant to federal financial assistance, including those highlighted in the [HHS Administrative and National Policy Requirements](#).
- Federal laws regarding accessibility if you receive a request for information in accessible formats. See [CMS Accessibility Requirements](#) on our website.

Reporting

If you are successful, you will have to submit financial and performance reports. Reporting requirements include:

- Semiannual Progress Reports.
- Federal Financial Reports (FFR).
- Federal Funding Accountability and Transparency Act ([FFATA](#)).
- Federal Awardee Performance and Integrity Information System (FAPIIS).
- Payment Management System (PMS).
- Audit reporting (Federal Audit Clearinghouse).
- Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification.

For more information on reporting, see [Post-Award Reporting Requirements](#) on our website.

Continued eligibility

Continued funding is contingent on satisfactory progress, compliance with the terms and conditions, and the availability of funds.

For CMS to issue you continuation funding, you must demonstrate satisfactory progress. If we issue all the funding in the first year, then you must continue to show satisfactory progress to maintain access to your funds. CMS may adjust awards to a lower amount if the applicant fails to meet performance milestones.

At any time, we could decrease funding or terminate your award if you fail to perform the requirements of the award. [See 45 CFR 75.372](#), Termination.

Satisfactory progress for selected award recipients includes, but is not limited to:

- Satisfactory performance for selected award recipients includes but is not limited to meeting the milestones proposed in the grant application and outlined in the Work Plan to continue to be eligible throughout the project period.

Health information technology interoperability

If you receive an award, you must agree to the following conditions when implementing, acquiring, or upgrading health IT. These conditions also apply to all subrecipients.

- Compliance with [45 CFR part 170, subpart B](#). Make sure your activities meet these standards if they support the activity.
- Certified Health IT for Eligible Clinicians and Hospitals. Use only health IT certified by the [ONC Health IT Certification Program](#) for activities related to Sections 4101, 4102, and 4201 of the HITECH Act.

If 45 CFR part 170, subpart B standards do not support the activity, we encourage you to:

- Use health IT that meets non-proprietary standards.
- Follow specifications from consensus-based standards development organizations.
- Consider standards identified in the [ONC Interoperability Standards Advisory](#).

Cybersecurity requirements

You must create a cybersecurity plan if your project involves both of the following conditions:

- You have ongoing access to HHS information or technology systems.
- You handle personal identifiable information (PII) or personal health information (PHI) from HHS.

You must base the plan on the [NIST Cybersecurity Framework](#). Your plan should include the following steps:

Identify:

- List all assets and accounts with access to HHS systems or PII/PHI.

Protect:

- Limit access to only those who need it for award activities.
- Ensure all staff complete annual cybersecurity and privacy training. Free training is available at 405(d): Knowledge on Demand (hhs.gov).
- Use multi-factor authentication for all users accessing HHS systems.
- Regularly backup and test sensitive data.

Detect:

- Install antivirus or anti-malware software on all devices connected to HHS systems.

Respond:

- Create an incident response plan. See [Incident-Response-Plan-Basics_508c.pdf \(cisa.gov\)](#) for guidance.
- Have procedures to report cybersecurity incidents to HHS within 48 hours. A cybersecurity incident is:
 - Any unplanned interruption or reduction of quality, or
 - An event that could actually or potentially jeopardize confidentiality, integrity, or availability of the system and its information.

Recover:

- Investigate and fix security gaps after any incident.

Non-discrimination and assurance

If you receive an award, you must follow all applicable nondiscrimination laws. You agree to this when you register in SAM.gov. You must also submit an Assurance of Compliance ([HHS-690](#)). To learn more, see the [Laws and Regulations Enforced by the HHS Office for Civil Rights](#).



Contacts and Support

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Agency contacts

Program and eligibility

For questions related to grant eligibility, please email PMPolicy@cms.hhs.gov.

Administration and budget

For administrative and budget related questions, please email PMPolicy@cms.hhs.gov.

Grants.gov

Grants.gov provides 24/7 support. You can call 1-800-518-4726 or email support@grants.gov. Hold on to your ticket number.

SAM.gov

If you need help, you can call 866-606-8220 or live chat with the [Federal Service Desk](#).

Reference websites

- [U.S. Department of Health and Human Services \(HHS\)](#)
- [CMS Grants and Cooperative Agreements](#)
- [Grants.gov Accessibility Information](#)
- [Code of Federal Regulations \(C.F.R.\)](#)
- [United States Code \(U.S.C.\)](#)

Endnotes

1. Grandfathered plans are health plans created or purchased on or before March 23, 2010 that meet the criteria outlined in 45 C.F.R. § 147.140. [↑](#)
2. For a list of State-based Exchanges (SBEs) and State-based Exchanges on the Federal Platform (SBE-FPs) that would not be eligible to receive funding from this grant, please visit the [State-based Exchanges page on cms.gov](#). Because Illinois intends to operate an SBE by January 1, 2026, it is not listed as an eligible state. [↑](#)
3. See [information on essential health benefits \(EHB\) benchmark plans](#) for more details on the specific EHB-benchmark plan changes since 2020. [↑](#)
4. [CMS.gov, Health Equity](#). [↑](#)
5. Under 45 CFR 156.111(b)(2)(ii), the typical employer plans are defined as: one of the selecting State's 10 base-benchmark plan options established at § 156.100, and available for the selecting State's selection for the 2017 plan year; or the largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the State (provided that: the product has at least 10 percent of the total enrollment of the five largest large group health insurance products in the State; the plan provides minimum value, as defined under § 156.145; the benefits are not excepted benefits, as established under § 146.145(b), and § 148.220; and the benefits in the plan are from a plan year beginning after December 31, 2013. [↑](#)