DEPARTMENT OF HUMAN SERVICES

Appendix A: Eligible providers and provider delivery locations for AE

Who is eligible to participate in TMaH?

Eligible Partner Delivery Locations may include but are not limited to hospitals, Birth Centers, obstetrician-gynecology practices, mental and behavioral health practices, FQHCs/clinics, Tribal sites, and other points of care.

Eligible Partner Providers may include but are not limited to obstetrician-gynecologists, all types of midwives, physicians, fetal medicine specialists, nurses, mental and behavioral health practitioners, and other clinical and support staff, such as doulas, home visiting staff, lactation consultants, and Perinatal Community Health Workers.

Locations and Providers must provide care and services in Hennepin County, where the model is piloting.

At the time of application, providers at applying organizations must meet one of the following conditions:

- enrolled as a Minnesota Medicaid provider,
- contracted with a Minnesota managed care plan, or
- employed with an organization supporting Medicaid beneficiaries.

Providers must be licensed and/or credentialed and in good standing with applicable state and federal oversight bodies and must have or obtain a National Provider Identifier through the National Plan and Provider Enumeration System to bill for services.

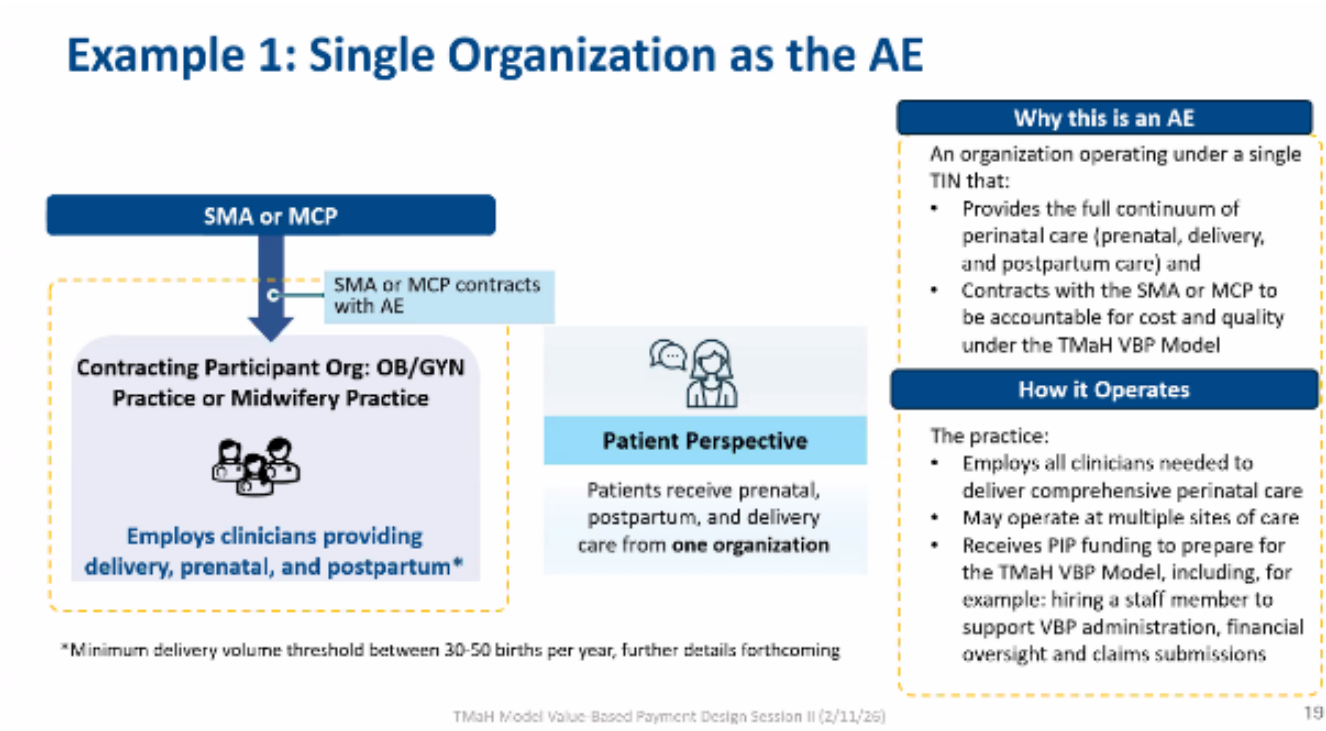
TMaH is encouraging eligible organizations to partner and apply together in alignment with model components. MN's TMaH model is strongly encouraging the inclusion of safety net providers and community organizations. Partners will determine how the partnership would function and how payments would be split across care and services. Partners will share proposed structure in the application. Partnership and collaboration within the model could operate in a few different ways.

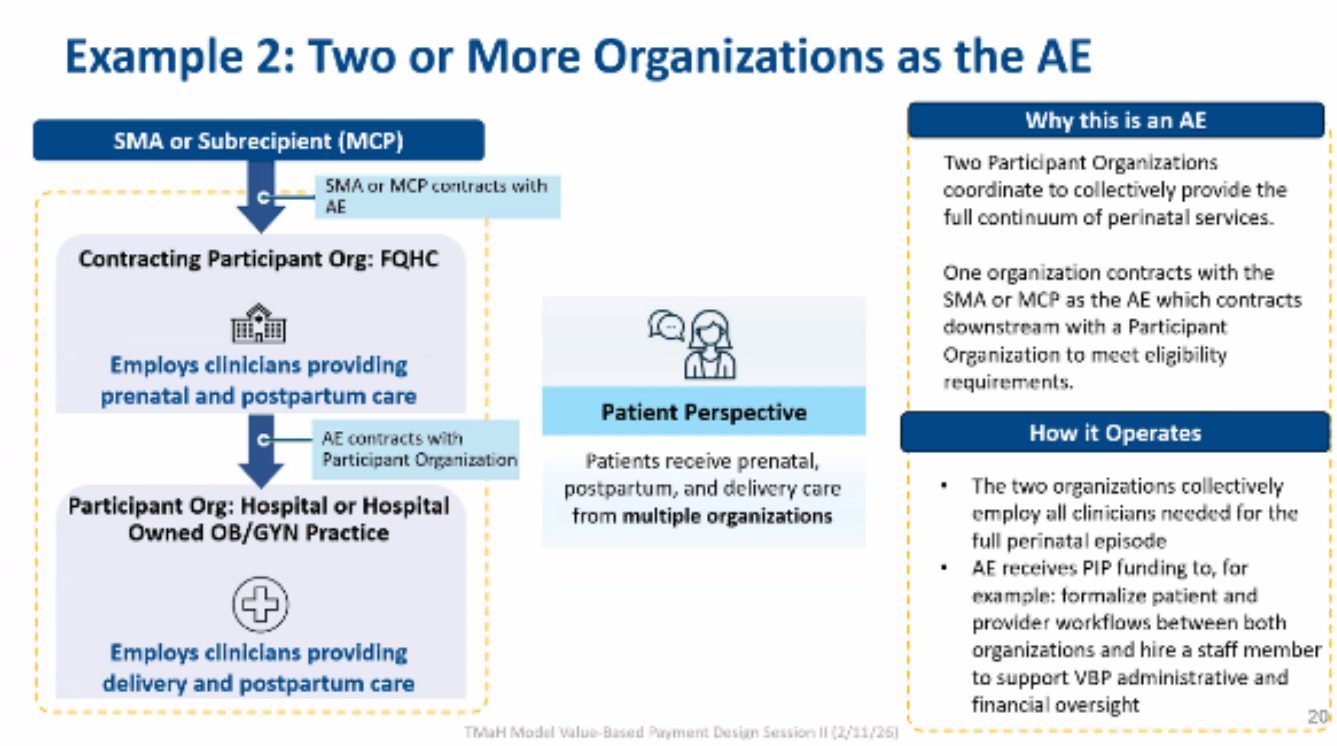
Partners come together as an "Accountable Entity" (AE) to apply

A TMaH Accountable Entity (AE) is the practice(s) accountable for care in the TMaH model. These are clinics or practices providing maternal health services, including OB-GYN practices, FQHCs, and birth centers.

The AE must provide the full range of perinatal care (prenatal, delivery, and postpartum care), which can be provided among different organizations within the AE.

Hospitals may serve as participants in the AE, but are restricted from serving as the primary AE organization unless they provide the full range of perinatal care (prenatal, labor/delivery, and postpartum care) AND contractual assurances that at least 80% of the AE's portion of the shared savings payment will be given to the individuals who provided a majority of the prenatal and postpartum care.

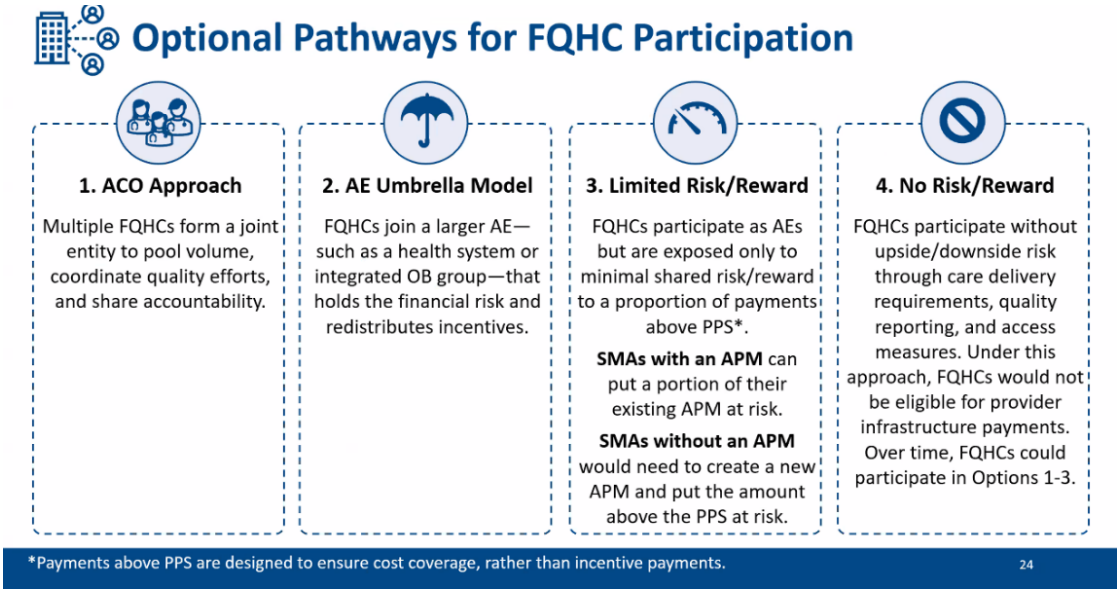


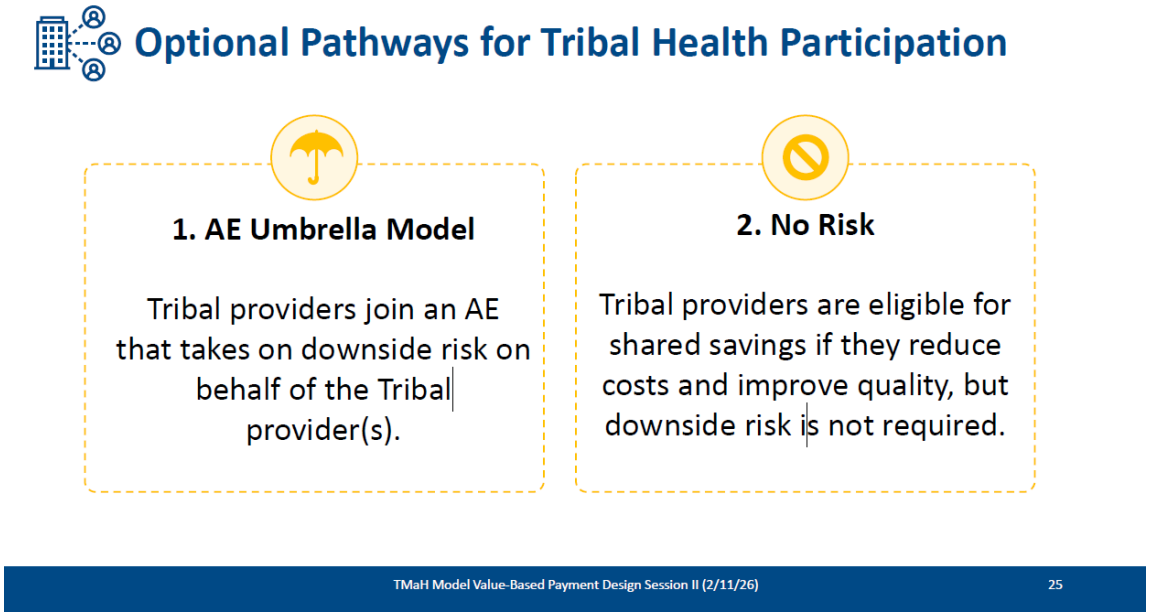


Safety Net Provider (SNP) Participation—Safety net providers such as FQHCs and tribal organizations and clinics can serve as the primary applicant but must apply jointly with a site location that does deliveries if they do not provide delivery care.

Unique SNP reimbursement structures require flexibility related to phased-in downside risk and potentially the case rate payment:

- FQHCs: The Medicaid Prospective Payment System (PPS) is the single required rate that states must pay FQHCs for a single visit. Many SMAs pay an alternative rate either equal to or greater than the PPS rate, known as an Alternative Payment Methodology (APM) rate
- Tribal Health Providers: The Indian Health Service (IHS) All-Inclusive Rate (AIR) is the U.S. Office of Personnel Management-determined payment methodology for Medicaid or Medicare services furnished in IHS-operated or Tribally operated (Section 638) facilities.





AEs must be identified by a tax identification number (TIN). Even if multiple organizations come together, there must be a primary single TIN forming a business relationship with one of Minnesota's Managed Care Plans.

This accountable entity will be responsible for:

- meeting cost and quality outcomes
- complying with model terms and conditions
- distributing shared savings and losses

Selected AEs will need to submit a Memorandum of Agreement (MOA) or Memorandum of Understanding (MOU) between all participating organizations prior to final award.

Who cannot be an AE?

- × Individual clinicians without organizational infrastructure
- × Hospitals that do not provide prenatal or postpartum services cannot be an AE on their own but can join with others
- × Practices/FQHCs where providers do not perform labor/delivery cannot be an AE on their own but can join with others
- × AEs below minimum delivery volume requirement of 30-50 births/year*

*CMS has proposed 30-50 births as the minimum delivery number for AE eligibility. This number is subject to change based on CMS guidance.

Transforming Maternal Health (TMaH) Model Value-Based Payment Frequently Asked Questions

Overview

CMS will be regularly releasing Frequently Asked Questions (FAQ) based on questions received on the Transforming Maternal Health (TMaH) Value-Based Payment (VBP) Model. The FAQ below is related to material presented during the **TMaH Value-Based Payment Design Session II Workshop** on February 11, 2026 – please see the workshop materials for additional details.

Question	Answer
What is an Accountable Entity (AE) and which providers can participate in the TMaH VBP Model?	TMaH Model Accountable Entities (AEs) are provider organizations that deliver prenatal, labor and delivery, and postpartum ("perinatal") care and agree to be accountable for cost and quality outcomes under the TMaH VBP Model. AEs are intended to be the providers with a direct impact on patient care. These providers have the greatest ability to manage care continuity and influence outcomes across the perinatal period. For this reason, the model prioritizes practice-level accountability, where performance tracking and financial incentives can most directly support care improvement. An AE may be structured as: 1. A single organization under one tax identification number (TIN)—such as an obstetrics and gynecology (OB/GYN) practice, hospital-based OB/GYN practice, family medicine practice, federally qualified health center (FQHC), midwifery practice, or birth center—where the organization provides all perinatal professional services; OR 2. Multiple organizations ("Participant Organizations") that formally join together to meet program requirements—for example, one practice providing prenatal and postpartum care and another providing delivery services. Participating organizations contract with the state or managed care plan through a single primary TIN, while maintaining their individual operations.
Do state Medicaid agencies (SMAs) have the flexibility to reimburse a variety of maternal health services such as non-nurse midwives (nurse midwives already must be reimbursed), lactation consultants, doulas and perinatal community health workers (P-CHWs) as part of their TMaH VBP Model?	Yes, in fact we encourage the inclusion of the full array of maternal health services to be included in care teams.

Question	Answer
Who contracts with providers under the TMaH Model in managed care states?	Managed Care Plans will contract with participating AEs and administer the prospective monthly payment and retrospective payments consistent with model requirements. The TMaH Model team is working with the Center for Medicaid & CHIP Services (CMCS), which sets national policies and manages operations for the Medicaid and Children's Health Insurance Program (CHIP), to ensure that shared savings are distributed in a manner that aligns with Medicaid managed care regulations.
For FQHCs that provide only prenatal and postpartum care and work with OB/GYNs who deliver at the hospital, will the FQHC have to join with the OB/GYN delivery group to become an AE?	Yes, an AE must include either one practice that performs all perinatal care services including labor/delivery, or multiple entities that collectively provide all perinatal care services. In this case, since the FQHC providers do not provide patients with labor/delivery services, the FQHC would need to join with the OB/GYN delivery group to form an AE.
Who are the ideal candidates to become an Accountable Entity (AE)?	The ideal candidate for an AE in the TMaH Model is a practice that provides all perinatal care services, or that provides prenatal and postpartum care and then has a partnership with practice that performs labor and delivery care. This type of entity could be, for example, a standalone OB/GYN practice, a hospital-based OB/GYN practice, or other practices that deliver prenatal care (e.g. birth centers, family medicine practices, FQHCs, rural health clinics). Practices that do not provide all perinatal care would be required to partner with a practice that offers the missing service in order to form an AE for the TMAH VBP Model. Additional information and details on AEs and attribution scenarios are included in the February 11, 2026 workshop materials.
If a practice providing prenatal/postpartum care and a practice performing labor/delivery services do NOT want to form an AE, can they split the retrospective shared savings payment?	No. The retrospective shared savings payment is only available to AEs. The two practices would be required to form an AE to be eligible for the retrospective shared savings payment.
If a prenatal provider and a delivery provider want to come together to form an AE, can they split the retrospective shared savings payment?	Yes. If a practice providing prenatal and postpartum care (midwifery practice, FQHC, family medicine practices etc.) and a labor/delivery practice (e.g. hospital-based OB/GYN practice) join together to form an AE, both the prenatal/postpartum practice and hospital-based OB/GYN practice together can decide how to split the retrospective shared savings payment. However, the model will require that hospitals serving within or as the AE provide contractual assurances that shared savings will be reinvested in preventive perinatal services (including clinical staffing, community health workers, care coordination programs, or other maternal health service enhancements).
What will make a patient eligible for the TMaH Model?	All Medicaid and CHIP enrolled pregnant women between the ages of 12 and 55 are eligible to be enrolled in the TMaH Model.

Question	Answer
What conditions/characteristics will exclude otherwise eligible patients?	The following types of beneficiaries or events will be excluded from the TMaH VBP Model (additional technical specifications are forthcoming): • Dual eligible beneficiaries • Individuals who are out of age range (younger than 12 or older than 55 years old) • Individuals who have experienced a miscarriage or stillbirth • Individuals who left care against medical advice • High-cost outliers or conditions • Individuals who switched or transferred providers in third trimester
In states that deliver Medicaid services using both managed care and fee-for-service (FFS) payment, do SMAs need to include FFS patients in the TMaH VBP Model?	No. SMAs can elect to implement the TMaH VBP Model in either their managed care or FFS programs, or both.
How does the TMaH VBP Model integrate other providers who also play a role in improving perinatal and birth outcomes, such as perinatal providers of specialty care and pediatricians?	CMS acknowledges that other providers, such as perinatal providers of specialty care and pediatricians, may also play a critical role in supporting improved perinatal and birth outcomes. Please also note that multiple entity types may join together as one AE. For example, a specialty provider practice that provides services to a high proportion of pregnant mothers could be included as a Participant Organization within the AE. Importantly, the AE must deliver all perinatal care services, including labor/delivery services to be included in the perinatal episode of care. We are not expecting that pediatric practices would be included as a Participant Organization within the AE, since they do not typically provide perinatal care services.
Does the TMaH VBP Model assume that FQHCs, multiple practice groups, and larger healthcare systems will contractually connect as Accountable Care Organizations (ACO)?	There is no official designation of "ACO" in Medicaid, but multiple organizations (“Participant Organizations”) can formally join together to meet program requirements to become an Accountable Entity (AE).
Can a birth center be an AE on its own?	Yes, so long as it meets the AE requirements.
Will CMS provide any more guidance about the Provider Infrastructure Payments (PIP)?	Yes, CMS plans to release additional guidance for SMAs on the use of Provider Infrastructure Payments in Q2 CY 2026. Please also send any specific questions you may have to your Project Officer. CMS will address state-specific questions as appropriate.
Are there thresholds or tiers for performance-based payments in the TMaH VBP Model?	In the retrospective component of the TMaH VBP Model, quality measures will include performance thresholds for determining shared savings, and the distribution of incentive payments will be adjusted based on each AE's quality performance. Higher quality performance may result in a greater percentage of shared savings being awarded. This approach ensures that incentive payments reward high-value care rather than cost reductions alone.

Question	Answer
What is the difference between the prospective monthly payment and shared savings payments and why does the TMaH VBP Model have two types of payments?	Prospective payments are monthly payments, also called a case rate, triggered during the second trimester and based on each Accountable Entity's historical professional claims; these payments replace fee-for-service or global payments for covered services and provide predictable, upfront funding to support care coordination, prevention, and comprehensive prenatal and postpartum care. Retrospective performance-based payments are calculated at the end of the episode, and AE's are eligible for shared savings contingent on meeting defined quality thresholds and performing below a risk-adjusted cost benchmark. The cost benchmark includes professional and facility fees. Together, these two payment types reflect common VBP design: prospective monthly payments stabilize revenue and enable practice-level change, while shared savings align financial rewards with improved outcomes and cost effectiveness over the full episode of care.
Are the TMaH VBP Model prospective monthly payments launched when a patient enters the system or universal based on the estimated number of patients?	Within TMaH VBP Model, the prospective monthly payment, is triggered by a prenatal visit in the second trimester at which time the pregnant person is "attributed" to the AE. Once triggered, the case rate continues to the second month postpartum unless perinatal care services are transferred to a provider outside of the AE. Patients are attributed beginning in the second trimester to avoid high rates of provider switching in the first trimester and to support appropriate referrals without incentivizing premature retention or offloading of patients. Attribution does not begin in the third trimester to ensure providers have sufficient time to influence outcomes and are not discouraged from referring patients who require higher levels of care.
How does the TMaH VBP Model affect a practice's revenue compared to historical Medicaid payments?	Participating in the TMaH VBP Model will provide practices with upfront support, predictable monthly revenue, and the opportunity to earn additional performance-based payments. Practices that join TMaH may be eligible for Provider Infrastructure Payments, which can help fund care delivery improvements, expand capacity, and build the capabilities needed for value-based care—without requiring practices to finance these investments on their own. Practices can also apply these new VBP capabilities beyond TMaH to other value-based arrangements. In addition, practices will receive a monthly prospective monthly payment (case rate) that is based on their historical professional claims, providing a predictable revenue stream that generally reflects what they have earned in the past. This steady monthly payment supports day-to-day care delivery and care coordination throughout the perinatal period. At the end of the episode, practices may also earn shared savings when they meet quality targets and reduce avoidable costs compared to a risk-adjusted benchmark. Retrospective shared savings is designed to reward high-quality, efficient care and can increase overall practice revenue. CMS will also provide technical assistance to support clear communication about expected revenue impacts and help practices understand how TMaH payments compare to historical Medicaid payments.

Question	Answer
What happens if an Accountable Entity (AE) does not meet the quality requirements?	If an AE does not meet the minimum quality performance requirements—including either established performance thresholds or defined improvement targets—it would not be eligible to receive shared savings for that performance period. In this case, the AE would continue to receive its prospective monthly payments, but no additional incentive payment would be awarded. This approach ensures that shared savings are only distributed when cost performance is accompanied by acceptable quality of care. CMS will provide additional details on the quality calculations in future workshops and technical specifications.
Do SMAs need to allocate specific funds towards the TMaH VBP Model payments in addition to FFS payments?	No. SMAs will not be required to pay providers anything additional outside of the prospective monthly payments, which are based on historic payment rates, and shared savings for AEs that meet quality benchmarks and reduce costs.
Can support for those providing wraparound services be a part of prospective monthly payments or retrospective payments?	Yes, AE's can use their prospective monthly payments or part of their shared savings to support a variety of services providing better care for their perinatal patients, including home visits.
Why are we only paying for services until 60 days postpartum when most states are now covering 12 months? What will happen after 60 days?	The TMaH VBP Model includes services through 60 days postpartum for two primary reasons. First, limiting the episode to 60 days allows for timely reconciliation and payment, ensuring that performance-based incentives are delivered close enough to the care period to meaningfully influence provider behavior and care delivery. Second, from a clinical perspective, the majority of pregnancy-related complications occur within the early postpartum period, particularly in the first six weeks, as noted by the American College of Obstetricians and Gynecologists (ACOG). Care beyond 60 days postpartum remains critical and continues to be covered under Medicaid, but will be paid for through fee-for-service and/or other state and managed care plans mechanisms.
How are prenatal and preventive care costs included in shared savings when Accountable Entities (AEs) receive a flat prospective monthly payment?	The prospective monthly payment is based on each AE's historical Medicaid payments, which already include the costs of prenatal and preventive care. During the episode, these services are generally paid through the prospective monthly payment instead of fee-for-service. Some services may be excluded from the prospective monthly payment—to ensure that they continue to be provided when clinically appropriate (for example, ultrasounds)—but will still be included in the cost benchmark for the retrospective payment.
Will SMAs be allowed to decide which type of VBP arrangement to implement, based on their state context?	No. In order to ensure robust evaluation of the model and it ultimate ability to be certified and expanded (per CMS statute), CMS intends for the TMaH VBP Model to be consistent across all participant SMAs, with some flexibility as needed for specific state context and implementation. As described in the "Roadmap to Value" section of the Notice of Funding Opportunity (NOFO), CMS will be leading the design of the maternal health VBP arrangements that all SMA participating in the TMaH Model are then expected to implement.

Question	Answer
How will the shift from receiving global payments to participating in TMaH value-based payment (VBP) Model benefit the provider and practice?	While global payments simplify billing, they are not tied to performance or outcomes. Participating in the TMaH VBP odel builds on that simplicity while adding accountability and upside potential by linking payment to quality and cost performance. Practices continue to receive predictable, upfront payments through the prospective monthly payment, and also gain the opportunity to earn shared savings when improved prenatal and postpartum care leads to better outcomes and lower avoidable costs.
How will TMaH VBP Model payments account for high-risk patients?	First, risk adjustment will be applied to retrospective cost benchmarks, so that AEs serving higher-risk patient populations are compared against appropriately adjusted spending targets. Additionally, TMaH will consider risk adjustment for relevant quality measures. In addition to risk adjustment, the TMaH VBP Model is designed to ensure that providers caring for higher-risk pregnant and postpartum individuals are not unfairly penalized for the additional costs necessary to provide perinatal care to this population. For example: • Understanding that practices will have different starting points on quality metric performance, practices will be eligible for shared savings for meeting the cost benchmark and making *improvements* towards the benchmark, even if the quality measure benchmark is not met.

Appendix C: TMaH Required Milestones and Activities

Required Elements		
Pillar 1 Access, Infrastructure and Workforce	Pillar 2 Quality Improvement and Safety	Pillar 3 Whole-Person Care Delivery
1. Increase access to the midwifery workforce 2. Increase access to birth centers 3. Cover[1] Doula Services 4. Improve data infrastructure 5. Develop payment model	1. Support implementation of AIM patient safety bundles 2. Support "Birthing-Friendly" hospital designation	1. Increase risk assessments, screenings, referrals and follow-up for perinatal depression, anxiety, tobacco use, substance use disorder, and upstream drivers of health 2. Increase Home Monitoring of diabetes and hypertension 3. Develop a Prevention & Quality Plan
Optional Elements (Other Available Technical Assistance)		
Pillar 1 Access, Infrastructure and Workforce	Pillar 2 Quality Improvement and Safety	Pillar 3 Whole-Person Care Delivery
▪ Cover[2] certified midwives (CMs) and certified professional midwives (CPMs) ▪ Cover[3] Perinatal Community Health Workers (CHWs) ▪ Create regional partnerships in rural areas ▪ Extend Medicaid eligibility to 12 months postpartum	▪ Promote shared decision-making	▪ Expand group perinatal care ▪ Increase use of home visits, mobile clinics and telehealth ▪ Expand oral health care

Each required element has associated Pre-Implementation Milestones, which must be completed no later than the end of Model Year 3. These required Pre-Implementation Milestones are listed below:

➢ **Pillar 1. Element 1: Increase access to the midwifery workforce:**

- Complete an assessment of midwifery workforce capacity in the state and identify options for covering additional types of midwives licensed in the state
- Assess and create a billing pathway for interprofessional consultations between midwives

[1] Include Doula Services among those eligible for Medicaid payment. Doula Services are defined in Section 'Definitions' and are provided by a non-clinical trained professional (e.g. Doula or Perinatal CHW).

[2] Include certified midwives and/or certified professional midwives among those eligible for Medicaid payment

[3] Include Perinatal Community Health Worker services among those eligible for Medicaid payment

and other providers, including maternal fetal medicine specialists, as appropriate and needed

- Complete payment analysis that compares the reimbursement rate for midwives as a proportion of a benchmark rate (for fee schedule updates as appropriate), and implement a process to complete a comparable analysis on an annual basis thereafter

➢ **Pillar 1**. **Element 2: Increase Access to Birth Centers**

- Complete a payment analysis that compares the facility fee rate for Birth Centers as a proportion of a relevant benchmark rate, and has a process in place for completing an annual analysis thereafter
- Create a plan for providing information to pregnant beneficiaries on Birth Centers, if licensed and operating in the state
- Complete an implementation plan for establishing more sustainable reimbursement rates for Birth Centers

➢ **Pillar 1**. **Element 3: Cover Doula Services (provided by non-clinical trained professionals (e.g. Doula or Perinatal CHW)**

- Complete workplan for initial payment analysis
- Complete a payment analysis that compares the reimbursement rate for Doula Services as a proportion of a relevant benchmark rate, and implement a process for completing an analysis annually thereafter
- If Doula Services are not already covered as a Medicaid service, submit, or have a timeline and process in place for submitting and implementing, a Medicaid State Plan Amendment (SPA)/Section 1115 demonstration program to cover Doula Services
- Convene a State Doula Support Council, if no such council has already been established

➢ **Pillar 1. Element 4: Improve Data Infrastructure**

- Establish a timeline and plan for linking mother-infant Medicaid IDs with vital records data, if the data have not yet been linked by the end of Model Year 2. Plans should include the execution of necessary recurring data-sharing and related agreements for linking mother-infant Medicaid IDs with vital records data to support long-term model monitoring and program evaluation.
- Complete data needs assessment and draft work plan with Partner Providers and Partner Care Delivery Locations to stratify demographic data, or identify challenges and has a clear timeline and process for such stratification
- Complete data needs assessment and draft work plan to identify Model beneficiaries who are also utilizing social service and benefit programs such as WIC/SNAP, for the purpose of measuring and addressing cross-program enrollment gaps
- Collect and report stratified demographic data, and match Beneficiary data across social service and benefit programs such as WIC/SNAP
- Ensure accurate and timely Medicaid claims data reporting using T-MSIS as follows:
    - In Model Year 2, the Recipient will: (1) ensure participation of data leads or staff with decision-making authority in coaching calls with Implementation and Monitoring contractor **t**o understand and improve the submission of T-MSIS data; and (2) initiate data system changes needed (at the state level, in partnership with MCOs and CMS as needed) to effectuate identified improvement needs.

- By the end of Quarter 1 of Model Year 3 (March 31, 2027), Recipient will either: (1) ensure that T-MSIS data satisfies CMS requirements for quality and integrity to enable calculation of rates and quality benchmarks by CMS; or (2) establish alternative process to obtain the required data for participating TMaH entities.

Pillar 1. Element 5: Implement Payment Model

- With policy and analytic guidance, create a plan, process, and timeline for implementing the payment model requirements, including:
  - Using the appropriate Medicaid authority to implement the payment model
  - Identifying and documenting personnel necessary to implement the payment model, including description of roles and responsibilities and budget to support efforts
  - Developing a stakeholder engagement plan for ongoing conversations with providers and Managed Care Plans, where applicable
  - Quarterly meeting cadence established with CMS staff and contractors
  - Submitting draft payment model implementation workplan to CMS
  - Final payment model implementation workplan submitted to CMS, including Managed Care Plan engagement plan, and Managed Care Plan contracting timeline
  - Establish payment model benchmarks in partnership with CMS, including cost and quality thresholds

➢ **Pillar 2. Element 1: Support Implementation of AIM Patient Safety Bundles**

- Establish partnership (regularly participate in meetings, share information and action items) with Perinatal Quality Collaborative (PQC) or leading AIM patient safety entity to support selection and rollout of AIM patient safety bundles across state/region, particularly in facilities where no bundles have been implemented
- Design implementation plan to build capacity for participating in AIM patient safety bundles
- Support enhanced data collection to monitor hospital safety bundle outcomes
- Work with AIM and PQC convenors to expand database to systematically collect relevant quality, process or structure and outcomes measures data

Pillar 2. Element 2: Support "Birthing-Friendly" Hospital Designation

- Complete analysis of hospitals and Critical Access Hospitals with birthing facilities to identify existing barriers for such hospitals to attain the "Birthing-Friendly" hospital designation and strategies for the state, hospitals or other entities to take to address such barriers
- Attest that the "Birthing-Friendly" hospital designation is displayed in provider directories, where applicable

Pillar 3. Element 1: Increase Risk Assessments, Screenings, Referrals and Follow-up for Perinatal Depression, Anxiety, Tobacco Use, Substance Use Disorder, and upstream drivers of health

- *Risk Assessment:*
  - Identify and select risk assessment tools, as appropriate
  - Complete a plan to implement medical and non-medical risk assessments for risk- appropriate care

- *Screening/Referral for Behavioral Health Needs:*
    - Create a process/journey map of existing screening and referral processes for perinatal beneficiaries with behavioral health needs that identifies areas of improvement
    - Identify workflows and data collection processes for screening-related quality measures
    - Select specific screening tools
    - Identify areas of improvement through completed process map
    - Draft screening/referral process implementation plan to address identified gaps, including identification of key action steps for the state and participating providers and CBOs and a timeline for implementation.
    - Train hospital and provider staff, as appropriate, on selected screening tools and processes
    - Establish specific follow-up protocol for positive screens and made appropriate workforce linkages
- *Screening/Referral for Substance Use Disorder (SUD) and Tobacco Use:*
    - Draft a process/journey map of existing screening and referral processes for perinatal beneficiaries with SUD or tobacco use
    - Identify workflows and data collection processes for quality measures
    - Finalize selection of specific screening tools
    - Draft implementation plan to address identified gaps
    - Train hospital and provider staff, as appropriate on specific screening tools
    - Specific follow-up protocol for positive SUD or tobacco-use screens established and behavioral health workforce linkages made, where needed
- *Screening/Referral for upstream drivers of health:*
    - Draft health implementation plan to address identified gaps in referrals for non-medical needs
    - Identify healthy workflows and data collection processes for quality measures
    - Finalize selection of specific screening tools
    - Establish health bi-directional referral pathways such that providers can connect beneficiaries to CBOs and receive notification when the CBO is engaged
    - Train health staff on specific screening tools
    - Establish health specific follow-up protocols for identified needs

➢ **Pillar 3. Element 2: Home Monitoring for hypertension and diabetes**

- Determine whether a SPA or waiver is needed for Medicaid coverage of Home Monitoring services and devices
- Create a draft partnership plan between the Recipient and public health department, Managed Care Plan (MCP) and/or other organization (e.g., university) on the design and implementation of Home Monitoring, as appropriate
- Complete draft SPA/waiver documents, as needed, and submitted for internal review, as required

- Meet with partners, such as the state public health department, MCP and/or other organization (e.g., university) and updated partnership plan, as appropriate
- Draft a plan (including information on Medicaid coverage and reimbursement, information for providers on offering and tracking Home Monitoring services, devices and apps needed) for how to implement Home Monitoring

➢ **Pillar 3. Element 3: Prevention & Quality Plan (PQP)**

- The Recipient must **s**ubmit a preliminary PQP to CMS in Model Year 2 and an updated PQP annually thereafter in the form and manner specified by CMS. PQPs will identify the state's prevention area, external engagement, intervention, and population. PQPs should be supported by relevant data about strategies with specific populations of focus; what interventions would be most applicable to assist in that prevention (including external engagement); and collection of prevention interventions that align to quality metrics of the model. Recipient must establish a process for measuring and tracking stratified outcomes in state or sub-state region for the health conditions of interest. CMS will issue forthcoming guidance on format and due date.

DEPARTMENT OF HUMAN SERVICES

Appendix D: Provider Infrastructure Payments (PIP)

The Provider Infrastructure Payments may only be used by Partner Providers and Partner Care Delivery Locations for activities approved by CMS, including but not limited to the activities listed below and subject to final CMS approval:

- **Patient Safety Initiatives and Maternal Care Assessment:**
  - Implementation of the PQC-led AIM patient safety bundles; such payments may not duplicate or supplant funds provided by Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), or any other federal or state source for the same purpose.
  - Planning, patient-flow revision, acquisition of electronic health record (EHR) systems or coding changes or other activities required to effectively use medical and non-medical risk assessments to drive risk appropriate care.
- **Quality Measure Reporting:**
  - Provider surveys
  - Data reporting on the below model quality measures
    - Low-risk cesarean delivery
    - Screening for maternal depression and follow-up
    - Severe obstetric complications
    - Timeliness of prenatal and postpartum care
    - Data reporting on additional quality assurance measures (Note: CMS will specify which measures Recipients will need to report and provide technical assistance where needed.)
- **Data integration**
  - EHR upgrades and data infrastructure improvement, as needed, to meet model data collection and reporting requirements
  - Connections to enable EHRs to exchange data
  - Integration with CBOs to share screening and referral information (and for CBOs to share notifications back to the referring provider to meet social, health, and mental needs in compliance with state and federal data privacy laws
- **Team-based care**
  - Support regular and ongoing interprofessional care team meetings and planned quality assurance and improvement activities. In addition to obstetricians and other physicians and registered nurses, the maternal care team may include doulas, Perinatal Community Health Workers, CHWs, midwives, physician assistants and behavioral health providers, as appropriate.
- **Enhanced access to care:**
  - Offer one or more alternatives to traditional office visits to increase access to care in ways that best meet the needs of the population. This may include Home Monitoring for diabetes and hypertension or other telehealth initiatives, group perinatal visits, home visits, alternate location visits, or expanded early morning, evening, and/or weekend hours.

- **Connections to CBOs to address upstream drivers of health and mental health needs:**
    - Identification of local entities that can help address non-medical (food insecurity, transportation, housing, etc.) and/or mental health (e.g., perinatal depression and anxiety), or tobacco or substance use disorder-related needs of patients insured by Medicaid & CHIP and integrate them into screening, referral and follow-up activities, where legally permissible and appropriate to do so.

Appendix E: CMS Standard and TMaH Program Terms and conditions

Transforming Maternal Health (TMaH) Model

Program Terms and Conditions

Model Year 2

The following are the Program Terms and Conditions ("PTCs") for the Transforming Maternal Health (TMaH) Model. The requirements contained in the Notice of Funding Opportunity, FON# CMS-2N2-25-001, (the "NOFO") are incorporated by reference and are attached hereto. In the event of any inconsistency between the provisions of these Program Terms and Conditions and the provisions of the NOFO, the provisions of these Program Terms and Conditions will prevail.

The Recipient must comply with the representations, assurances and certifications made by the Recipient in the Recipient's application (the "Application") submitted in response to the NOFO, including any attachments, revisions or amendments to the Application approved in writing by CMS.

DEFINITIONS

The following definitions apply for the purpose of these Program Terms and Conditions:

- **"Accountable Entity (AE)"** means a clinic or practices providing maternal health care services, including OB-GYN practices, FQHCs, and birth centers, that agree to be accountable for maternal health care cost and quality outcomes. The AE is the legal entity that forms a business relationship with the state or Managed Care Plan (MCP), held accountable for care and therefore cost and quality outcomes for the TMaH value-based payment model. The AE will be identified in claims using their Tax Identification Number (TIN).
- **"Beneficiary"** means a person who has been determined eligible and is currently receiving Medicaid or CHIP.
- **"Birth Center"** means a health facility that is not a hospital, where childbirth is planned to occur away from the pregnant person's residence and that is licensed or otherwise approved by the State to provide prenatal, labor and delivery, or postpartum care and other ambulatory services.
- **"Budget Period (BP)"** means the time interval from the start date of a funded portion of an award to the end date of that funded portion, during which recipients and subrecipients are authorized to incur financial obligations of the funds awarded, including any funds carried forward or other revisions pursuant to 2 CFR 200.308. The current 12-month budget period is stated on the Notice of Award, in Summary Federal Award Financial Information #19. Budget Periods run concurrently with model years as described in the TMaH Model NOFO, Section B2 'Cooperative Agreement Period Funding per Recipient.'
- **"Community-Based Organization (CBO)"** means a public or private not-for-profit organization that provides specific resources and services to the community or to a targeted population within the community. CBOs include but are not limited to community health centers, childcare providers, home visiting programs, state and local domestic violence coalitions, domestic violence shelters, and related domestic violence programs, food banks, and those organized to provide homeless services, other Health Related Social Need services, maternal education, and training services or to advocate for community improvement.
- **"Cooperative Agreement" or "Cooperative Agreement Award"** means a legal instrument of financial assistance between CMS and the Recipient consistent with 31 U.S.C. §§ 6302-6305 that:

- Is used to enter into a relationship the principal purpose of which is to transfer anything of value from CMS to the Recipient to carry out a public purpose authorized by a law of the United States (see 31 U.S.C. § 6101(3)); and not to acquire property or services for the federal government or for the federal government's direct benefit or use, and
- Is distinguished from a grant in that it provides for substantial involvement between CMS and the Recipient in carrying out the approved activities under this award (see 31 U.S.C. § 6305(2))

- **"Cooperative Agreement Period of Performance"** means the period beginning on January 1, 2025, and ending on December 31, 2034, for a total of ten years.
- **"Doula Services"** means emotional, physical, and informational support during pregnancy, delivery, and after childbirth, provided by a non-clinical trained professional (e.g. Doula or Perinatal Community Health Worker (CHW)). Services established under the TMaH Model must include, but are not limited to, the following:
    - **Prenatal Services**: Promoting health literacy and understanding of the normal process of pregnancy and fetal development; assisting with the development of a birth plan; supporting personal preferences around childbirth; providing emotional support and encouraging self-advocacy; reinforcing practices known to promote positive outcomes such as breastfeeding; coordinating referrals or linkages to community-based support services to address upstream drivers of health;
    - **Labor and Delivery Services:** Providing physical comfort measures, information, and emotional support; advocating for Beneficiary needs; being an active member of the birth team; and
    - **Postpartum Services:** Education regarding newborn care, nutrition, and safety; supporting breastfeeding; providing emotional support and encouraging self-care measures; supporting individuals in attending recommended medical appointments; coordinating referrals or linkages to community-based support services to address upstream drivers of health.
- **"Home Monitoring"** means the use of digital technologies to collect health data from patients in one location and electronically transmit that information securely to providers in a different location.
- **"Implementation Period"** means the period beginning on January 1, 2028, and ending on December 31, 2034.
- **"Model Year (MY)"** means the 12-month calendar periods set forth in Section 7 'Cooperative Agreement Period of Performance and Budget Periods.'
- "**Non-Competing Continuation (NCC) Application"** means an application for additional funding (i.e., for the next Budget Period) within a previously approved period of performance, through a non-competing process.
- **"Non-Competing Continuation (NCC) Award"** means the award for additional funding in a subsequent Budget Period following the submission and approval of an NCC Application.
- **"Participant Provider"** means those eligible providers in an Accountable Entity, as defined by their Medicaid ID and employ clinicians that provide both prenatal/postpartum care and delivery services.

- **"Partner Provider"** means a maternal health provider or practice providing maternity care services to Medicaid and CHIP beneficiaries in the TMaH Model. These providers may include but are not limited to obstetrician-gynecologists, midwives, physicians, fetal medicine specialists, nurses, mental and behavioral health practitioners, and other clinical and support staff, such as doulas, lactation consultants, and Perinatal Community Health Workers.
- **"Partner Care Delivery Locations"** means locations where maternity care services are provided to Medicaid and CHIP beneficiaries by Partner Providers. These locations may include but are not limited to hospitals, Birth Centers, obstetrician-gynecology practices, mental and behavioral health practices, rural health clinics, FQHCs, Tribal sites and other points of care.
- **"Partner Organizations"** means non-clinical organizations that will partner with Recipient and/or Partner Providers and Partner Provider Care Delivery Locations to implement the TMaH Model, including but not limited to state public health departments, Perinatal Quality Collaboratives, maternal mortality review committees, Managed Care Plans, Community-Based Organizations, universities, and other non-clinical organizations.
- **"Perinatal Community Health Worker"** means a trusted member or close associate of the birthing community who serves as a liaison with health and social services to facilitate access to services and improve the quality and cultural competence of service delivery. Such workers build individual and community capacity by increasing patients' health knowledge and self-efficacy through activities such as outreach, community education, informal counseling, social support, and advocacy.
- **"Perinatal Quality Collaborative"** means a statewide or a multi-state network of multidisciplinary teams of perinatal healthcare providers and public health professionals working to improve maternal and infant outcomes through the implementation of quality improvement initiatives designed to continually monitor, analyze, and improve the care provided.
- **"Pre-Implementation Period"** means Model Years 1, 2, and 3 of the Cooperative Agreement Period of Performance, beginning on January 1, 2025, and ending on December 31, 2027.
- "**Prevention & Quality Plan**" **or "PQP"** means a document that assesses and outlines how the Recipient will address upstream drivers of health, such as transportation, food insecurity, utilities, and housing, in the identified test region.
- **"Provider Infrastructure Payment"** means a payment made by the Recipient to Partner Providers and Partner Care Delivery Locations to support care delivery transformation. Such payments may only be used by providers for the activities described in Section A.4.3.1 of the TMaH Model NOFO and are subject to CMS approval.
- **"Recipient"** means the State Medicaid Agency that submitted the Application for CMS's consideration and received the Notice of Award (NoA) from CMS. This does not include Subrecipients.
- **"Remediation"** means intermediate actions taken by the Recipient to correct identified deficiencies and produce improvements that enable the Recipient to meet the final milestones as described in Section 20 'TMaH Model Pillars, Required Elements and Associated Milestones.'
- **"Severe Maternal Morbidity"** means unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health. To identify delivery hospitalizations with SMM, the CDC uses administrative hospital discharge data

and International Classification of Diseases, Tenth Version (ICD-10) diagnosis and procedure codes. A list of indicators and corresponding ICD-10 codes used to identify delivery hospitalizations with SMM can be found here.

- **"Severe Obstetric Complications"** (ePC-07) refers to an electronic clinical quality measure (eCQM) from The Joint Commission that captures the proportion of patients that experience severe maternal complications during an inpatient delivery hospitalization. This eCQM is submitted by hospitals to CMS annually through the Hospital Inpatient Quality Reporting Program. Additional information and specifications for ePC-07 can be found here.
- **"State Doula Support Council"** means a group convened by the relevant state Medicaid agency to advise the state agency on how best to increase the number of nonclinical trained professionals performing Doula Services who are trained, practicing, and enrolled as Medicaid providers. The State Doula Support Council shall not advise the Federal government, including CMS or CMS contractors, on any matter.
- **"Subaward"** means an award provided by the Recipient to a Subrecipient for the subrecipient to carry out part of a federal award received by the Recipient. It does not include payments to a contractor or payments to an individual that is a Beneficiary of a federal program. A Subaward must be provided through a written agreement between the Recipient and the Subrecipient.
- **"Subrecipient"** means a non-Federal entity that receives a Subaward from the Recipient to carry out activities related to the award.
- **"Terms and Conditions of the Notice of Award "** means, collectively, the following: 1) the Recipient Specific Terms and Conditions (if applicable); 2) these Program Terms and Conditions; and 3) the Standard Terms and Conditions incorporated by reference in, and included as an attachment to, the Notice of Award (NoA).
- **"Upstream Drivers of Health"** refers to social and economic needs that individuals experience that affect their ability to maintain their health and well-being. The TMaH Model is specifically focusing on adverse social and economic conditions in the domains of food insecurity, housing insecurity, utilities, and transportation needs that negatively affect a person's health or health care.

GENERAL

1. **CMS Center for Medicare & Medicaid Innovation Project Officer (PO).** Unless otherwise specified in writing, the name and contact information of the PO responsible for the technical and programmatic administration aspects of the award is identified in field 10 of the Notice of Award (Program Official Contact Information).
2. **CMS Grants Management Specialist.** Unless otherwise specified in writing, the Grants Management Specialist assigned responsibility for responding to the Recipient's questions about financial and administrative (non-programmatic) aspects of the award is identified in field 9 of the Notice of Award (Awarding Agency Contact Information).
3. **Notice of Funding Opportunity (NOFO).** All relevant project requirements and definitions outlined in the NOFO (CMS-2N2-25-001) apply to this award and have been incorporated into the Terms and Conditions of the Notice of Award by reference.
4. **Role of CMS in a Cooperative Agreement Award.** Under the Recipient's Cooperative Agreement Award, CMS' purpose is to support and stimulate the Recipient's activities by involvement in, and otherwise working jointly with, the Recipient in a partnership role. The Recipient can expect substantial collaboration, participation, and/or intervention in the

oversight of the project by CMS. Substantial involvement may include collaboration or participation by CMS program staff in activities specified in the NoA and, as appropriate, decision-making at specified milestones related to performance, e.g., requiring CMS approval before undertaking the next phase of a project, collaborating in the design of a service delivery model, etc. Substantial involvement pertains to programmatic involvement, **not** administrative oversight. See TMaH Model NOFO Section F4 'Cooperative Agreement Terms and Conditions of Award.'

5. **Role of the Recipient in a Cooperative Agreement Award**. The Recipient retains the primary responsibility and dominant role for planning, directing, and executing TMAH Model activities with substantial CMS involvement within the Recipient's state. Despite CMS' involvement, the Recipient remains ultimately accountable for the project, and for the use of these funds consistent with program expectations detailed in these Program Terms and Conditions. See also "Cooperative Agreement" definition above as well as TMaH Model NOFO Section F4 'Cooperative Agreement Terms and Conditions of Award.'

6. **Waivers for Models Conducted Under Section 1115A of the Social Security Act ("the Act").** Under Section 1115A(d)(1) of the Act, the Secretary may waive such requirements of Titles XI and XVIII and of Sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and 1934 (other than subsections (b)(1)(A) and (c)(5) of such section) of the Act as may be necessary solely for purposes of carrying out Section 1115A with respect to testing the TMaH Model. CMS may withdraw or modify any waivers issued by CMS if the Recipient does not comply with the requirements set forth in the Terms and Conditions of the Notice of Award, including these Program Terms and Conditions, or other associated documentation issued under the TMaH Model.

   Additionally, CMS provides no opinion on the legality of any contractual or financial arrangement that Recipient or any Subrecipient has proposed, implemented, or documented, including in the Recipient's updated Implementation Plan. The receipt or approval by CMS of any such documents during the application process or otherwise must not be construed as a waiver or modification of any applicable laws, rules, or regulations, and will not preclude CMS, HHS, OIG, a law enforcement agency, or any other federal agency from enforcing all applicable laws, rules, and regulations.

7. **Cooperative Agreement Period of Performance and Budget Periods.** The Cooperative Agreement Period of Performance for this award is located on page 1 of the NoA, Section Summary Federal Award Financial Information, in field #26. The current Budget Period is located in field #19 on the NoA. The Cooperative Agreement Period of Performance and Budget Period are each specified below.

   The Cooperative Agreement Period of Performance consists of ten (10) Budget Periods (BPs) that overlap with both the Pre-Implementation Period and the Implementation Period as set forth in Table 1.

TABLE 1 Cooperative Agreement Period of Performance

Budget Period (BP)	**Model Year (MY)**	**Program Period**	**Start Date**	**End Date**
Budget Period 1	1	Pre-Implementation Period	**January 1, 2025**	**December 31, 2025**
Budget Period 2	2	Pre-Implementation Period	**January 1, 2026**	**December 31, 2026**

Budget Period 3	3	Pre-Implementation Period	**January 1, 2027**	**December 31, 2027**
Budget Period 4	4	Implementation Period	**January 1, 2028**	**December 31, 2028**
Budget Period 5	5	Implementation Period	**January 1, 2029**	**December 31, 2029**
Budget Period 6	6	Implementation Period	**January 1, 2030**	**December 31, 2030**
Budget Period 7	7	Implementation Period	**January 1, 2031**	**December 31, 2031**
Budget Period 8	8	Implementation Period	**January 1, 2032**	**December 31, 2032**
Budget Period 9	9	Implementation Period	**January 1, 2033**	**December 31, 2033**
Budget Period 10	10	Implementation Period	**January 1, 2034**	**December 31, 2034**

The funding approved for Budget Period 2 is outlined in the NoA that will accompany these Program Terms and Conditions. See field #25 of the NoA.

8. Restrictions of Funds. Specific restrictions of funds, if applicable, have been detailed in the Recipient Specific Terms and Conditions. In addition to the restrictions set out in the Recipient Specific Terms and Conditions, such restrictions shall include the following:

a) The Recipient must request prior approval for activities or costs to support new Subrecipients, contractual, and consultant agreements not already approved through a NoA. A detailed itemized budget must be provided for all Subrecipients, contractual, and consultant agreements. If this information is unknown at the time of Application or for a subsequent NCC Application, the Recipient must follow-up and provide this information via a Revision (NoA Other) or Revision (Budget) amendment in GrantSolutions as soon as this information can be provided to CMS. Additionally, please see NOFO Appendix I, Guidance for Preparing a Budget Request and Narrative for required contractual and consultant questions the Recipient must address. The Recipient may not incur costs or draw down funds to support these activities until CMS provides approval.

b) CMS may restrict funding if the Recipient is not compliant with the requirements in these Program Terms and Conditions, including performance on the milestones outlined in Section 20 'TMaH Model Pillars, Required Elements and Associated Milestones.' If CMS restricts Recipient's funding due to non-compliance, CMS may provide the Recipient access to previously restricted funding once Recipient is compliant with the requirements herein.

9. Continued Funding. Continued funding is conditional on the availability of appropriated funds, recipient satisfactory performance, and compliance with the Terms and Conditions of Award. At any time, CMS can decrease funding, recover funding, or terminate an award if a Recipient fails to perform the requirements of the award. The award may also otherwise be terminated to the extent authorized by law, if the agency determines the award no longer effectuates program goals or agency priorities.

The following constitutes satisfactory progress:

- Completing interim steps toward Pre-Implementation Period Milestones in MY1 and MY2, as detailed in the Technical Assistance Workplan developed in concert with CMS.
- Successful completion of all Pre-Implementation Period Milestones for Required Elements by the end of MY3, as listed in Section 20 'TMaH Model Pillars, Required Elements and Associated Milestones.'

- Successful completion of Implementation Period Milestones in Model Years 4-10, which will be developed no later than Model Year 3 after consultation with Recipient. These Implementation Period Milestones are expected to include implementing the payment approach; continuing, sustaining, or enhancing all programs and interventions developed during Model Years 1-3 in response to Pre-Implementation requirements.

Non-Competing Continuation Applications: As stated in the Standard Terms and Conditions, Section 28 'Continued Funding,' the Recipient must submit a Non-Competing Continuation (NCC) Application for each Budget Period as a prerequisite to continued funding when the Cooperative Agreement Period of Performance comprises multiple Budget Periods. The Recipient must request an NCC Award 90 days before the end of each Budget Period beginning with Budget Period 1, by submitting an NCC Application and any required documents via GrantSolutions.

The CMS Grants Management Specialist will provide instructions for completing and submitting each NCC Application to the Recipient approximately 120 days prior to the end of Budget Period. If the NCC Application is approved, CMS will issue the Recipient a NCC Award for next Budget Period prior to the expiration of the current Budget Period. See Standard Terms and Conditions Section 5 'Funding for Recipients' for additional requirements.

The Recipient will not have authority to utilize unobligated funds remaining from the previous Budget Period in the new Budget Period without prior written approval from CMS. The Recipient may request prior approval from CMS to carry over unobligated funds from the previous Budget Period to the new Budget Period to complete previously approved activities/costs. The CMS Grants Management Specialist will provide information and instructions on this process.

10. **Use of Funds.** The Recipient must only use funds for the purposes stated in the NOFO and the purposes stated in the application that are approved by CMS, including any subsequent budget revisions approved by CMS. The Recipient shall not use award funds to pay for services currently reimbursable by Medicaid or to supplant existing funding from other sources.

    The Recipient is responsible for ensuring that no federal funds provided under this award are used for any purpose not stated in the NOFO and approved by CMS. CMS may request documentation of the Recipient's internal controls to ensure that resources are used appropriately. If any federal funds are used for an unapproved purpose, the Recipient must notify the CMS Grants Management Specialist and the CMS Project Officer at the time of discovery and provide a mitigation plan to remedy the problem to the CMS Grants Management Specialist and to the CMS Project Officer.

    Note: CMS will allow reimbursement of pre-award costs starting January 1, 2026, for Budget Period 2. These costs are allowable only if incurred on or after the federal award start date and included in your approved Model Year 2 budget.

    CMS prohibits the use of funds under this award for any of the activities/costs outlined in the Standard Terms and Conditions, Section 27 'Prohibited Use of Grant or Cooperative Agreement Funds' unless an exception is specifically authorized by statute. Additionally, the Recipient cannot use funds for the following activities:

    - Reimbursement of pre-award costs;
    - Payment for new construction or renovation of any facility;
    - Providing individuals with items or services that are already funded through any other source, including, but not limited to Medicaid and CHIP.

11. **Duplication.** The Recipient is responsible for ensuring that no federal funds provided under this award are used to provide technical assistance or other services that are duplicative of funds and services authorized under other Federal programs or initiatives. CMS may request documentation of the Recipient's internal controls to ensure that resources are used in the most efficient manner and that use of funds are not duplicative of other Federal funds as stated above. If any duplication occurs, the Recipient must notify the CMS Grants Management Specialist and the CMS Project Officer at the time of discovery and provide a mitigation plan to remedy the problem to the CMS Grants Management Specialist and to the CMS Project Officer.

REPORTING REQUIREMENTS

12. **Complete and Accurate Submissions.** The Recipient shall ensure that all data, reports, and documentation that it or its subrecipient(s) or contractor(s) submit to CMS or its contractor(s) in support of model activities are complete and accurate to the best of the Recipient's knowledge, and that such data are submitted in a format that complies with CMS requirements. The Recipient must correct, and facilitate corrections, for any inaccurate or incomplete data, reports, or documentation previously submitted to CMS by it or its Subrecipients, no later than 2 weeks after it becomes aware of the inaccuracy or incompleteness in a manner and form specified by CMS. The Recipient may be subject to Remediation if CMS does not receive timely, complete, and accurate data, reports, and documentation (See Section 32 'Remediation Actions,' and Section 34 'Termination').

13. **Management Tools.** CMS reserves the right to require the Recipient to use management tools (Payment Management System, GrantSolutions, Salesforce, Innovation Support Platform, or others) for all information and data submissions, including without limitation: tracking model data, tracking operational milestones, and/or for submitting the programmatic and financial reports. CMS will provide the Recipient with access to these management tools and related instructions.

14. **Award Monitoring**. The Recipient shall assume responsibility for the accuracy and completeness of the information contained in all communications, including technical documents, reports and data submitted for this project. CMS will monitor the project to assess Recipient's performance, including identification of potential problems and areas where additional technical assistance might be necessary. CMS monitoring activities may include, but are not limited to, the following: (1) phone calls, (2) scheduled teleconferences or web conferences between the Recipient and the Project Officer, (3) review of programmatic progress and financial reports, (4) prior-approval requests to utilize funding, (5) spend rates, (6) correspondence between the Recipient and CMS, (7) audit reports, (8) site visits, and (9) other activities and information available to CMS.

    - **Active Participation in Monitoring Activities.** During all teleconferences, web conferences, or site visits, the Recipient must be prepared to provide substantive discussion on several key areas including:
        - The status of model activities, milestones (see Section 20 'TMaH Model Pillars, Required Elements and Associated Milestones'), and any revisions to established goal.
        - Their collaborative work with Partner Providers, Partner Care Delivery Locations, and Subrecipients, highlighting both successes and measurable outcomes achieved under the model.
        - Any significant opportunities, challenges or delays the Recipient, Subrecipients, or other model partners have encountered, explaining how these issues impact the overall project timeline.

- Organizational changes including personnel and budget modifications.
- Technical assistance previously received from CMS.
- Any additional support needs, as well as other project-related issues.

- **Monitoring Data.** The Recipient must provide CMS-specified data elements for monitoring to CMS and/or its contractor(s) in a form and manner and by a deadline specified by CMS. Data for monitoring includes, but are not limited to: notes, agendas and materials discussed during Project Officer phone calls and email communications; programmatic reports; progress toward milestones; and financial expenditure reports. CMS reserves the right to update data elements and the form and manner of submission, as well as other related data reporting requirements as needed in future.

Nothing in these Program Terms and Conditions must be construed to limit or otherwise prevent CMS from monitoring Recipient.

15. Communication/Participation.

- The Recipient must cooperate and participate in technical assistance activities as specified in these Program Terms and Conditions. Such cooperation may include adhering to project-related training, assisting with the development of materials to be used in the project, or other activities to support the Recipient's capacity to fully realize its project. The Recipient will cooperate with CMS contractors and other Recipients to foster project-to-project knowledge transfer of non- proprietary information and to meaningfully participate in technical assistance/implementation conference calls. This cooperation includes that the Recipient will allow CMS or its contractors access to the Recipients' facilities and systems for these purposes. The Recipient will not interfere with this right to access. CMS also reserves the right to require the Recipient to participate in additional technical assistance activities as needed.
- The Recipient must disseminate information received from CMS to all internal and external individuals or entities affected by the NOA, including Partner Providers, Partner Care Delivery Locations and Partner Organizations, to ensure timely and effective communications.
- The Recipient must develop and maintain a communications management plan for all internal and external communications with all individuals or entities related to this NOA such that the Recipient maintains timely and effective communications throughout the Cooperative Agreement Period of Performance.
- The Recipient must provide the CMS Project Officer with an accurate record of contact information for all key personnel working on this award throughout the period of performance. At minimum, this contact information must include the staff name, title, role of staff supporting the award, email address, and telephone number. Recipient must notify CMS of changes in key personnel as specified in Section 18 'Personnel Changes.'
- Further, if CMS establishes a listserv or other means of providing electronic communications, then the Recipient must subscribe to and use that system(s). CMS will notify the Recipient of the applicable listserv(s) to subscribe to or other means of communication, as applicable.

16. Progress Reports. Recipients must cooperate and comply with any Federal oversight as it may pertain to the Terms and Conditions of the Notice of Award. The Recipient must submit the required progress reports as further detailed below.

- Semi-Annual Report. The semi-annual reports are specific to activities completed and progress achieved during the prior six months. Each semi-annual report shall include

at a minimum the status of each element in the state's work plan, a narrative summary of the period's accomplishments, barriers or challenges to meeting elements benchmark, and any additional requirements identified by CMS.

    - The semi-annual report is due 30 calendar days after the end of the reporting period.

- Final Report. The Recipient must provide a final report to CMS. This report must provide a cumulative summary of activities completed during the entire Cooperative Agreement Period of Performance, including, but not limited to, a complete discussion of the use of funds for model activities, analysis of effectiveness or success of the model, lessons learned, a list of any approved publications, and a description of activities that will be sustained as a result of the model.

    - The Final Progress Report is due, along with other required closeout materials, 120 days after the end of the Cooperative Agreement Period of Performance.

Reports must be electronically submitted to GrantSolutions via

the Performance Progress Report (PPR) Module. The final PPR must be submitted no later than 120 days after the NoA period of performance ends on December 31, 2034.

Recipients with the following roles can view, edit, and submit the PPR:

- Authorizing Organizational Representative (AOR)
- Principal Investigator/Program Director (PI/PD)

Recipients who can edit or submit the PPR receive email notifications from GrantSolutions in the following instances:

- 14 days before the PPR is due;
- One day after the PPR is due if the report was not submitted;
- When the PPR is submitted;
- When the PPR is returned by the CMS for changes;
- When the PPR is accepted by the CMS.

Upon review, the CMS Project Officer will either accept or return the PPR to the Recipient for additional information or clarification. The cooperative agreement will not be considered complete and in accordance with the applicable terms and conditions until the CMS Project Officer has accepted all required reports.

CMS reserves the right to update reporting periods or due dates if needed and to require that Recipient clarify or provide additional details in these reports.

Report Type	**Reporting Period**	**Due Date**
Semi-Annual Report 1	January 1 - June 30, 2025	July 30, 2025
Semi-Annual Report 2	July 1 - December 31, 2025	January 30, 2026
Semi-Annual Report 3	January 1 - June 30, 2026	July 30, 2026
Semi-Annual Report 4	July 1 - December 31, 2026	January 30, 2027
Semi-Annual Report 5	January 1, 2027 - June 30, 2027	July 30, 2027

Semi-Annual Report 6	July 1 - December 31, 2027	January 30, 2028
Semi-Annual Report 7	January 1 - June 30, 2028	July 30, 2028
Semi-Annual Report 8	July 1 - December 31, 2028	January 30, 2029
Semi-Annual Report 9	January 1 - June 30, 2029	July 30, 2029
Semi-Annual Report 10	July 1 - December 31, 2029	January 30, 2030
Semi-Annual Report 11	January 1 - June 30, 2030	July 30, 2030
Semi-Annual Report 12	July 1 - December 31, 2030	January 30, 2031
Semi-Annual Report 13	January 1 - June 30, 2031	July 30, 2031
Semi-Annual Report 14	July 1 - December 31, 2031	January 30, 2032
Semi-Annual Report 15	January 1 - June 30, 2032	July 30, 2032
Semi-Annual Report 16	July 1 - December 31, 2032	January 30, 2033
Semi-Annual Report 17	January 1 - June 30, 2033	July 30, 2033
Semi-Annual Report 18	July 1 - December 31, 2033	January 30, 2034
Semi-Annual Report 19	January 1 - June 30, 2034	July 30, 2034
Final Report	January 1, 2025 - December 31, 2034	April 30, 2035

All progress reports must be in a format compliant with section 508 of the Rehabilitation Act (29 U.S.C. 794d).

Recipient's failure to submit required reports or the absence of satisfactory progress reports may result in CMS deciding to terminate Recipient's Award, and to allocate those funds as determined by CMS.

Termination of the NOA will end the Recipient's participation in the TMaH Model, as well as the participation of Partner Providers, Partner Care Delivery Locations and Partner Organizations.

CMS reserves the right to modify time frames and required data elements reported in all technical documents and reports submitted to better measure outcomes for Recipients with specialized goals and strategies. CMS may also require the reporting of additional data elements over the course of the Cooperative Agreement to fully assess Recipient performance. CMS reserves the right to request the Recipient to clarify or provide additional details in these reports.

17. **Financial Reports.** The Recipient is required to record expenses in real-time as well as submit annual expenditure Federal Financial Reports (FFRs)-SF-425s via the Payment Management System, as described in the Standard Terms and Conditions, Section 29(D) 'Financial Reporting,' in accordance with the following schedule:

    a) **Annual Expenditure Federal Financial Report.** The Recipient must complete the Annual Expenditure Federal Financial Report (SF-425 or FFR) in the Payment Management System no later than 90 days following the last day of the applicable annual reporting period listed in these Program Terms and Conditions. For specific directions on filing the Annual Expenditure Federal Financial Report, see Standard Terms and Conditions, Section 29(D) 'Financial Reporting.'

    b) **Final Expenditure Federal Financial Report.** The Recipient must submit the

final Expenditure Federal Financial Report (SF-425 or FFR) in the Payment Management System no later than 120 days following the end of the Cooperative Agreement Period of Performance.

PRIOR APPROVALS

18. **Personnel Changes.** Key personnel changes require prior CMS approval. The Recipient must submit a personnel change request in GrantSolutions. The Recipient must notify the CMS Project Officer and the CMS Grants Management Specialist within ten (10) calendar days before any key personnel changes affecting the award, including principal investigators/project director. Alternatively, if Recipient becomes aware of any key personnel change fewer than ten (10) calendar days before the change is effective, then Recipient must notify CMS within ten (10) calendar days of when the Recipient becomes aware. See Standard Terms and Conditions, Section 13 'Prior Approval Requirements' for additional information.

    There are two personnel request types:

    a) **Revision (NoA Other):** Changes to other key personnel besides the Project Director, including the Authorized Organizational Representative (AOR), Program Manager and any other key personnel noted in the approved application.

    b) **Revision (PI/PD):** Change in Project Director. See Standard Terms and Conditions, Section 13 'Prior Approval Requirements' for additional information.

19. **Change in Scope.** Prior approval from CMS is required for a change in scope if Recipient anticipates deviating from the original scope of work as described in the CMS approved grant application for which the Cooperative Agreement was awarded. If proposing changes, the Recipient must first consult with the CMS Project Officer prior to submitting a formal amendment request in GrantSolutions. The formal request must include a detailed explanation for the change to the scope of work. If the amendment request is approved, the CMS Grants Management Officer will issue a revised Notice of Award indicating approval. See Standard Terms and Conditions, Section 13 'Prior Approval Requirements' for additional information.

20. **TMaH Model Pillars, Required Elements and Associated Milestones.** The TMaH Model is organized into three pillars, with required and optional elements, designed to address the key issue areas that affect maternal health outcomes (see Table 2 below):

    - Pillar 1: Access, Infrastructure and Workforce
    - Pillar 2: Quality Improvement and Patient Safety
    - Pillar 3: Whole-Person Care Delivery

TABLE 2 Model Pillars and Elements

Required Elements		
Pillar 1 Access, Infrastructure and Workforce	Pillar 2 Quality Improvement and Safety	Pillar 3 Whole-Person Care Delivery
1. Increase access to the midwifery workforce 2. Increase access to birth centers 3. Cover[1] Doula Services 4. Improve data infrastructure 5. Develop payment model	1. Support implementation of AIM patient safety bundles 2. Support "Birthing-Friendly" hospital designation	1. Increase risk assessments, screenings, referrals and follow-up for perinatal depression, anxiety, tobacco use, substance use disorder, and upstream drivers of health 2. Increase Home Monitoring of diabetes and hypertension 3. Develop a Prevention & Quality Plan
Optional Elements (Other Available Technical Assistance)		
Pillar 1 Access, Infrastructure and Workforce	Pillar 2 Quality Improvement and Safety	Pillar 3 Whole-Person Care Delivery
▪ Cover[2] certified midwives (CMs) and certified professional midwives (CPMs) ▪ Cover[3] Perinatal Community Health Workers (CHWs) ▪ Create regional partnerships in rural areas ▪ Extend Medicaid eligibility to 12 months postpartum	▪ Promote shared decision-making	▪ Expand group perinatal care ▪ Increase use of home visits, mobile clinics and telehealth ▪ Expand oral health care

Each required element has associated Pre-Implementation Milestones, which must be completed no later than the end of Model Year 3. These required Pre-Implementation Milestones are listed below:

➢ **Pillar 1. Element 1: Increase access to the midwifery workforce:**

- Complete an assessment of midwifery workforce capacity in the state and identify options for covering additional types of midwives licensed in the state
- Assess and create a billing pathway for interprofessional consultations between midwives

[1] Include Doula Services among those eligible for Medicaid payment. Doula Services are defined in Section 'Definitions' and are provided by a non-clinical trained professional (e.g. Doula or Perinatal CHW).

[2] Include certified midwives and/or certified professional midwives among those eligible for Medicaid payment

[3] Include Perinatal Community Health Worker services among those eligible for Medicaid payment

and other providers, including maternal fetal medicine specialists, as appropriate and needed

- Complete payment analysis that compares the reimbursement rate for midwives as a proportion of a benchmark rate (for fee schedule updates as appropriate), and implement a process to complete a comparable analysis on an annual basis thereafter

➢ **Pillar 1**. **Element 2: Increase Access to Birth Centers**

- Complete a payment analysis that compares the facility fee rate for Birth Centers as a proportion of a relevant benchmark rate, and has a process in place for completing an annual analysis thereafter
- Create a plan for providing information to pregnant beneficiaries on Birth Centers, if licensed and operating in the state
- Complete an implementation plan for establishing more sustainable reimbursement rates for Birth Centers

➢ **Pillar 1**. **Element 3: Cover Doula Services (provided by non-clinical trained professionals (e.g. Doula or Perinatal CHW)**

- Complete workplan for initial payment analysis
- Complete a payment analysis that compares the reimbursement rate for Doula Services as a proportion of a relevant benchmark rate, and implement a process for completing an analysis annually thereafter
- If Doula Services are not already covered as a Medicaid service, submit, or have a timeline and process in place for submitting and implementing, a Medicaid State Plan Amendment (SPA)/Section 1115 demonstration program to cover Doula Services
- Convene a State Doula Support Council, if no such council has already been established

➢ **Pillar 1. Element 4: Improve Data Infrastructure**

- Establish a timeline and plan for linking mother-infant Medicaid IDs with vital records data, if the data have not yet been linked by the end of Model Year 2. Plans should include the execution of necessary recurring data-sharing and related agreements for linking mother-infant Medicaid IDs with vital records data to support long-term model monitoring and program evaluation.
- Complete data needs assessment and draft work plan with Partner Providers and Partner Care Delivery Locations to stratify demographic data, or identify challenges and has a clear timeline and process for such stratification
- Complete data needs assessment and draft work plan to identify Model beneficiaries who are also utilizing social service and benefit programs such as WIC/SNAP, for the purpose of measuring and addressing cross-program enrollment gaps
- Collect and report stratified demographic data, and match Beneficiary data across social service and benefit programs such as WIC/SNAP
- Ensure accurate and timely Medicaid claims data reporting using T-MSIS as follows:
    - In Model Year 2, the Recipient will: (1) ensure participation of data leads or staff with decision-making authority in coaching calls with Implementation and Monitoring contractor **t**o understand and improve the submission of T-MSIS data; and (2) initiate data system changes needed (at the state level, in partnership with MCOs and CMS as needed) to effectuate identified improvement needs.

- By the end of Quarter 1 of Model Year 3 (March 31, 2027), Recipient will either: (1) ensure that T-MSIS data satisfies CMS requirements for quality and integrity to enable calculation of rates and quality benchmarks by CMS; or (2) establish alternative process to obtain the required data for participating TMaH entities.

Pillar 1. Element 5: Implement Payment Model

- With policy and analytic guidance, create a plan, process, and timeline for implementing the payment model requirements, including:
  - Using the appropriate Medicaid authority to implement the payment model
  - Identifying and documenting personnel necessary to implement the payment model, including description of roles and responsibilities and budget to support efforts
  - Developing a stakeholder engagement plan for ongoing conversations with providers and Managed Care Plans, where applicable
  - Quarterly meeting cadence established with CMS staff and contractors
  - Submitting draft payment model implementation workplan to CMS
  - Final payment model implementation workplan submitted to CMS, including Managed Care Plan engagement plan, and Managed Care Plan contracting timeline
  - Establish payment model benchmarks in partnership with CMS, including cost and quality thresholds

➢ **Pillar 2. Element 1: Support Implementation of AIM Patient Safety Bundles**

- Establish partnership (regularly participate in meetings, share information and action items) with Perinatal Quality Collaborative (PQC) or leading AIM patient safety entity to support selection and rollout of AIM patient safety bundles across state/region, particularly in facilities where no bundles have been implemented
- Design implementation plan to build capacity for participating in AIM patient safety bundles
- Support enhanced data collection to monitor hospital safety bundle outcomes
- Work with AIM and PQC convenors to expand database to systematically collect relevant quality, process or structure and outcomes measures data

Pillar 2. Element 2: Support "Birthing-Friendly" Hospital Designation

- Complete analysis of hospitals and Critical Access Hospitals with birthing facilities to identify existing barriers for such hospitals to attain the "Birthing-Friendly" hospital designation and strategies for the state, hospitals or other entities to take to address such barriers
- Attest that the "Birthing-Friendly" hospital designation is displayed in provider directories, where applicable

Pillar 3. Element 1: Increase Risk Assessments, Screenings, Referrals and Follow-up for Perinatal Depression, Anxiety, Tobacco Use, Substance Use Disorder, and upstream drivers of health

- *Risk Assessment:*
  - Identify and select risk assessment tools, as appropriate
  - Complete a plan to implement medical and non-medical risk assessments for risk- appropriate care

- *Screening/Referral for Behavioral Health Needs:*
    - Create a process/journey map of existing screening and referral processes for perinatal beneficiaries with behavioral health needs that identifies areas of improvement
    - Identify workflows and data collection processes for screening-related quality measures
    - Select specific screening tools
    - Identify areas of improvement through completed process map
    - Draft screening/referral process implementation plan to address identified gaps, including identification of key action steps for the state and participating providers and CBOs and a timeline for implementation.
    - Train hospital and provider staff, as appropriate, on selected screening tools and processes
    - Establish specific follow-up protocol for positive screens and made appropriate workforce linkages
- *Screening/Referral for Substance Use Disorder (SUD) and Tobacco Use:*
    - Draft a process/journey map of existing screening and referral processes for perinatal beneficiaries with SUD or tobacco use
    - Identify workflows and data collection processes for quality measures
    - Finalize selection of specific screening tools
    - Draft implementation plan to address identified gaps
    - Train hospital and provider staff, as appropriate on specific screening tools
    - Specific follow-up protocol for positive SUD or tobacco-use screens established and behavioral health workforce linkages made, where needed
- *Screening/Referral for upstream drivers of health:*
    - Draft health implementation plan to address identified gaps in referrals for non-medical needs
    - Identify healthy workflows and data collection processes for quality measures
    - Finalize selection of specific screening tools
    - Establish health bi-directional referral pathways such that providers can connect beneficiaries to CBOs and receive notification when the CBO is engaged
    - Train health staff on specific screening tools
    - Establish health specific follow-up protocols for identified needs

➢ **Pillar 3. Element 2: Home Monitoring for hypertension and diabetes**

- Determine whether a SPA or waiver is needed for Medicaid coverage of Home Monitoring services and devices
- Create a draft partnership plan between the Recipient and public health department, Managed Care Plan (MCP) and/or other organization (e.g., university) on the design and implementation of Home Monitoring, as appropriate
- Complete draft SPA/waiver documents, as needed, and submitted for internal review, as required

- Meet with partners, such as the state public health department, MCP and/or other organization (e.g., university) and updated partnership plan, as appropriate
- Draft a plan (including information on Medicaid coverage and reimbursement, information for providers on offering and tracking Home Monitoring services, devices and apps needed) for how to implement Home Monitoring

➢ **Pillar 3. Element 3: Prevention & Quality Plan (PQP)**

- The Recipient must **s**ubmit a preliminary PQP to CMS in Model Year 2 and an updated PQP annually thereafter in the form and manner specified by CMS. PQPs will identify the state's prevention area, external engagement, intervention, and population. PQPs should be supported by relevant data about strategies with specific populations of focus; what interventions would be most applicable to assist in that prevention (including external engagement); and collection of prevention interventions that align to quality metrics of the model. Recipient must establish a process for measuring and tracking stratified outcomes in state or sub-state region for the health conditions of interest. CMS will issue forthcoming guidance on format and due date.

EXTENSION REQUESTS

21. Requesting an extension. Recipients seeking an extension on the submission of any deliverable or milestone must request the extension in writing to their PO at least 10 days before the deadline. The Authorized Organizational Representative (AOR) must sign the request and submit it as a Grant Message in GrantSolutions. The brief written request must cite at a minimum:

1) The specific requirement/milestone and original submission date

2) The Recipient's proposed new submission date or estimated timeframe for submission, and

3) The reason(s) for the extension request.

If the milestone is missed and no extension was requested or granted, the submission is considered late. Remediation may occur at CMS' discretion based on extension requests and missed milestones. The PO, in consultation with the Grants Management Specialist, has the discretion to approve or reject any requested extension. The PO will submit a written response (approval or denial) to the request via Grant Message in GrantSolutions.

PAYMENT MODEL REQUIREMENTS

Recipients may implement the payment model directly in a FFS program and/or via risk-based managed- care plans (MCPs). While CMS will be responsible for the design of the payment model, we will partner closely with Recipients and other key interested groups, such as providers, to gather input and design the TMaH payment model details during the first three years. The payment model must align with existing federal Medicaid and CHIP requirements, and some parameters of the payment methodology may vary based on state laws and regulations as well as regional and local labor pools and other variables.

As a condition of participation in the TMaH Model, all Recipients must agree to implement the payment model, consistent with the parameters outlined below.

22. Provider Infrastructure Payments:

- Starting no later than the last day of Quarter 1 in Model Year 3 (**March 31, 2027**), Recipient must follow CMS's forthcoming guidance and process, as noted below, to disseminate a

portion of their Cooperative Agreement funding to Partner Providers and Partner Care Delivery Locations as Provider Infrastructure Payments to fund care delivery transformation activities outlined below. Recipients may disseminate a portion of their Cooperative Agreement funding as Provider Infrastructure Payments to Partner Providers and Partner Care Delivery Locations for more than one year (e.g. starting in Model Year 2) but must make these payments for at least one year beginning no later than Quarter 1 of Model Year 3 (**March 31, 2027**).

- Provider Infrastructure Payments will be awarded as part of annual Cooperative Agreement funding to Recipients who have qualified for non-competing continuation funding. Recipients must comply with CMS guidelines regarding Provider Infrastructure Payment funding, including but not limited to the use of a needs assessment or similar decision-making tool for Provider Infrastructure Payment funding determinations, subject to CMS approval. The annual total of Provider Infrastructure Payments dispersed by a Recipient may not exceed the TMaH Cooperative Agreement total funding amount for Model Year 3.
- Recipients will be responsible for regularly dispersing the Provider Infrastructure Payments, on a semi-annual basis or at the discretion of the Recipient subject to CMS approval, to Partner Providers and Partner Care Delivery Locations to support the activities through Subrecipient agreements as detailed below.
- Provider Infrastructure Payments must not duplicate or supplant existing federal, state, or local funds available for the same activities.
- Recipients must execute a legal agreement (subaward) with a Subrecipient(s) for the purpose of administering Provider Infrastructure Payments. Such agreement must require that the entity cooperate with all CMS monitoring requests and activities and provide CMS (through the Recipient) with access to records, data and information necessary to comply with such monitoring requests and activities. The Recipient must ensure that each entity adheres to the requirements and timelines for submitting information to CMS. Subrecipients may include a Partner Provider, Partner Care Delivery Location, or a third party, such as a managed-care entity, foundation, or another entity dispersing payments to Partner Providers and Partner Care Delivery Locations. All subawards must be in accordance with 2 CFR § 200.331, Subrecipient and contractor determinations. Recipients may not administer Provider Infrastructure Payments directly to providers through their fee for service systems, pursuant to their provider agreements, or through existing agreements with a Managed Care Plan pursuant to 42 CFR Part 438.
- Further, if Provider Infrastructure Payments are not administered directly to Partner Providers or Partner Care Delivery Locations as Subrecipients, then all third party Subrecipients must execute a legal agreement with each entity receiving Provider Infrastructure Payments. Such agreements with a Partner Provider or Partner Care Delivery Location to make Provider Infrastructure Payments must require that the entity cooperate with all CMS monitoring requests and activities and provide CMS (through the Recipient) with access to records, data and information necessary to comply with such monitoring requests and activities. The Recipient must ensure that Partner Provider and Partner Care Delivery Locations adhere to the requirements and timelines for submitting information to CMS.
- Recipient shall repay to CMS some or all the Provider Infrastructure Payment as specified by CMS if the Partner Provider or Partner Care Delivery Location uses the Provider Infrastructure Payment for a purpose other than the permitted use described herein.
- The Provider Infrastructure Payments may only be used by Partner Providers and Partner Care Delivery Locations for activities approved by CMS, including but not limited to the

activities listed below, which must be detailed in the Recipient's budget workbook and budget narrative, subject to CMS approval:

- **Patient Safety Initiatives and Maternal Care Assessment:**
  - Implementation of the PQC-led AIM patient safety bundles; such payments may not duplicate or supplant funds provided by Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), or any other federal or state source for the same purpose.
  - Achievement of the "Birthing-Friendly" hospital designation (for hospitals only).
  - Planning, patient-flow revision, acquisition of electronic health record (EHR) systems or coding changes or other activities required to effectively use medical and non-medical risk assessments to drive risk-appropriate care.
- **Quality Measure Reporting:**
  - Data reporting on the below model quality measures (see TMaH Model NOFO Section A.4.3.33 'Quality Measures'), subject to federal and state privacy laws.
    - Low-risk cesarean delivery
    - Screening for maternal depression and follow-up
    - Severe obstetric complications
    - Timeliness of prenatal and postpartum care
  - Data reporting on additional quality assurance measures (see TMaH Model NOFO Section A.4.6 'Measures and Reporting'). CMS will specify which measures Recipients will need to report and provide technical assistance where needed.
  - Provider surveys
- **Data integration and other activities to support data-driven maternity care:**
  - EHR upgrades and data infrastructure improvement, as needed, to meet model data collection and reporting requirements.
  - Connections to enable providers' EHRs to exchange data with regional or national networks facilitating health information exchange.
  - Creation of dashboards to support quality improvement activities.
  - Integration with CBOs to share screening and referral information (and for CBOs to share notifications back to the referring provider) to meet patient's upstream drivers of health and behavioral health needs in compliance with state and federal data privacy laws.
- **Team-Based Care:**
  - Support regular and ongoing interprofessional care team meetings and planned quality assurance and improvement activities. In addition to obstetricians and other physicians and registered nurses, the maternal care team may include doulas, Perinatal Community Health Workers, CHWs, midwives, physician assistants and behavioral health providers, as appropriate.
- **Enhanced Access to Care:**

        - Offer one or more alternatives to traditional office visits to increase access to care in ways that best meet the needs of the population. This may include Home Monitoring for diabetes and hypertension or other telehealth initiatives, group perinatal visits, home visits, alternate location visits, or expanded early morning, evening, and/or weekend hours.
    - **Connections to CBOs to address upstream drivers of health and behavioral health needs:**
        - Identification of local entities that can help address non-medical and/or, mental health (e.g., depression and anxiety), or substance use disorder-related needs of beneficiaries and integrate them into screening, referral and follow-up activities, where legally permissible and appropriate to do so.

23. Incentivizing High Quality Care Through Value-Based Payments

- Starting no later than the start of Model Year 4, Recipients will transition to the TMaH value-based payment model, the design of which will be led by CMS in collaboration with Recipients and other key stakeholders. As part of this value-based payment design, Partner Providers and Partner Care Delivery Locations will become eligible for upside-only payments based on Model Year 4 performance, to be paid by Recipient using the appropriate Medicaid authority and following CMS review processes. Payments would be disbursed following a reasonable period for claims run out and analysis. **Cooperative Agreement funding cannot be used for these payments.**
- During Model Years 1-5, Recipients and their identified partners are required to participate in discussions with CMS at times and dates of CMS' choosing. Topics may include but are not limited to:
    - Aligning the payment model design with the TMaH Model's key maternal health outcome goals
    - Analysis of different types of payment approaches, including structuring performance benchmarks and the role of risk adjustment methodology
    - Identification of potential quality measures to be included in the arrangement
    - Data sharing, collection, and processing considerations
    - Partner Provider, Partner Care Delivery Location, and Beneficiary inclusion and exclusion criteria
    - Attribution methodology
    - Implementation considerations for managed care and FFS environments
- Using historical data, CMS will establish risk-adjusted quality and cost benchmarks on a pre- determined set of measures for calculating the upside-only performance payment amount. Partner Providers and Partner Care Delivery Locations will receive value-based payments based on performance. Payment methodologies for these payments will be finalized during the Pre-Implementation Period.
- **Quality Measures:** The following quality measure concepts will be used to determine Performance Incentive Payments in MY4 and beyond (see below). These measures will be finalized by the end of MY3. Additional details can be found in Table 4 of the TMaH NOFO. Measures may be added or removed from the list used to determine Performance Incentive Payments throughout the model as new data and research becomes available.
    - Low-risk cesarean delivery

- Maternal depression screening and follow-up
- Severe obstetric complications
- Timeliness of prenatal and postpartum care

- **Quality and Cost Measure Benchmarks:** CMS will create cost and quality benchmarks using 2-3 years of claims data and vital records information. Recipients will be required to collaborate in this process by submitting vital records data and participating in financial and quality-focused meetings with CMS.

24. **Partner Provider Information.** The Recipient must submit Partner Provider information **by October 1, 2026**, in the form and manner specified by CMS. The submission must include the following:
    - Full legal name
    - All doing business as (DBAs) names
    - Address
    - Tax Identification Number (TIN)
    - National Provider Identification (NPI) number (if applicable) of each care-delivery partner
    - Verification that each Partner Provider is in compliance with any applicable Medicaid Program Integrity requirements at 42 C.F.R. Part 455
    - Data-sharing plan between the entities, if applicable
    - Reporting requirements between the entities, if applicable
25. **Partner Care Delivery Location Information**. Recipient must submit in a form and manner specified by CMS the following information for each Partner Care Delivery Location **by October 1, 2026**:
    - Full legal name
    - All DBAs
    - Address
    - Tax Identification Number (TIN)
    - National Provider Identification (NPI) number (if applicable)
    - Verification that each Partner Care Delivery Location is in compliance with any applicable Medicaid Program Integrity requirements at 42 C.F.R. Part 455
    - Data-sharing plan between the entities, if applicable
    - Reporting requirements between the entities, if applicable
26. **Partner Organization Information**. Recipient must submit in a form and manner specified by CMS the following information for each Partner Organization **by October 1, 2026**:
    - Full legal name
    - All DBAs
    - Address
    - Tax Identification Number (TIN), (if applicable)
    - Verification that each Partner Organization is in compliance with any applicable Medicaid Program Integrity requirements at 42 C.F.R. Part 455
    - Data-sharing plan between the entities, if applicable
    - Reporting requirements between the entities, if applicable
27. **Provider Participation Standards**. The Recipient submitted to CMS a written policy detailing its standards for selecting providers that will render health care services to TMaH Model Beneficiaries in Model Year 1. The policy is required to clearly identify the criteria the Recipient and its partners will use to select and monitor Partner Providers. The Recipient must

submit any updates to these standards to CMS **by July 30 of each year.**

28. **Documentation of Managed Care Plan Participation**. If applicable, Recipient must submit to CMS updated or new documentation that confirms Managed Care Plans' agreement to participate in the TMaH Model due by **July 30 of each year**. The documentation should confirm that Recipient has engaged all Managed Care Plans whose enrolled beneficiaries are receiving services through the TMaH Model.

29. **Data Collection and Submissions.** The Recipient must accurately collect and submit all required data in the form and manner requested by CMS and/or its contractors. Recipient must become a health oversight agency (as defined by https://www.healthIT.gov) and/or execute any data sharing/data use agreements with CMS for the purposes of data sharing prior to the start of MY4. The Recipient must work with Managed Care Plans to report required data and execute any data sharing/data use agreements with the appropriate state agency, such as the State Public Health Department, for the purposes of sharing upstream drivers of health, vital records, and other requested data with CMS. Recipient must ensure that Partner Provider, Partner Care Delivery Locations and Partner Organizations adhere to the requirements and timelines for submitting data to CMS.

30. **Evaluation.**

a) The Recipient shall participate in all TMaH Model Evaluation activities. Recipient is an "entity participating" in the testing of a model under section 1115A of the Act and as such is required by 42 CFR § 403.1110(b) to collect and report such data as may be required by CMS or its contractor to carry out TMaH Model monitoring and evaluation. See Section 30 'Evaluation.'

Recipient is required to cooperate with CMS' and its contractors' efforts to conduct the federal evaluation. The evaluation is independent, federally funded, and statutorily required as part of the cooperative agreement. Recipient is responsible for ensuring that its care delivery partner(s), their clinical delivery sites, and other Sub-recipients and sub-contractors cooperate with evaluation efforts by CMS, including its contractor(s). Such efforts may include but are not limited to (1) patient- and program-level data provision, including ensuring that data Recipient obtains from third parties is available to CMS at no additional cost to CMS, (2) provision of personal identifiers that will allow TMaH Model Beneficiaries to be identified in the Transformed Medicaid Statistical Information System (T-MSIS), and (3) qualitative evaluation tasks.

Qualitative evaluation tasks include without limitation

(1) arranging site visits, observations, interviews, and focus groups with providers and patients as well as program staff,

(2) screening patients for upstream determinants of health,

(3) submitting patient medical information through a system that complies with privacy standards including the Health Insurance Portability and Accountability Act (HIPAA) and 42 C.F.R. Part 2,

(4) gathering required consent, including authorization from beneficiaries for themselves and for their infants to access and transmit individualized, identified vital records and associated data, and

(5) other activities as needed.

Recipient shall accurately collect and submit all required data elements in the form and format requested by CMS or its contractor(s). Such data will include but are not limited to:

(1) specified identifiable and person-level screening, referral and navigation data

elements

(2) Medicaid claims data

(3) information on contacts and communications with beneficiaries

(4) other data generated by award Sub-recipients that CMS determines is necessary to evaluate the TMaH Model

Recipient shall maintain and update the consent template form throughout the period of performance as needed for Recipient and its care delivery partner(s), clinical delivery site(s), providers, and other partners to gather beneficiary data necessary for the federal evaluation.

All data collected during the period of performance shall be submitted to CMS in a timely manner. Recipients will need to provide complete data submissions prior to the period of performance end date to ensure complete data submissions are timely. CMS reserves the right to adjust monitoring data requirements as needed. To the extent practicable, CMS will provide Recipient at least 90 days' advance notice of any such adjustments.

b) **Institutional Requirements Including IRB Approval.** Recipient shall plan for and carry out the collection and reporting of any individually identifiable health information (including protected health information) that may be required for the evaluation and monitoring of the TMaH Model and shall ensure that its Subrecipients have planned for and do the same. As Innovation Center models are exempt from IRB approval, in preparing to participate in the TMaH Model, Recipient and its Subrecipients shall ensure that any institutional requirements (e.g., review by an Institutional Review Board (IRB)) are completed in time to ensure that the data collection and reporting obligations under 42 CFR § 403.1110(b) are met at the time and in the form and manner specified by CMS. As noted in TMaH Model NOFO Section F.6.1.2 'Evaluation,' Recipient is solely responsible for any Institutional Review Board (IRB) procedures and approvals or any other permissions from its organizations or states that may be needed to submit these data. All IRB materials (if applicable), including any consent forms, must contain an explicit statement that allows identifiable and person-level data (PII) collected under this award to be shared with and submitted to CMS and its contractors for the purpose of carrying out the monitoring and evaluation of the TMaH Model. Should an institutional requirement present a barrier to Recipient or its Subrecipients meeting these data collection and reporting obligations, Recipient may be subject to termination pursuant to Standard Terms and Conditions Section 35 'Termination.' In ensuring conformance with this section, CMS encourages Recipient and its Subrecipients to discuss their obligations under 42 CFR § 403.1110(b) with any approving bodies (such as an IRB). Failure to obtain IRB approval, if applicable, for the requisite reporting to CMS and its contractors under 42 CFR § 403.1110(b) will not relieve Recipient's and Subrecipients' obligations under 42 CFR § 403.1110(b).

c) F.6.1.2 Programmatic Reporting of the NOFO. CMS may require Recipients to meet at one or more times as agreed upon between CMS and the Recipient, prior to and/or following the submission date, to discuss the feasibility and/or appropriateness of test and comparison region parameters proposed in Recipient's application. These discussions may result in required modifications to the test and comparison regions.

31. Technical Assistance. The Recipient must participate in technical assistance and learning opportunities offered by CMS, including:

a) Respond to CMS and its contractors and staff when using various mechanisms such as surveys or interviews to identify Recipient technical assistance and education needs.

b) Collaborate with CMS to operationalize a data-driven and goal-oriented education system that builds on existing capacity within the Recipient's state or sub-state region.

c) Participate in the identification and dissemination of promising practices that may involve sharing lessons learned with other Recipients (e.g., present on webinars).

d) Share information on state and federal programs that complement TMaH Model interventions in the communities that Recipients serve.

e) Develop, track and report to CMS and its contractors and staff on quality improvement efforts, activities, and program improvement efforts and measures, at regular intervals.

f) Participate in technical assistance and learning activities hosted by CMS. Activities include webinars, peer-to-peer learning, teleconferences, etc. CMS anticipates events occurring at least once a month throughout the model.

g) Participate in multi-stakeholder convenings. Convenings will serve as a crucial forum to drive alignment among key stakeholders and build partnership and relationships among those stakeholders, in order to advance the development and operations of Medicaid payment authorities and waivers, partners, and data sharing. Examples of key partners include state and local public health offices, maternal health and licensing agencies, Managed Care Plans, social service providers, maternal health care team members and more. CMS anticipates up to two virtual convenings per year.

REMEDIATION ACTIONS, ENFORCEMENT ACTIONS, AND TERMINATION

32. Remediation Actions. CMS may impose additional specific award conditions as needed in accordance with **2 CFR 200.208 Specific award conditions** for Recipient's failure to comply and meet the deadlines stated in Section 20 'TMaH Model Pillars, Required Elements and Associated Milestones.' CMS will determine the specific remediation activities and corrective actions. These activities and actions may include, but are not limited to:

a) Requiring payments as reimbursements rather than advance payments

b) Withholding authority to proceed to the next phase until receipt of evidence of acceptable performance within a given period of performance (i.e., developing a plan to address non-compliance, extending the Recipient's Pre-Implementation Period)

c) Requiring additional, more detailed financial reports

d) Requiring additional project monitoring

e) Requiring the non-Federal entity to obtain technical or management assistance or

f) Establishing additional prior approvals

33. Enforcement Actions. CMS may take an enforcement action against the Recipient if CMS determines that the Recipient is non-compliant with the Terms and Conditions of the Notice of Award. Failure to comply with the Terms and Conditions of the Notice of Award includes, but is not limited to, the following:

a) A documented pattern of non-cooperation with CMS, its contractors, HHS, or other federal agencies

b) Failure to receive and implement technical assistance provided by CMS or its contractors

c) Failure to comply with the Terms and Conditions of this Award, including the failure to meet any milestone or reporting requirement included in these Program Terms and Conditions

d) Failure to provide complete and accurate data, including failure to provide data in a

timely manner or other information requested by CMS in a format accessible to CMS and its contractors

e) Failure to maintain valid authority to implement this model as approved by CMS

f) Improper use of Cooperative Agreement Award funds

If the Recipient is non-compliant with the Terms and Conditions of the Notice of Award, CMS may take an enforcement action against the Recipient. Potential enforcement actions may include, but are not limited to, (1) restricting Cooperative Agreement Award funds through temporarily withholding cash payments, (2) withholding further funds for the project, (3) wholly or partially suspending or terminating the award, and (4) other legal remedies as applicable, such as converting to the reimbursement payment method. See also Section 36'Notification of Risk or Significant Problems.' CMS may amend these Program Terms and Conditions without the consent of the Recipient, as stated in these Program Terms and Conditions, for good cause, or as necessary to comply with applicable federal or state law, regulatory requirements, accreditation standards or licensing guidelines or rules. CMS must include with any such amendment an explanation of the reasons for the amendment. To the extent practicable, CMS must provide the Recipient with 30 days advance written notice of any unilateral amendment, which notice must specify the amendment's effective date.

34. Termination by CMS. CMS may terminate any award for material noncompliance. Material noncompliance includes, but is not limited to, (1) violation of the Terms and Conditions of the Notice of Award; (2) failure to perform award activities in a satisfactory manner; (3) improper management or use of award funds; or (4) fraud, waste, abuse, mismanagement, or criminal activity. If the cooperative agreement is terminated, all funding provided through this award, not yet obligated, must be returned to HHS.

Section 1115A(b)(3)(B) requires the Secretary to terminate or modify the design and implementation of a model unless the Secretary determines after testing has begun that the model is expected to: (1) improve quality of care without increasing Medicare, Medicaid and CHIP spending; (2) reduce Medicare, Medicaid and CHIP spending without reducing quality of care; or (3) improve quality of care and reduce spending for Medicare, Medicaid, and CHIP. The Recipient should refer to Standard Terms and Conditions Section 35 'Termination' for additional termination specifications. The regulations that pertain to termination are stated in 2 CFR 200.340. In the event of a conflict between the terms of this section and the regulations, the regulations shall prevail.

35. Notification of Risk or Significant Problems. The Recipient shall immediately upon discovery[4] notify in writing the CMS Project Officer and CMS Grants Management Specialist of any significant problems or risks relating to the administrative, financial, and programmatic aspects of the award. Significant problems include, but are not limited to, adverse findings pursuant to Standard Terms and Conditions, Section 31 'Affirmative Duty to Track All Parties to the Award' or issues or barriers that may cause the Recipient to miss Model milestones described in the Terms and Conditions of Award, or failure to implement the TMaH Model as described in the NoA.

CMS may elect to allow the Recipient an opportunity to take appropriate remedies which may include the Recipient accepting specific award conditions, technical assistance, and/or adhering to a non-compliance action plan within a timeframe and manner determined by CMS. If the Recipient fails to meet the terms of any non-compliance action plan within the designated timeframe, CMS may terminate this Cooperative Agreement Award.

If the Recipient's actions endanger the public health and welfare, CMS may immediately terminate this Cooperative Agreement Award without the opportunity for corrective action.

The regulations that pertain to suspension and termination are referenced in the Standard Terms and Conditions, Sections 23 ‘Suspension and Debarment Regulations’.

[4] A problem is considered “discovered” as of the first day on which the problem is known, or reasonably should have been known, to the Recipient or to any employee, officer, or agent of the Recipient’s business associate.

Centers for Medicare & Medicaid Services
Standard[1] Grant and Cooperative Agreement Terms and Conditions

These terms and conditions apply to all funded award actions issued on or after December 14, 2025

GENERAL

1. **Recipient**. The recipient named on the Notice of Award (NoA) in field #1 is the non-federal entity that receives a federal award directly from CMS to carry out an activity under this Federal program.

   Recipients must comply with all terms and conditions of their NoAs, including:
   (a) These Standard Terms and Conditions
   (b) Recipient Specific Terms and Conditions, if applicable
   (c) Program Terms and Conditions
   (d) requirements of the authorizing statutes and implementing regulations for the program under which the NoA is funded
   (e) applicable requirements or limitations in appropriations acts
   (f) terms and conditions included in the HHS Grants Policy Statement **HHS GPS - effective 10/1/2025** in effect at the time of a new, noncompeting continuation, or renewal, or supplemental awards
   (g) the **HHS Administrative and National Policy Requirements**
   (h) Statutory and national policy requirements in **2 CFR 300.300**
   (i) applicable grant regulations in **2 CFR 200** and **2 CFR 300**
   (j) any policies or requirements specific to the award; and
   (k) any requirements included in the Notice of Funding Opportunity (NOFO).

2. **Acceptance of Application & Terms of Agreement.** By drawing or otherwise obtaining funds from the U.S. Department of Health and Human Services (DHHS) Payment Management System (PMS), the recipient:

   (a) acknowledges and accepts the terms and conditions of the award
   (b) is obligated to perform in accordance with the requirements of the award; and
   (c) certifies that proper financial management controls and accounting systems, to include personnel policies and procedures, have been established to adequately administer Federal awards and the funds drawn down.

   Additionally, by accepting this award, including the obligation, expenditure, or drawdown of award funds, recipient certifies as follows:

[1] Standard Terms and Conditions include all possible grants administrative requirements for CMS awards. All standard terms and conditions apply unless the requirement is not applicable based on the project awarded. Recipients should contact their assigned Grants Management Specialist if they have questions about whether an administrative term and condition applies to the award.

By applying for or accepting federal funds from HHS, recipients certify compliance with all federal antidiscrimination laws and these requirements and that complying with those laws is a material condition of receiving federal funding streams. Recipients are responsible for ensuring subrecipients, contractors, and partners also comply.

The recipient hereby agrees that it will comply with **Title VI of the Civil Rights Act of 1964**, as amended (codified at 42 U.S.C. 2000d et seq.), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 80); **Section 504 of the Rehabilitation Act of 1973**, as amended (codified at 29 U.S.C. 794), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 84); **Title IX of the Education Amendments of 1972**, as amended (codified at 20 U.S.C. § 1681 et seq.) and all requirements imposed by or pursuant to the Regulation of the Department of the Health and Human Services (45 CFR Part 86); The **Age Discrimination Act of 1975**, as amended (codified at 42 U.S.C. § 6101 et seq.), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 91); and **Section 1557 of the Patient Protection and Affordable Care Act**, as amended (codified at 42 U.S.C. § 18116), and all requirements imposed by or pursuant to the Regulation of the Department of the Health and Human Services (45 CFR Part 92).

For Programs that could implicate **Title IX** (i.e., awards to or for school, colleges, universities, 4-H programs, non-governmental organization (NGO) programs, sports programs, and education-related awards to prisons or other detention facilitates):

- Recipient is compliant with Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. §§ 1681 et seq., including the requirements set forth in Presidential Executive Order 14168 titled Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, and Title VI of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000d et seq., and recipient will remain compliant for the duration of the NoA.
- The above requirements are conditions of payment that go to the essence of the NoA and are therefore material terms of the NoA.
- Payments under the NoA are predicated on compliance with the above requirements, and therefore recipient is not eligible for funding under the NoA or to retain any funding under the NoA absent compliance with the above requirements.
- Recipient acknowledges that this certification reflects a change in the government's position regarding the materiality of the foregoing requirements and therefore any prior payment of similar claims does not reflect the materiality of the foregoing requirements to this NoA.

Recipient acknowledges that a knowing false statement relating to recipient's compliance with the above requirements and/or eligibility for the NOA may subject recipient to liability under the False Claims Act, **31 U.S.C. § 3729**, and/or criminal liability, including under **18 U.S.C. § 287** and **18 U.S.C. § 1001**.

If the recipient cannot accept the terms and conditions of this NoA, the recipient must notify the Grants Management Officer (GMO), in writing, within thirty (30) days of the issue date of this NoA in accordance with the **HHS Grant Policy Statement (GPS) 2.6.1: Accepting the Award**. Once an award is accepted by a recipient, the contents of the NoA are binding on the recipient unless and until modified by a revised NoA signed by the GMO.

3. **Court Orders**. Any term or condition in this NoA, including those incorporated by reference, that HHS is enjoined by court order from imposing or enforcing shall not apply or be enforced as to any recipient or subrecipient to which that court order applies and while that court order is in effect.

4. **Cooperative Agreements**. A cooperative agreement is an alternative assistance instrument to be used in lieu of a grant whenever substantial Federal involvement with the recipient during performance is anticipated. The difference between grants and cooperative agreements is the degree of Federal programmatic involvement rather than the type of administrative requirements imposed. Therefore, statutes, regulations, policies, and the information contained in these Standard Terms and Conditions that are applicable to grants also apply to cooperative agreements, unless otherwise stated. Your NoA states whether the funding mechanism is a grant or cooperative agreement.

5. **Funding for Recipients.** All funding provided under this award must be used by the Recipient exclusively for the program referenced in the NoA and described in the NOFO and outlined in the recipient's approved application. This includes any approved revisions, as applicable, made subsequent to the recipient's approved application.
    - Funds available to pay allowable costs during the period of performance include both Federal funds awarded and approved carryover balances.
    - Federal award funds must supplement, not replace (supplant) non-federal funds. All recipients who receive awards under programs must ensure that federal funds do not supplant funds that have been budgeted for the same purpose through non-federal sources. Applicants or award recipients may be required to demonstrate and document that a reduction in non-federal resources occurred for reasons other than the receipt of expected receipt of federal funds.

6. **Recipient Roles and Responsibilities.**
    - Principal Investigator/Project Director (PI/PD): The PI/PD is the individual(s) employed and designated by the recipient to direct the project or program being supported by the award. The PI/PD is responsible and accountable to officials of the recipient organization for the proper conduct of the project, program, or activity, whether or not they receive salaries or compensation under the award.

      The recipient Organization must identify a PI/PD who will dedicate sufficient time and effort (minimally 25%) to manage and provide oversight of the grant/cooperative agreement program. Sufficient time and effort are defined as the time and effort required to successfully fulfill all program requirements and expectations as well as meet the project goals. You must justify the time committed as necessary to meet this threshold. CMS reserves the right to require additional time.

NOTE: A PI/PD must be committed financially to this award, i.e., the position must be funded with federal funds or alternatively, can be funded as a cost-share (in-kind) by the recipient (or a combination of the two). A PI/PD cannot dedicate time as a cost share (in-kind) without documenting this commitment on the Notice of Award (as a non-federal share). This is true, even if there is no required cost sharing for the award. The recipient has a choice as to how the PI/PD is funded.

- Authorized Organizational Representative (AOR): The AOR is an employee of the recipient and has authority to act for the organization. The AOR is responsible for meeting award requirements, properly managing the award, and providing oversight. The AOR's signature on a grant application guarantees that the information in the application is correct and the organization is responsible for following all requirements.

  While we do not require a minimum level of effort for the AOR because the necessary time commitment will vary, the AOR (if an award is received) acknowledges and confirms upon recipient's drawdown of funds his/her responsibility to provide oversight of the award and to provide the necessary signature approvals on all documents. Additionally, the AOR must attend meetings with CMS as required by the terms and conditions of award. An AOR must ensure he/she allocates sufficient time for financial oversight, programmatic monitoring, and compliance with CMS grant requirements. CMS reserves the right to require additional effort if the time committed is insufficient.

- Key Personnel:
  The PI/PD and other individuals who contribute to the programmatic development or execution of a project in a substantive, measurable way, whether they receive salaries or compensation under the award.

7. **Uniform Administrative Requirements, Cost Principles, and Audit Requirements.** The NoA issued is subject to the administrative requirements, cost principles, and audit requirements that govern Federal monies associated with this NoA, as applicable, in the Uniform Guidance – **2 CFR 200** and **2 CFR 300**.

   In accordance with **2 CFR 300.106**, the Department of Health and Human Services adopts the Office of Management and Budget (OMB) guidance in 2 CFR part 200, with the additions included in this part (part 300) and **part 376 of this chapter**. Thus, this part gives regulatory effect to the OMB guidance and supplements the guidance as needed for the Department.

8. **Fraud, Waste, and Abuse.** The HHS Office of the Inspector General (OIG) maintains a toll-free number (1-800-HHS-TIPS [1-800-447-8477]) for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements as well as the **HHS OIG website**. Information may also be submitted by **email** or by mail to:

   Office of the Inspector General
   U.S. Department of Health & Human Services

Attn: HOTLINE
330 Independence Ave., SW
Washington, DC 20201

Such reports are treated as sensitive material and submitters may decline to give their names if they choose to remain anonymous.

9. **Medicare and Medicaid anti-kickback** statute is hereby incorporated by reference: **42 U.S.C. § 1320a-7b**.

10. **Payment.** The Division of Payment Management does not award grants. The issuance of grant awards and other financial assistance is the responsibility of the awarding agencies. Once an award is made, the funds are posted in recipient accounts established in the Payment Management System (PMS). Recipients may then access their funds by using the PMS funds request process.

    Recipients must indicate which approved activity(ies) from the budget category(ies) identified on the SF-424A Form (e.g., personnel, supplies) that the payment request will cover. Also include the amount requested for each budget category. Do not include Personally Identifying Information (PII) in your request.

    The PMS funds request process enables recipients to request funds using a Personal Computer with an Internet connection. The funds are then delivered to the recipient via Electronic Funds Transfer (EFT). If you are a new grant recipient, register in PMS **here**. If you need further help with that process, please contact the One-DHHS Help Desk via email at **PMSSupport@psc.hhs.gov** or call (877) 614-5533 for assistance.

    For Federal Payment requirements, refer to **2 CFR 200.305, Federal Payment** as well as **2 CFR 300.305**.

11. **GrantSolutions and email addresses.** Recipients must maintain an active account with GrantSolutions (GS) to communicate, receive, and obtain documentation from CMS. If the designated recipient Authorized Organizational Representative (AOR) and Project Director (PD) do not already have accounts in GS, they must contact GS immediately upon receipt of award to complete a user account form. Any change in key personnel, must also be communicated to CMS and GS staff so that the key responsible individuals are current and correct within the GS system.

12. **Reservation of Rights.** Nothing contained in this NoA is intended or shall be construed as a waiver by the United States Department of Justice, the Internal Revenue Service, the Federal Trade Commission, HHS OIG, or CMS of any right to institute any proceeding or action against the recipient for violations of any statutes, rules or regulations administered by the Government, or to prevent or limit the rights of the Government to obtain relief under any other federal statutes or regulations, or on account of any violation of this award or any other provision of law. The NoA shall not be construed to bind any Government agency except CMS, and this NoA binds CMS only to the extent provided herein, unless prohibited by law.

The failure by CMS to require performance of any provision shall not affect CMS's right to require performance at any time thereafter, nor shall a waiver of any breach or default result in a waiver of the provision itself.

ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

13. Prior Approval Requirements. CMS anticipates that the recipient may need to modify the recipient's NoA budget or other aspects of its approved application during performance to accomplish the award's programmatic objectives. In general, recipients are permitted to rebudget within and between budget categories to meet unanticipated needs and to make other types of post-award changes, provided that the changes still meet the statutory program requirements and the regulatory requirements under **2 CFR 200** and **2 CFR 300**, as applicable.

Items that require prior approval (i.e. formal written approval) from the GMO, as stated in the Terms and Conditions of the NoA and HHS grant regulations must be submitted in writing. Based on the nature, extent, and timing of the request, the GMO may approve, deny, or request additional material to further document and evaluate your request.

A recipient must request approval of post-award changes to its award through submission of an amendment in GS (based upon the applicable change request). Only an amended NoA signed by the GMO is considered valid approval. Verbal authorization is not approval and is not binding on CMS. Recipients who proceed without prior approval, do so at their own risk.

Amendment Type guidance:

- If a budget revision/change request impacts more than one budget category, utilize Revision (Budget) amendment type.
- If budget revision change request only impacts one budget category, utilize Revision (NoA Other) amendment type.
- If the change requested does not match a possible amendment type from the selection list in GS, utilize Revision (NoA Other) amendment type.

Prior approval is **required** for but is not limited to:

- Changes in Key Personnel and Level of Effort;
- Budget Revisions (see also Standard Term and Condition, 14. *Revision of Budget and Program Plans*);
- Subaward activities not yet proposed or approved;
- Consultant/Contract activities not yet proposed or approved;
- Changes in Scope;
- Carryover Requests;
- No Cost Extensions;
- Lifting of Funding Restrictions;
- Removal of Non-Compliance Plans;
- Equipment and other capital expenditures **2 CFR 200.439**
- Rearrangement and reconversion costs **2 CFR 200.462**

Activities that require prior approval are further detailed in HHS grant **2 CFR 200.407, Prior written approval (prior approval)**, **2 CFR 200.308, Revision of budget and program plans**, and the HHS Grants Policy Statement.

14. **Revision of Budget and Program Plans.** Recipients must consult and comply with requirements outlined under **2 CFR 200.308, Revision of budget and program plans**.

    In accordance with **2 CFR 200.308(i), Transfer of Funds**, CMS requires prior approval for budget revisions where the transfer of funds among direct cost categories or programs, functions and activities in which the Federal share of the project exceeds the Simplified Acquisition Threshold ($350,000) and the **cumulative amount** of such transfers exceeds or is expected **to exceed 10 percent** of the total budget as last approved. CMS cannot permit a transfer that would cause any Federal appropriation to be used for purposes other than those consistent with the appropriation.

15. **Travel Costs.** Recipients must comply with the requirements in **2 CFR 200.475.**

16. **Conflict of Interest Policies.** Recipient must comply with the conflict-of-interest policy requirements outlined **here**. See also **2 CFR 200.112** and **2 CFR 300.112**.

17. **Bankruptcy.** If recipient or one of its subrecipients enters bankruptcy proceedings, whether voluntary or involuntary, the recipient agrees to provide written notice of the bankruptcy to the CMS Grants Management Specialist and CMS Project Officer (PO) within five (5) days of initiation of the proceedings. This notice shall include the date on which the bankruptcy petition was filed, the identity of the court in which the bankruptcy petition was filed, a copy of any and all of the legal pleadings, and a listing of Government grant and cooperative agreement numbers and grant offices for all Government grants and cooperative agreements against which final payment has not been made.

18. **Prohibition on certain telecommunications and video surveillance services or equipment.** **2 CFR 200.216** is incorporated herein by reference.

19. **Human Subjects Protection.** If applicable to recipient's program, the recipient bears ultimate responsibility for protecting human subjects under the award, including human subjects at all sites, and for ensuring that a Federal-wide Assurance (FWA) approved by the Office for Human Research Protections (OHRP) and certification of Institutional Review Board (IRB) review and approval have been obtained before human subjects research can be conducted at each collaborating site. For more information about OHRP, FWA, and IRBs, click **here**.

    Recipients may not draw funds from PMS, request funds from the paying office, or make obligations against Federal funds for research involving human subjects at any site engaged in nonexempt research for any period not covered by both an OHRP-approved assurance and IRB approval consistent with **45 CFR Part 46**. Costs associated with IRB review of human research protocols are not allowable as direct charges under grants and cooperative agreements unless such costs are not covered by the organization's indirect cost rate.

HHS requires recipients and others involved in grant/cooperative agreement-supported research to take appropriate actions to protect the confidentiality of information about and the privacy of individuals participating in the research. Recipients, subrecipients, Investigators, IRBs, and other appropriate entities must ensure that policies and procedures are in place to protect identifying information and must oversee compliance with those policies and procedures.

20. **Privacy and Security of Health Information.** The recipient shall put all appropriate regulatory, administrative, technical, and physical safeguards in place before applicable program activities begin to protect the privacy and security of individually identifiable health information. In doing so, regardless of whether it is a covered entity (CE) or business associate (BA) as those terms are defined under the HIPAA Privacy Rule, the recipient shall ensure its own and its subrecipients' and contractors' policies and procedures are at least as stringent (i.e., protective of privacy) as those governing the use and disclosure of protected health information by HIPAA CEs and their BAs under **45 CFR Part 160** and **45 CFR Part 164**. The recipient and its subrecipients should consult with their own counsel and refer to the **HIPAA guidance materials** for further information about the requirements in 45 CFR Parts 160 and 164.

21. **Employee Whistleblower Protections.** Federal law mandates that all Federal contractors, subcontractors, recipients, subrecipients, or personal services contractors, must inform their employees in writing of the rights and remedies provided under this section, in the predominant native language of the workforce. For more information click **here**.

22. **Mandatory Disclosures.** Consistent with **2 CFR 200.113, Mandatory disclosures**, applicants and recipients must promptly disclose, in writing, to CMS with a copy to the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Additionally, subrecipients must promptly disclose, in a timely manner, in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to CMS and to the HHS OIG at the following addresses:

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

    Materials must also be scanned and emailed to your Grants Management Specialist.

    AND

U.S. Department of Health & Human Services
Office of Inspector General
ATTN: Mandatory Grant Disclosures, Intake Coordinator
330 Independence Avenue, SW, Cohen Building
Room 5527
Washington, DC 20201
Fax: (202) 205-0604 (Include "Mandatory Grant Disclosures" in subject line) or
Email: **MandatoryGranteeDisclosures@oig.hhs.gov**

Failure to make required disclosures can result in any of the remedies described in **2 CFR 200.339, Remedies for noncompliance**, including suspension or debarment (See **2 CFR 200 Part 180** & **2 CFR 200 Part 376** and **31 U.S.C. 3321**).

The recipient must include this mandatory disclosure requirement in all subawards and contracts under this award.

23. **Suspension and Debarment Regulations.** **2 CFR 200.214** is incorporated herein by reference.

24. **Appropriations Provision.** The Department of Health and Human Services (HHS) operates under Appropriations and Extensions Acts, as applicable, each fiscal year. Recipients must review and comply with applicable General Provisions for the Department of Health and Human Services included within the Appropriations Law for the current fiscal year. These provisions may apply to all recipients of HHS federal funding OR may apply directly to recipients of federal funding from one or more HHS agencies.

    Salary Limitations: None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II. This salary cap applies to direct salaries. Recipients may pay salaries at a rate higher than the Executive Level II if the amount beyond the HHS salary cap is paid with non-HHS funds. Since the Executive Level II rate and HHS Appropriations Act citation changes each year, HHS refers to the most recent information posted on the Office of Personnel Management (OPM) website at **2025 Executive Level II Pay Scale** (January 1, 2025 – December 31, 2025). Please consult **the OPM website (Salaries and Wages)** in January 2026 for the salary cap for 2026 (January 1, 2026 – December 31, 2026).

25. **Cybersecurity.** 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.

    See the **HHS Administrative and National Policy Requirements** for full information.

26. Health Information Technology (HIT) Interoperability Language. Recipient is subject to the Health Information Technology and Interoperability requirements stated **here**.

COST PRINCIPLES

CMS recipients and subrecipients must comply with the cost principles set forth in HHS regulations at 2 CFR 200, Subpart E. Recipients and subrecipients must also use these principles as a guide in pricing fixed-price contracts and subcontracts when costs are used in determining the appropriate price. Hospitals must follow **Appendix IX to 2 CFR 300**. **Principles for Determining Costs Applicable to Research and Development Under Grants and Contracts with Hospitals.**

For-profit recipients are subject to 48 CFR subpart 31.2[2]. For more detailed information on applicability and exemptions, refer to **2 CFR 200.401**.

Guidelines for determining direct and indirect (F&A) costs charged to Federal awards are provided in **2 CFR 200 Direct and Indirect Costs** and **Special considerations for States, Local Governments, and Indian tribes**. Requirements for development and submission of indirect (F&A) cost rate proposals and cost allocation plans are contained in Appendices III - Appendix IX to Part 200.

For-profit entities which receive the preponderance of their federal awards from HHS may contact the Division of **Financial Advisory Services (DFAS), Indirect Cost Branch**, to negotiate an indirect cost rate. Otherwise, for-profit organizations are limited to the 15% de minimis rate in accordance with 2 CFR **200.414(f)**.

27. Prohibited Uses of Grant or Cooperative Agreement Funds. The following list contains costs that are unallowable for all CMS programs. Recipients must consult the Program Terms and Conditions for other prohibited costs specific to the grant or cooperative agreement program.

- 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. 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.
- Goods or services not allocable to the approved project.
- Supplanting existing state, local, tribal, or private funding of infrastructure or services, such as staff salaries.
- Construction.

[2] There are no cost principles specifically applicable to grants to for-profit organizations. Therefore, the cost principles set forth in the FAR (48 CFR subpart 31.2) generally are used to determine allowable costs under CMS grants to for-profit organizations. As provided in those cost principles, **allowable travel costs** may not exceed those established by the FTR.

- Capital expenditures for improvements to land, buildings, or equipment that materially increase their value or useful life as a direct cost except with the prior written approval.
- The cost of independent research and development, including their proportionate share of indirect costs in accordance with **2 CFR 300.477**.
- Profit to any recipient even if the recipient is a for-profit organization. Profit is any amount in excess of allowable direct and indirect costs.
- Funds 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. See also **45 CFR part 93**, **2 CFR 200.450, Lobbying,** and applicable Appropriations Law**.**

- 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 recipients can lobby at their own expense if they can segregate federal funds from other financial resources used for lobbying.
- Certain telecommunications and video surveillance equipment. See **2 CFR 200.216**.
- Costs of promotional items and memorabilia, including models, gifts, and souvenirs.
- Costs of advertising and public relations designed solely to promote the non-Federal entity.
- Meals unless in limited circumstances such as:
    - Subjects and patients under study;
    - Where specifically approved as part of the project or program activity (not recipient specific), e.g., in programs providing children's services; and
    - As part of a per diem or subsistence allowance provided in conjunction with allowable travel.

For guidance on some types of costs that we restrict or do not allow, see **2 CFR 200, General Provisions for Selected Items of Costs**.

POST AWARD MONITORING AND REPORTING

28. Continued funding is contingent on satisfactory progress, compliance with the terms and conditions, program authority, and the availability of funds. The NoA identifies the period of performance, which may include multiple 12-month budget periods. If a period of performance is comprised of multiple budget periods, the recipient must submit a non-competing continuation application each year as a prerequisite to continued funding.

Recipients must demonstrate satisfactory performance during the previous funding cycle(s) to be issued additional year funding; or, in the case of multi-year awards where all funding is issued in the first year, to ensure continued access to funding. Recipients should refer to the NOFO and Program Terms and Conditions for additional information on satisfactory progress.

Additionally, as is noted in 2 CFR 200, CMS annually conducts a review of risks posed by applicants prior to award (recipients should review the factors in their entirety at **2 CFR 200.206, Federal agency review of risk posed by applicants**). At-risk recipients, including those which do not comply with reporting requirements or have outstanding audit findings, may not receive a non-competing continuation award.

Alternatively, recipients could receive decreased funding, or their award could be terminated subject to the provisions at **2 CFR 200.340, Termination** if they are non-compliant with the terms and conditions of award. See also Standard Term and Condition, 35. *Termination*.

29. Reporting Requirements. Recipients must comply with the reporting requirements outlined in the Recipient Specific, Standard **and** Program Terms and Conditions of the NoA. The general information and guidance for financial and programmatic reporting provided below supplements the specifics included in the Program Terms and Conditions.

A. PROJECT AND DATA INTEGRITY

Recipients must protect the confidentiality of all project-related information that includes personally identifying information.

The recipient must assume responsibility for the accuracy and completeness of the information contained in all technical documents and reports submitted. The CMS PO shall not direct the interpretation of the data used in preparing these documents or reports.

At any phase in the project, including the project's conclusion, the recipient, if requested by the CMS PO, must deliver to CMS materials, systems, or other items used, developed, refined or enhanced in the course of, or under the award. The recipient agrees that CMS must have a royalty-free, nonexclusive and irrevocable license to reproduce, publish, or otherwise use and authorize others to use the items for Federal government purposes. See also **200.315(b), Intangible Property**.

B. SYSTEM OF AWARD MANAGEMENT (SAM) AND UNIVERSAL ENTITY IDENTIFIER (UEI) REQUIREMENTS

This NoA is subject to the requirements of **2 CFR part 25, Appendix A** which is specifically incorporated herein by reference. Recipient must maintain current information in SAM, at all times when an award is active or if there is an application pending review. Recipient must review and update the information **at least once a year** after the initial registration to remain active, and more frequently if required by changes

in the information. This requirement flows down to subrecipients and contractors under awards or subawards.

As part of its SAM registration and renewal process, recipient must also complete or update its **Responsibility/Qualification (R/Q)** reporting to reflect information about its civil, criminal, or administrative proceedings. **Applicants/recipients must answer "Yes" to question #1 (shown below) of the Proceedings question in SAM.gov to view and answer all relevant questions**.

- Is your business or organization, as represented by the Unique Entity ID on this entity registration, responding to a Federal procurement opportunity that contains the provision at FAR 52.209-7, subject to the clause in FAR 52.209-9 in a current Federal contract**, or** applying for a Federal grant opportunity which contains the award term and condition described in 2 C.F.R. 200 **Appendix XII to Part 200, Award Term and Condition for Recipient Integrity and Performance Matters**?

C. SUBAWARD REPORTING AND EXECUTIVE COMPENSATION (FFATA)

This NoA is subject to the reporting requirements of the Federal Funding Accountability and Transparency Act of 2006 (Public Law 109-282), as implemented by **2 CFR Part 170**. Requirements include:

A. First tier subaward reporting of $40,000 or more in federal funds. Due no later than 30 days after issuance of subaward.
B. Executive compensation reporting, if required, as referenced in 2 CFR Part 170. Due no later than 30 days after issuance of subaward.

D. FINANCIAL REPORTING

HHS recipients must record recipient expenses in real-time as well as submit quarterly, semi-annual, or annual expenditure Federal Financial Reports (FFRs) as described below and stipulated in the Program Terms and Conditions of Award. Instructions on how to complete the FFR can be found **here** after logging onto PMS.

- Quarterly and semi-annual expenditure reports are due no later than 30 days following the applicable period.
- Annual expenditure FFRs are due no later than 90 days following the applicable budget period end date or 12-month period for multi-year budget periods.
- Final FFRs are due no later than 120 days following the period of performance end date.
    - The final FFR must show cumulative expenditures under the NoA and any unobligated balance of federal funds and as appropriate, all other parts of the form must be completed.

- Additionally, recipient must liquidate all obligations incurred under the award not later than 120 days after the end of the period of performance. This deadline may be extended with prior written approval from the CMS Grants Management Specialist.

E. PROGRAMMATIC REPORTING

See **2 CFR §200.301**, **Performance Measurement**, and Program Terms and Conditions for specific details on required information.

Submission of Progress Reports to PMS
Recipients must submit progress reports to GrantSolutions via the Performance Progress Report (PPR) module.

Recipients with the following roles can view, edit, and electronically submit the PPR:
- Recipient's Authorized Organizational Representative (AOR)
- Principal Investigator/Program Director (PI/PD) assigned to the Award

The CMS Project Officer will either accept or return the PPR to the recipient for additional information or clarification. The grant or cooperative agreement is not considered complete and in accordance with the applicable terms and conditions of the NoA until all required reports have been accepted by the CMS Project Officer.

F. STEVENS AMENDMENT

When issuing statements, press releases, publications, requests for proposals, bid solicitations, and other documents – such as toolkits, resource guides, websites, and presentations – describing the projects or programs funded in whole or in part with HHS funds, the recipient must clearly state:

(1) the percentage and dollar amount of the total costs of the program or project funded with Federal money; and
(2) the percentage and dollar amount of the total costs of the project or program funded by non-governmental sources.

Acknowledgement of Support
When issuing statements resulting from activities supported by HHS financial assistance, the recipient entity must include an acknowledgement of federal assistance using one of the following or a similar statement (see immediately below).

If the HHS grant or cooperative agreement is NOT funded with other non-governmental sources:

This **[project/publication/program/website, etc.] [is/was]** supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human

Services (HHS) as part of a financial assistance award totaling **$XX** with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

The HHS grant or cooperative agreement IS partially funded with other nongovernmental sources:

This **[project/publication/program/website, etc.] [is/was]** supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling **$XX** with **XX** percentage funded by CMS/HHS and **$XX** amount and **XX** percentage funded by non-government source(s). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

(a) **Review by CMS.** Recipient shall submit the following to the CMS PO for review and comment unless specified otherwise in the Program Terms and Conditions:

(i) At least 30 days prior to its release:

- publications that report results from or describe information obtained through this award.
- any external formal presentation of any report or statistical or analytical material based on information obtained through this award. Formal presentation includes papers, articles, professional publication, speeches, and testimony.
- external presentation-related material, such as abstracts, power point presentations or other slide decks, posters, and videos.
- all public materials specific to the program including but not limited to, brochures, recruitment materials, informational materials, advertisements, website copy, website pages, videos, and op-ed articles.

(ii) At least 7 days prior to release:

- any press release or media advisory concerning the outcome of activities supported through this award.
- all media interviews, media requests, releases of information, filming, and broadcasts.

(b) For 1 year after completion of the project, the recipient shall continue to submit for review and comment all publications, presentations, and communications resulting from this award or based on information obtained through this award, including papers, articles, professional publications, power point presentations, posters, speeches, announcements, and testimony in any format, including digital technology.

(c) It is the policy of the HHS that the recipient must communicate to CMS how the dollar amounts and funding percentages are calculated, including whether or not indirect costs have been incorporated. Recipient must submit this

information to CMS for review and comment for each applicable type of result/accomplishment according to the same timeline schedule outlined in (a).

(d) Specifically excluded from the review and comment process are internal presentations, information discussions, in general, class lectures, and informal meetings and conversations with community leaders. However, if such a presentation or slide deck is later re-purposed for a public event, it will need to be submitted in advance for CMS review.

(e) One copy of each publication resulting from work performed under an HHS grant- supported project must accompany the final progress report.

G. USE OF DATA AND WORK PRODUCTS (REPORTING)

At any phase of the project, including the project's conclusion, the recipient, if so requested by the CMS PO, must submit copies of analytic data file(s) with appropriate documentation, representing the data developed/used in end-product analyses generated under the award.

- The analytic file(s) may include primary data collected, acquired or generated under the award and/or data furnished by CMS.
- The content, format, documentation, and schedule for production of the data file(s) will be agreed upon by the Principal Investigator/Project Director (PI/PD) and the CMS PO.
- The negotiated format(s) could include both file(s) that would be limited to CMS's internal use and file(s) that CMS could make available to the general public.

All data provided by CMS will be used for the research described in this grant/cooperative agreement NoA only and in connection with the Recipient's performance of its obligations and rights under this program. Recipient has an obligation to collect and secure data for future monitoring by CMS. The recipient will return any data provided by CMS or copies of data at the conclusion of the project. All proprietary information and technology of the recipient are and shall remain the sole property of the recipient.

If the PI/PD determines through this research that a significant new finding has been developed, he/she will communicate it to the CMS PO before formal dissemination to the general public. The recipient shall notify CMS of research conducted for publication.

H. ANNUAL PROPERTY REPORTING.

2 CFR 200.312, Federally owned and exempt property, is incorporated herein by reference. Recipient must submit annually an inventory listing of Federally owned property in its custody to CMS.

I. PATENTS AND INVENTIONS

In accordance with **2 CFR 200.448, Intellectual Property**, all recipients are subject to applicable regulations governing patents and inventions, including government-wide regulations issued by the Department of Commerce at **37 CFR Part 401**. If applicable, recipients must report any inventions on an annual basis using the non-competing continuation application or annual progress report for multi-year budget periods.

A Final Invention Statement and Certification (**Form HHS 568**) must be completed and submitted within 120 days following the expiration or termination of a grant or cooperative agreement.

- The Statement must include all inventions which were conceived or first actually reduced to practice under the grant or award, from the original effective date of support through the date of completion or termination.
- The Statement shall include any inventions reported previously for grants and cooperative agreements as part of a non-competing continuation application or annual progress report.
- Recipients must also provide details about all inventions that have been licensed but not patented and include details on income resulting from HHS-funded inventions and patents.

Unpatented research products or resources—research tools—may be made available through licensing to vendors or other investigators. Income earned from any resulting fees must be treated as program income. This reporting requirement is applicable to grants and cooperative agreements issued by the U.S. DHHS in support of research and research-related activities. For further guidance, please see the HHS GPS: *Patents and Inventions* and *Invention Reporting*.

J. AUDIT REPORTING (SEE 2 CFR 200.501, Audit requirements).

A non-Federal entity that expends **$1,000,000** or more during the non-Federal entity's FY in Federal awards must have a single or program-specific audit conducted for that year and submit an audit reporting package to the Federal Audit Clearinghouse (FAC). HHS grant awarding agencies are required to ensure that single or program-specific audits are completed and reported by recipients within nine months after the end of the audit period (recipient FY end date).

For questions and information concerning the FAC submission process, please contact the FAC (entity which assists Federal cognizant and oversight agencies in obtaining audit data and reporting packages) at 888-222-9907 or click **here**.

For-profits including for-profit hospitals should consult **2 CFR 300.218** for limitations on profit and program income.

Audits for for-profit organizations with HHS programs must be sent to:

- the HHS Audit Resolution Division (ARD) via email at **For-Profit_Audit@hhs.gov**
- copy to: CMS KC_OIG_Audit at **KC_OIG_Audit@cms.hhs.gov**

- copy to the Grants Management Specialist identified in Federal Awarding Agency box #9 on the NoA.
- All for-profit organization audit submission questions should be sent to ARD via email at **AuditResolution@hhs.gov**.

Do not send audits for organizations (for-profits) to the FAC.

SUBRECIPIENT PASS-THROUGH REQUIREMENTS

The recipient can provide a portion of the direct award to other organizations, called subrecipients, to accomplish the goals and objectives of the award. In this case, the recipient becomes a pass-through entity and the subrecipient's award is called a subaward. As a recipient, you must ensure the applicable general terms and conditions stated in this document flow down to subrecipients.

The recipient is **completely** legally and financially responsible for **all** aspects of this NoA including funds provided to subrecipients, in accordance with **2 CFR 200, Subpart D, Subrecipient monitoring and management**.

30. Subaward Reporting. Refer to Standard Term and Condition, 29(C) *Subaward Reporting and Executive Compensation (FFATA)*.

31. Affirmative Duty to Track All Parties to the Award. Recipient must at a minimum regularly track all subrecipients, including subrecipient key personnel and subcontractors in SAM.gov.

As provided in **2 CFR Part 180** and implemented in **2 CFR Part 376**, the recipient must check SAM.gov as follows to ensure that it does not make a subaward to an entity that is debarred, suspended, or ineligible:

- For all first-tier subawards regardless of potential value. Agencies must also require first tier- subrecipients and lower-tier subrecipients to check SAM.gov and
- For all first-tier procurement contracts with a value of **$40,000** or more and all lower tiers of subcontracts under covered non-procurement transactions (**2 CFR 376.220**).

The purpose of this affirmative duty is to track all parties that include health care, commercial, non-profit, and other people and entities to report immediately to the CMS PO and Grants Management Specialist those that cannot participate in federal programs or receive federal funds. The recipient cannot have any persons or entities on the NoA that cannot participate in federal programs or receive federal funds. If any of these systems are not publicly available, then the recipient must comply with the purpose and intent of this requirement using a process that meets at least the level of scrutiny provided by these databases.

The recipient shall provide the CMS PO and Grants Management Specialist with the National Provider Identifier (NPI), Tax ID, and EIN, as applicable, of all Key Personnel

and/or entities to the NoA that may include subrecipients. This list shall be provided to CMS as a Grant Note/Message in GS within **thirty (30) days** from the start of the award and must be maintained in real time throughout the NoA.

32. **Pass Through Entities, Subrecipients, and Contractors.** **2 CFR 200.331, Subrecipient and contractor determinations**, and **2 CFR 200.332, Requirements for pass-through entities**, are incorporated herein by reference.

    Recipient must monitor the activities of the subrecipient as necessary to ensure that the subaward is used for authorized purposes, in compliance with Federal statutes, regulations, and the terms and conditions of the subaward; and that subaward performance goals are achieved.

33. **Equal Treatment.** **45 CFR Part 87** is incorporated herein by reference.

REMEDIES FOR NONCOMPLIANCE

34. **Non-compliance**. **2 CFR 200.208, Specific conditions**, and **2 CFR 200.339, Remedies for noncompliance**, are incorporated herein by reference.

35. **Termination.** This NoA is subject to the termination provisions at **2 CFR 200.340**. Pursuant to 2 CFR 200.340, the recipient agrees by accepting this NoA that continued funding for the award is contingent upon:
    - the availability of appropriated funds,
    - recipient satisfactory performance,
    - compliance with the Terms and Conditions of the award, and
    - to the extent authorized by law, if CMS determines that the award no longer effectuates program goals or agency priorities.

    In accordance with 200.340(c), if CMS terminates the Federal award prior to the end of the period of performance due to the recipient's material failure to comply with the terms and conditions of the Federal award, CMS must report the termination in SAM.gov. Material noncompliance includes, but is not limited to, violation of the terms and conditions of the award; failure to perform award activities in a satisfactory manner; improper management or use of award funds; or fraud, waste, abuse, mismanagement, or criminal activity.

CLOSEOUT

36. **Withdrawal.** If the recipient decides to withdraw from this award prior to the end of the period of performance, it must provide written notification (both hard copy and via email) to the CMS Grants Management Specialist at least fifteen (15) days in advance of the date of official withdrawal and termination of these terms. The letter must be signed by the AOR and other appropriate individuals with authority and submitted as a Revision (NoA Other)

amendment in GrantSolutions. CMS will not be liable for any withdrawal close-out costs that are borne by the recipient. Recipients have three (3) days to return all unused grant funds.

37. **Disposition of Federally Owned Property, Equipment, and Residual Unused Supplies.** Upon completion (or early termination) of a project, the recipient must take appropriate disposition actions.

    Recipient must complete and submit the **SF-428 Cover Letter** and the **SF-428-B Tangible Personal Property Report, Final Report.** The Tangible Personal Property Report (SF-428) is a standard form to be used by awarding agencies to collect information related to tangible personal property when required by a Federal financial assistance award. This form:

    - allows recipients to request specific disposition of federally owned property and acquired equipment.
    - provides a means for calculating and transmitting appropriate compensation to CMS for residual unused supplies.

    As noted in 1.b of this report, if your agency is in possession of Federally-owned property or acquired equipment (defined as nonexpendable personal property with an acquisition cost of $10,000 or more under the award), you must also submit a **SF-428-S, Supplemental Sheet**, that lists and reports on all Federally owned or acquired equipment under the specific grant or cooperative agreement award. If there is no tangible personal property to report, select "d." in section 1 of the SF-428-B and indicate "none of the above."

    Recipient must request specific disposition instructions from CMS if the recipient has federally owned property. Otherwise, disposition instructions are here **§ 200.313 Equipment § 200.314 Supplies.**

38. **Records Retention.** **2 CFR 200.334, Records retention requirements** is incorporated herein by reference.

Appendix F: Sample Minnesota Department of Human Services Grant Contract Template

Minnesota Department of Human Services
Grant Contract

This Grant Contract, and all amendments and supplements to the contract ("CONTRACT"), is between the State of Minnesota, acting through its Department of Human Services, Click here to enter division name Division ("STATE") and , an independent grantee, not an employee of the State of Minnesota, located at ("GRANTEE").

RECITALS

STATE, pursuant to Minnesota Statutes, section 256.01, subdivision 2(a)(6) Click here to enter additional authority if applicable, has authority to enter into contracts for the following services: Click here to enter services.
STATE, in accordance with Minnesota Statutes, section 13.46, is permitted to share information with GRANTEE.
GRANTEE represents that it is duly qualified and willing to perform the services set forth in this CONTRACT to the satisfaction of STATE.
THEREFORE, the parties agree as follows:

CONTRACT

1. CONTRACT TERM AND SURVIVAL OF TERMS.

1.1. Effective date: This CONTRACT is effective on , or the date that STATE obtains all required signatures under Minnesota Statutes, section 16B.98, subdivision 5, whichever is later.

1.2. Expiration date.
In the event this CONTRACT is continued by way of an amendment or new agreement, the expiration date is as amended or the date the new agreement is fully executed, whichever is later. Notwithstanding the foregoing, in the event an amendment or new agreement is not fully executed within 60 calendar days of the original expiration date of XX, this CONTRACT will expire on XX.

1.3. No performance before notification by STATE. GRANTEE may not begin work under this CONTRACT, nor will any payments or reimbursements be made, until all required signatures have been obtained per Minn. Stat. § 16B.98, subd. 7, and GRANTEE is notified to begin work by STATE's Authorized Representative.

1.4. Survival of terms. GRANTEE shall have a continuing obligation after the expiration or termination of CONTRACT to comply with the following provisions of

CONTRACT: Indemnification; Information Privacy and Security; Intellectual Property Rights; Publicity; Ownership of Equipment; State audit; and Jurisdiction and Venue.

1.5. Time is of the essence. GRANTEE will perform its duties within the time limits established in CONTRACT unless it receives written approval from STATE. In performance of CONTRACT, time is of the essence.

2. GRANTEE'S DUTIES.

2.1. Duties. GRANTEE shall perform duties in accordance with **Attachment X**, Work Plan (separate document not included in sample template), which is attached and incorporated into this CONTRACT.

2.2. Grant Progress Reports.

GRANTEE shall submit Choose a period grant progress reports to the STATE. Grant progress reports shall summarize activities and outcomes for the given period, and may include, but are not limited to goals, objectives, activities, outcomes, challenges, lessons learned and financial information. GRANTEE shall submit program reports to the STATE according to the following schedule and in a mutually agreed upon format:

Due Date:	For service period:
Click here to enter date	Prior Choose a period
Click here to enter date	Prior Choose a period
Click here to enter date	Prior Choose a period
Click here to enter date	Prior Choose a period

2.3. Accessibility. Any information systems, tools, content, and work products produced under this CONTRACT, including but not limited to software applications, web sites, video, learning modules, webinars, presentations, etc., whether commercial, off-the-shelf (COTS) or custom, purchased or developed, must comply with the State of Minnesota Accessibility Standard,[1] as updated on July 1, 2024. This standard requires, in part, compliance with the Web Content Accessibility Guidelines (WCAG) 2.1 (Level AA) and Section 508 of the Rehabilitation Act of 1973.

Information technology deliverables and services offered must comply with the State of Minnesota Accessibility Standard and any documents, reports, communications, etc. contained in an electronic format that GRANTEE delivers to or disseminates for the STATE must be accessible. (The relevant requirements are contained under the "Standards" tab at the link above.) Information technology deliverables or services that do not meet the required number of standards or the specific standards required may be rejected and STATE may withhold payment pursuant to clause 3.2(a) of CONTRACT.

3. CONSIDERATION AND TERMS OF PAYMENT.

3.1. Consideration. STATE will pay for all services satisfactorily provided by GRANTEE under this CONTRACT.

a. Compensation.

1. GRANTEE will be paid in accordance with **Attachment X**, Budget, which is attached and incorporated into this CONTRACT (Not attached to sample grant contract).
2. Budget Modification.
   a. GRANTEE must obtain STATE written approval before changing any part of the budget.
   b. Notwithstanding Clause 19.1 of CONTRACT, shifting of funds between budget line items does not require an amendment if the amount shifted does not exceed 10% of that budget year total and does not change the total obligation amount.
   c. If GRANTEE's approved budget changes proceed without an amendment pursuant to this clause, GRANTEE must record the budget change in EGMS or on a form provided by STATE.

b. Travel and subsistence expenses. Reimbursement for travel and subsistence expenses actually and necessarily incurred as a result of GRANTEE's performance under this CONTRACT shall be no greater an amount than provided in the most current Commissioner's Plan, Chapter 15.[2] GRANTEE shall not be reimbursed for travel and subsistence expenses incurred outside the geographical boundaries of Minnesota unless it has received prior written approval from STATE. Minnesota shall be considered the home state for determining whether travel is out of state.

c. Administrative Costs. Pursuant to Minn. Stat. § 16B.98, subd. 1(a), GRANTEE administrative costs must be necessary and reasonable. Indirect costs will be limited to the de minimis rate unless GRANTEE provides a current Negotiated Indirect Cost Rate Agreement (NICRA).

d. Total obligation. The total obligation of STATE for all compensation and reimbursements to GRANTEE shall not exceed **Click here to enter amount in words dollars** (**$**).

e. Withholding. For compensation payable under this CONTRACT, which is subject to withholding under state or federal law, appropriate amounts will be deducted and withheld by STATE as required.

3.2. Terms of payment

a. Invoices. Payments shall be made by STATE promptly after GRANTEE submits an invoice for services performed and the services have been determined acceptable by STATE's authorized agent pursuant to Clause 4.1. Invoices shall be submitted in a form prescribed by STATE, if applicable, and according to the following schedule: **Quarterly**. If STATE does not prescribe a form, GRANTEE may submit invoices in a mutually agreed invoice format.

b. Federal funds. (Where applicable. If blank this section does not apply.) Payments are to be made from federal funds. If at any time such funds become unavailable, this CONTRACT shall be terminated immediately upon written notice of such fact by STATE to GRANTEE. In the event of such termination, GRANTEE shall be entitled to payment, determined on a pro rata basis, for services satisfactorily performed. An amendment must be executed any time any of the data elements listed in 2 CFR 200.332 and this clause, including the Assistance Listing number, are changed, such as additional funds from the same federal award or additional funds from a different federal award

***Pass-through requirements*.** GRANTEE acknowledges that, if it is a subrecipient of federal funds under this CONTRACT, GRANTEE may be subject to certain compliance obligations. GRANTEE can view these obligations in the Health and Human Services Grants Policy Statement,[3] in addition to specific public policy requirements related to the federal funds here. To the degree federal funds are used in this CONTRACT, STATE and GRANTEE agree to comply with all pass-through requirements, including each party's auditing requirements as stated in 2 C.F.R. § 200.332 (Requirements for pass-through entities)[4] and 2 C.F.R. §§ 200.501-521 (Subpart F – Audit Requirements).[5]

1. *GRANTEE's Name*: (Must match the name associated with the Unique Entity Identifier.)
2. *GRANTEE's Unique Entity Identifier*: Click here to enter Effective April 4, 2022, the Unique Entity Identifier is the 12-character alphanumeric identifier established and assigned at SAM.gov to uniquely identify business entities and must match GRANTEE's name.
3. *Federal Award Identification Number (FAIN)*: Click here to enter number
4. *Federal Award Date*: Click here to enter date (The date of the award to the MN Dept. of Human Services.)
5. *CONTRACT (subaward) Period of Performance*: Start date: **See section 1.1 above.** End date: **See section 1.2 above.**
6. *CONTRACT (subaward) Budget Period Start and End Date*: Click here to enter date.
7. *Amount of federal funds obligated to GRANTEE (subrecipient) in this CONTRACT*: **$** Click here to enter amount

8. *Total amount of federal funds committed to the GRANTEE (subrecipient), including this CONTRACT:* **$** Click here to enter amount

9. *Total Amount of the Federal Award from which the funds to the GRANTEE (subrecipient) are drawn:* **$**Click here to enter amount

10. *Federal Award Project description:* Click here to enter text.

11. *Name*:

A. Federal Awarding Agency: Click here to enter text

B. MN Dept. of Human Services (DHS)

C. Name and Contact information of DHS's awarding official: Click here to enter name and contact information of authorized representative

12. *Assistance Listings Number & Name* (formerly known as CFDA No.)*:* Click here to enter number, Click here to enter title, Click here to enter total amount made available at time of disbursement
13. *Is this federal award related to research and development?:* ☐ Yes ☐ No
14. *Indirect Cost Rate for the GRANTEE is:* Click here to enter rate (including if the *de minimis* rate is charged.)

4. CONDITIONS OF PAYMENT.

4.1. Satisfaction of STATE. All services provided by GRANTEE pursuant to this CONTRACT shall be performed to the satisfaction of STATE, as determined at the sole discretion of its authorized representative, and in accord with all applicable federal, state, and local laws, ordinances, rules, and regulations including business registration requirements of the Office of the Secretary of State. GRANTEE shall not receive payment for work found by STATE to be unsatisfactory, or performed in violation of federal, state, or local law, ordinance, rule, or regulation, or if GRANTEE has failed to provide Grant Progress Reports pursuant to Clause 2.2, or if the Progress Reports are determined to be unsatisfactory.

4.2. Payments to subcontractors. (If applicable) As required by Minn. Stat. § 16A.1245, GRANTEE must pay all subcontractors, within ten (10) calendar days of GRANTEE's receipt of payment from STATE for undisputed services provided by the subcontractor(s) and must pay interest at the rate of 1-1/2 percent per month or any part of a month to the subcontractor(s) on any undisputed amount not paid on time to the subcontractor(s).

4.3. Actual costs and reimbursable expenses. GRANTEE shall ensure that costs claimed for reimbursement shall be actual costs, to be determined in accordance with 2 C.F.R. § 200 et seq. if applicable. GRANTEE must maintain adequate documentation to support all costs submitted for reimbursement, ensuring they align with the terms of the award. GRANTEE shall not invoice STATE for services that are reimbursable via a public or private health insurance plan. If GRANTEE receives funds from a source other than STATE in exchange for services, then GRANTEE may not receive payment from STATE for those same services. GRANTEE shall seek reimbursement from all sources before seeking reimbursement pursuant to this CONTRACT._

4.4. Unexpended Funds.

GRANTEE must promptly return to the STATE any unexpended funds that have not been accounted for annually in a financial report to the STATE due at grant closeout.

5. PAYMENT RECOUPMENT.

GRANTEE must reimburse STATE upon demand or STATE may deduct from future payments under this CONTRACT or future CONTRACTS the following:

a. Any amounts received by GRANTEE from the STATE for contract services that have been inaccurately reported or are found to be unsubstantiated;

b. Any amounts paid by GRANTEE to a subcontractor not authorized in writing by STATE;

c. Any amount paid by STATE for services which either duplicate services covered by other specific grants or contracts, or amounts determined by STATE as non-allowable under the line-item budget, clause 3.1.a.;

d. Any amounts paid by STATE for which GRANTEE'S books, records and other documents are not sufficient to clearly substantiate that those amounts were used by GRANTEE to perform contract services, in accordance with clause 2, GRANTEE's Duties; and/or

e. Any amount identified as a financial audit exception.

6. TERMINATION.

6.1. Termination by the State.

a. Without cause. STATE may terminate this CONTRACT without cause, upon 30 days' written notice to GRANTEE. Upon termination, GRANTEE will be entitled to payment, determined on a pro rata basis, for services satisfactorily performed.

b. Termination for Cause. STATE may immediately terminate this CONTRACT if the STATE finds that there has been a failure to comply with the provisions of the CONTRACT, that reasonable progress has not been made or that the purposes for which the funds were granted have not been or will not be fulfilled. STATE may take action to protect the interests of the State of Minnesota, including the refusal to disburse additional funds and requiring the return of all or part of the funds already disbursed.

6.2. Termination by the Commissioner of Administration.

In accord with Minn. Stat. § 16B.991, subd. 2, the Commissioner of Administration may unilaterally terminate this CONTRACT if further performance under the CONTRACT would not serve agency purposes or is not in the best interest of the STATE.

6.3. Insufficient funds. STATE may immediately terminate this CONTRACT if it does not obtain funding from the Minnesota Legislature or other funding source; or if funding cannot be continued at a level sufficient to allow for the payment of the services covered here. Termination will be by written notice to GRANTEE. STATE is not obligated to pay for any services that are provided after the effective date of termination. GRANTEE will be entitled to payment, determined on a pro rata basis, for services satisfactorily performed to the extent that funds are available.

In the event of temporary lack of funding or appropriation, STATE may pause its obligations under this CONTRACT without terminating it. This pause will be for the duration of the lack of funding or appropriation and shall not be considered a termination of the CONTRACT. GRANTEE will be notified in writing of the temporary pause, and GRANTEE's ability to provide services may be temporarily suspended during this period. STATE will provide reasonable notice to GRANTEE of the lack of funding or appropriation and shall notify GRANTEE once funding is restored or appropriated, at which point the provision of services under the CONTRACT may resume.

STATE will not be assessed any penalty if the CONTRACT is terminated because of the decision of the Minnesota Legislature, or other funding source, not to appropriate funds. STATE must provide GRANTEE notice of the lack of funding within a reasonable time of STATE's receiving that notice.

6.4. Breach. Notwithstanding clause 6.1, upon STATE's knowledge of a curable material breach of the CONTRACT by GRANTEE, STATE shall provide GRANTEE written notice of the breach and ten (10) days to cure the breach. If GRANTEE does not cure the breach within the time allowed, GRANTEE will be in default of this CONTRACT and STATE may terminate the CONTRACT immediately thereafter. If GRANTEE has breached a material term of this CONTRACT and cure is not possible, STATE may immediately terminate this CONTRACT.

6.5. Conviction relating to a state grant. In accord with Minn. Stat. § 16B.991, subd. 1, this CONTRACT will immediately be terminated if the recipient is convicted of a criminal offense relating to a state grant agreement.

7. AUTHORIZED REPRESENTATIVES, RESPONSIBLE AUTHORITY, and PROJECT MANAGER.

7.1. State. STATE's authorized representative for the purposes of administration of this CONTRACT is **Click here to enter name** or successor. Phone and email: **Click here to enter phone** and **Click here to enter email** . This representative shall have final authority for acceptance of GRANTEE's services and if such services are accepted as satisfactory, shall so certify on each invoice submitted pursuant to Clause 3.2.

7.2. Grantee.

a. GRANTEE's Authorized Representative is **Click here to enter name** or successor. Phone and email: **Click here to enter phone** and **Click here to enter email**. If GRANTEE's Authorized Representative changes at any time during this CONTRACT, GRANTEE must immediately notify STATE.

b. GRANTEE must clearly post on GRANTEE's website the names of, and contact information for, the GRANTEE's leadership and the employee or other person who directly manages and oversees this CONTRACT on behalf of GRANTEE.

7.3. Information Privacy and Security. (If applicable) GRANTEE's responsible authority for the purposes of complying with data privacy and security for this CONTRACT is **Click here to enter name** or successor. Phone and email: **Click here to enter phone** and **Click here to enter email.**

8. INSURANCE REQUIREMENTS.

GRANTEE shall not begin work under the CONTRACT until it has obtained all the insurance described below and STATE has approved such insurance. GRANTEE shall maintain the insurance in force and effect throughout the term of the contract. GRANTEE is required to maintain and furnish satisfactory evidence of the following insurance policies.

8.1. Worker's Compensation. The GRANTEE certifies that it is in compliance with Minn. Stat. § 176.181, subd. 2, pertaining to workers' compensation insurance coverage. The GRANTEE's employees and agents will not be considered employees of the STATE. Any claims that may arise under the Minnesota Workers' Compensation Act on behalf of these employees or agents and any claims made by any third party as a consequence of any act or omission on the part of these employees or agents are in no way the STATE's obligation or responsibility. Minimum insurance limits are as follows:

- $100,000 – Bodily Injury by Disease per employee
- $500,000 – Bodily Injury by Disease aggregate
- $100,000 – Bodily Injury by Accident

If Minn. Stat. § 176.041 exempts GRANTEE from Workers' Compensation insurance mandates, including if GRANTEE has no employees in the State of Minnesota, GRANTEE must provide a written statement, signed by an authorized representative, indicating the qualifying exemption that excludes GRANTEE from the Minnesota Workers' Compensation requirements.

GRANTEE's employees and agents will not be considered employees of STATE. Any claims that may arise under the Minnesota Workers' Compensation Act on behalf of these employees or agents and any claims made by any third party as a consequence of any act or omission on the part of these employees or agents are in no way STATE's obligation or responsibility.

8.2. General Commercial Liability Insurance. GRANTEE agrees that it will at all times during the term of the grant contract keep in force a commercial general liability insurance policy with the following minimum insurance limits:

- $2,000,000 per occurrence
- $2,000,000 annual aggregate

Such insurance will protect it from claims for damages for bodily injury, including sickness or disease, death, and for care and loss of services as well as from claims for property damage, including loss of use which may arise from operations under the grant contract whether the operations are by GRANTEE or by a subcontractor or by anyone directly or indirectly employed by GRANTEE under the grant contract. STATE will be named as both an additional insured and a certificate holder on the general commercial liability policy.

8.3. Employee Theft & Dishonesty Policy. GRANTEE agrees to keep in force a blanket employee theft & employee dishonesty policy in at least the total amount of the first year's grant award as an addendum on its property insurance policy. If it is not feasible to include a blanket employee theft & employee dishonesty policy as an addendum to a property insurance policy, then GRANTEE must keep in force a stand-alone employee theft/employee dishonesty policy.

STATE will be named as both a joint payee and a certificate holder on the employee theft/employee dishonesty policy. Only in cases in which the first year's grant award exceeds the available employee theft/employee dishonesty coverage may grantees provide blanket employee theft/employee dishonesty insurance in an amount equal to either 25% of the yearly grant amount, or the first quarterly advance amount, whichever is greater.

Upon execution of this grant contract, GRANTEE shall furnish STATE with a certificate of employee theft/employee dishonesty insurance.

8.4. Commercial Automobile Liability Insurance. GRANTEE is required to maintain insurance protecting it from claims for damages for bodily injury as well as from claims for property damage resulting from the ownership, operation, maintenance or use of all owned, hired, and non-owned autos which may arise from operations under this CONTRACT. In the case that any work is subcontracted, GRANTEE will require the subcontractor to maintain Commercial Automobile Liability insurance that conforms to this section. Minimum insurance limits are as follows:

- $2,000,000 – per occurrence Combined Single limit for Bodily Injury and Property Damage

In addition, the following coverages should be included: Owned, Hired, and Non-owned Automobile.

8.5. Professional Liability Insurance.

This policy will provide coverage for all claims the GRANTEE may become legally obligated to pay resulting from any actual or alleged negligent act, error, or omission related to GRANTEE's professional services required under the CONTRACT. GRANTEE is required to carry the following **minimum** insurance limits:

- $2,000,000 – per claim or event
- $2,000,000 – annual aggregate

Any deductible will be the sole responsibility of the GRANTEE and may not exceed $50,000 without the written approval of the STATE. If the GRANTEE desires authority from the STATE to have a deductible in a higher amount, the GRANTEE shall so request in writing, specifying the amount of the desired deductible and providing financial documentation by submitting the most current audited financial statements so that the STATE can ascertain the ability of the GRANTEE to cover the deductible from its own resources.

The retroactive or prior acts date of such coverage shall not be after the effective date of this CONTRACT and GRANTEE shall maintain such insurance for a period of at least three (3) years, following completion of the work. If such insurance is discontinued, extended reporting period coverage must be obtained by GRANTEE to fulfill this requirement.

8.6. Additional Insurance Conditions:

a. GRANTEE's policies shall be primary insurance to any other valid and collectible insurance available to STATE with respect to any claim arising out of GRANTEE's performance under this CONTRACT.

b. If GRANTEE receives a cancellation notice from an insurance carrier providing coverage, GRANTEE agrees to notify STATE within five (5) business days with a copy of the cancellation notice, unless GRANTEE's policies contain a provision that coverage afforded under the policies will not be cancelled without at least thirty (30) days advance written notice to STATE.

c. GRANTEE is responsible for payment of CONTRACT related insurance premiums and deductibles.

d. STATE shall be named as a certificate holder on applicable policies.

e. An Umbrella or Excess Liability insurance policy may be used to supplement GRANTEE's policy limits to satisfy the full policy limits required by CONTRACT.

9. INDEMNIFICATION.

In the performance of this CONTRACT by GRANTEE, or GRANTEE's agents or employees, GRANTEE must indemnify, save, and hold harmless the STATE, its agents and employees, from any claims or causes of action, including attorney's fees incurred by STATE, to the extent they are caused by GRANTEE's:

a. Intentional, willful, or negligent acts or omissions;

b. Actions that give rise to strict liability; or

c. Breach of contract or warranty.

The indemnification obligations of this clause do not apply in the event the claim or cause of action is the result of STATE's sole negligence. This clause will not be construed to bar any legal remedies GRANTEE may have for STATE's failure to fulfill its obligation under this CONTRACT.

10. [OPTION 1] INFORMATION PRIVACY AND SECURITY.

a. It is expressly agreed that STATE will not be disclosing or providing information protected under the Minnesota Government Data Practices Act, Minnesota Statutes, Chapter 13 (the "Data Practices Act") as "not public data" on individuals to GRANTEE under this Contract. "Not public data" means any data that is classified as confidential, private, nonpublic, or protected nonpublic by statute, federal law or temporary classification. Minn. Stat. § 13.02, subd. 8a.

b. It is expressly agreed that GRANTEE will not create, receive, maintain, or transmit "protected health information", as defined in the Health Insurance Portability Accountability Act ("HIPAA"), 45 C.F.R. § 160.103, on behalf of STATE for a function or activity regulated by 45 C.F.R. 160 or 164. Accordingly, GRANTEE is not a "business associate" of STATE, as defined in HIPAA, 45 C.F.R. § 160.103 as a result of, or in connection with, this CONTRACT. Therefore, GRANTEE is not required to comply with the privacy provisions of HIPAA as a result of, or for purposes of, performing under this CONTRACT. If GRANTEE has responsibilities to comply with the Data Practices Act or HIPAA for reasons other than this CONTRACT, GRANTEE will be responsible for its own compliance.

c. Notwithstanding paragraph a. and b., in its capacity as GRANTEE under this CONTRACT, GRANTEE must comply with the provisions of the Data Practices Act as though it were a governmental entity as defined by the Data Practices Act. GRANTEE will be performing functions of a government entity under Minn. Stat. § 13.05, subd. 11, and thus any data created, collected, received, stored, used, maintained or disseminated by GRANTEE in performing its duties under this contract is subject to the protections of the Data Practices Act. The civil remedies of Minn. Stat. § 13.08 apply to the release of the data governed by the Data Practices Act, Minn. Stat. Ch. 13, by either GRANTEE or STATE.

d. In its capacity as GRANTEE under this contract, GRANTEE is being made an agent of the "welfare system" as defined in Minn. Stat. § 13.46, subd. 1, and any data collected, created, received, stored,

used, maintained or disseminated by GRANTEE in performing its duties under this Contract is explicitly subject to the protections of Minn. Stat. § 13.46.

e. If GRANTEE receives a request to release data created, collected, received, stored, used, maintained or disseminated by GRANTEE in performing its duties under this CONTRACT, GRANTEE must immediately notify and consult with STATE's Authorized Representative as to how GRANTEE should respond to the request.

f. Under this CONTRACT, GRANTEE is performing the functions of a government entity including, but not limited to, responding appropriately pursuant to Minn. Stat. §§ 13.03 and 13.04 to requests for data created, collected, received, stored, used, maintained, or disseminated by GRANTEE in performing its duties under this CONTRACT.

g. GRANTEE's obligations while performing the functions of a government entity include, but are not limited to, complying with Minn. Stat. § 13.05, subd. 5 to establish appropriate security safeguards for all records containing data on individuals.

h. GRANTEE must comply with Minn. Stat. § 13.055 to investigate and appropriately report or notify regarding any potential unauthorized acquisition of data created, collected, received, stored, used, maintained, or disseminated by GRANTEE in performing its duties under this CONTRACT.

10. [OPTION 2] INFORMATION PRIVACY AND SECURITY.

Information privacy and security shall be governed by the "Data Sharing Agreement Terms and Conditions," which is attached and incorporated into this Contract as **Attachment Click here to enter letter**, except that the parties further agree to comply with any agreed-upon amendments to the Data Sharing Agreement.

10. [OPTION 3] INFORMATION PRIVACY AND SECURITY.

Information privacy and security shall be governed by the "Data Sharing and Business Associate Agreement Terms and Conditions" which is attached and incorporated into this CONTRACT as **Attachment Click here to enter letter** , except that the parties further agree to comply with any agreed-upon amendments to the Data Sharing Agreement and Business Associate Agreement.

11. INTELLECTUAL PROPERTY RIGHTS.

11.1. Definitions. Works means all inventions, improvements, discoveries (whether or not patentable or copyrightable), databases, computer programs, reports, notes, studies, photographs, negatives, designs, drawings, specifications, materials, tapes, and disks conceived, reduced to practice, created or originated by GRANTEE, its employees, agents, and subcontractors, either individually or jointly with others in the performance of the CONTRACT. Works includes "Documents." Documents are the originals of any data bases, computer programs, reports, notes, studies, photographs, negatives, designs, drawings, specifications, materials, tapes, disks, or other materials, whether in tangible or electronic forms, prepared by GRANTEE, its employees, agents, or subcontractors, in the performance of this CONTRACT.

11.2. Ownership. STATE owns all rights, title, and interest in all of the intellectual property, including copyrights, patents, trade secrets, trademarks, and service marks in the Works and Documents created and paid for under this CONTRACT. The Works and Documents will be the exclusive property of STATE and all such Works and Documents must be immediately returned to STATE by GRANTEE upon completion or termination of this CONTRACT. To the extent possible, those Works eligible for copyright protection under the United States Copyright Act will be deemed to be "works made for hire." If using STATE data, GRANTEE must cite the data, or make clear by referencing that STATE is the source.

11.3. Responsibilities.

a. **Notification.** Whenever any Works or Documents (whether or not patentable) are made or conceived for the first time or actually or constructively reduced to practice by GRANTEE, including its employees and subcontractors, and are created and paid for under this CONTRACT, GRANTEE will immediately

give STATE's Authorized Representative written notice thereof, and must promptly furnish the Authorized Representative with complete information and/or disclosure thereon. GRANTEE will assign all right, title, and interest it may have in the Works and the Documents to STATE.

b. **Filing and recording of ownership interests.** GRANTEE must, at the request of STATE, execute all papers and perform all other acts necessary to transfer or record STATE's ownership interest in the Works and Documents created and paid for under this CONTRACT. GRANTEE must perform all acts and take all steps necessary to ensure that all intellectual property rights in these Works and Documents are the sole property of STATE, and that neither GRANTEE nor its employees, agents, or subcontractors retain any interest in and to these Works and Documents.

c. **Duty not to infringe on intellectual property rights of others.** GRANTEE represents and warrants that the Works and Documents created and paid for under this CONTRACT do not and will not infringe upon any intellectual property rights of other persons or entities.
Notwithstanding Clause 9, GRANTEE will indemnify; defend, to the extent permitted by the Attorney General; and hold harmless STATE, at GRANTEE's expense, from any action or claim brought against STATE to the extent that it is based on a claim that all or part of these Works or Documents infringe upon the intellectual property rights of others. GRANTEE will be responsible for payment of any and all such claims, demands, obligations, liabilities, costs, and damages, including but not limited to, attorney's fees. If such a claim or action arises, or in GRANTEE's or STATE's opinion is likely to arise, GRANTEE must, at STATE's discretion, either procure for STATE the right or license to use the intellectual property rights at issue or replace or modify the allegedly infringing Works or Documents as necessary and appropriate to obviate the infringement claim. This remedy of STATE will be in addition to and not exclusive of other remedies provided by law.

d. **Federal license granted.** If federal funds are used in the payment of this CONTRACT, pursuant to 45 C.F.R. § 75.322, the U.S. Department of Health and Human Services is granted a royalty-free, nonexclusive and irrevocable right to reproduce, publish, or otherwise use the work for Federal purposes, and to authorize others to do so.

12. PUBLICITY.

12.1. General publicity. Any publicity regarding the subject matter of this CONTRACT must identify STATE as the sponsoring agency and must not be released without prior written approval from the STATE's authorized representative. For purposes of this provision, publicity includes notices, informational pamphlets, press releases, research, reports, signs, websites, social media, and similar public notices prepared by or for the GRANTEE individually or jointly with others, or any subcontractors, with respect to the program, publications, or services provided resulting from this CONTRACT. All projects primarily funded by state grant appropriation must publicly credit the State of Minnesota, including on the GRANTEE's website when practicable.

12.2. Endorsement. GRANTEE must not claim that STATE endorses its products or services.

13. VOTER REGISTRATION REQUIREMENT.

GRANTEE certifies that it will comply with Minn. Stat. § 201.162 by providing voter registration services for its employees and for the public served by GRANTEE. Voter Registration materials can be found at the Secretary of State's website.[6]

14. OWNERSHIP OF EQUIPMENT.

The STATE shall have the right to require transfer of all equipment purchased with grant funds (including title) to STATE or to an eligible non-STATE party named by the STATE. If federal funds are granted by the STATE,

then disposition of all equipment purchased under this grant contract shall be in accordance with OMB Uniform Grant Guidance, 2 C.F.R. § 200.313. For all equipment having a current per unit fair market value of $10,000 or more, STATE shall have the right to require transfer of the equipment (including title) to the Federal Government. These rights will normally be exercised by STATE only if the project or program for which the equipment was acquired is transferred from one grantee to another.

15. AUDIT REQUIREMENTS AND GRANTEE DEBARMENT INFORMATION.

15.1. State audit.

Under Minn. Stat. § 16B.98, subd. 8, the books, records, documents, and accounting procedures and practices of the GRANTEE or other party that are relevant to the CONTRACT are subject to examination by STATE and either the legislative auditor or the state auditor, as appropriate, for a minimum of six years from the CONTRACT end date, receipt and approval of all final reports, or the required period of time to satisfy all state and program retention requirements, whichever is later.

15.2. Independent audit. If GRANTEE conducts or undergoes an independent audit during the term of this CONTRACT, notice of the audit must be submitted to STATE within thirty (30) days of the audit's completion and a copy provided, if requested.

15.3. Federal audit requirements. GRANTEE certifies it will comply with 2 C.F.R § 200.501 et seq., as applicable. To the extent federal funds are used for this CONTRACT, GRANTEE acknowledges that GRANTEE and STATE shall comply with the requirements of 2 C.F.R. § 200.332. Non-Federal entities expending $1,000,000 or more of federal funding in a fiscal year must obtain a single or program-specific audit conducted for that year in accordance with 2 C.F.R. § 200.501. Failure to comply with these requirements could result in forfeiture of federal funds.

15.4. Debarment by the State of Minnesota or the federal government.

GRANTEE certifies that neither it nor its principals are presently debarred or suspended by the State of Minnesota, or any of its departments, commissions, agencies, or political subdivisions, as shown on the Suspended and Debarred Vendors List[7], or by the federal government at SAM.gov | Search.[8] GRANTEE's certification is a material representation upon which the CONTRACT award was based. GRANTEE shall provide immediate written notice to STATE's authorized representative if at any time it learns that this certification was erroneous when submitted or becomes erroneous by reason of changed circumstances.

15.5. Certification regarding debarment, suspension, ineligibility, and voluntary exclusion – lower tier covered transactions.

GRANTEE's certification is a material representation upon which CONTRACT award was based. Federal money will be used or may potentially be used to pay for all or part of the work under CONTRACT, therefore GRANTEE must certify the following, as required by 2 C.F.R § 180, or its regulatory equivalent.

a. Instructions for Certification

1. By signing and submitting this CONTRACT, the prospective lower tier participant is providing the certification set out below.
2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
3. The prospective lower tier participant shall provide immediate written notice to the person to which this CONTRACT is submitted if at any time the prospective lower tier participant learns that its

certification was erroneous when submitted or had become erroneous by reason of changed circumstances.

4. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverages sections of rules implementing Executive Order 12549. You may contact the person to which this CONTRACT is submitted for assistance in obtaining a copy of those regulations.
5. The prospective lower tier participant agrees by submitting this response that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 C.F.R. part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.
6. The prospective lower tier participant further agrees by submitting this CONTRACT that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 C.F.R part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.
8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 C.F.R. part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

b. Lower Tier Covered Transactions.

1. The prospective lower tier participant certifies, by submission of this CONTRACT, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.
2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this CONTRACT.

16. GRANTEE DATA DISCLOSURE.

Consistent with Minn. Stat. §§ 270B.09, 270C.65, subd. 3, and 270C.66, and other applicable law, GRANTEE understands that disclosure of its social security number, federal employer tax identification number, and/or Minnesota tax identification number, already provided to the STATE, may be provided to federal and state tax agencies and state personnel involved in the payment of state obligations. These identification numbers may be used in the enforcement of federal and state tax laws which could result in action requiring GRANTEE to file state tax returns and pay delinquent state tax liabilities, if any.

17. JURISDICTION AND VENUE.

This CONTRACT, and amendments and supplements, are governed by the laws of the State of Minnesota. Venue for all legal proceedings arising out of this CONTRACT, or breach of the CONTRACT, shall be in the state or federal court with competent jurisdiction in Ramsey County, Minnesota.

18. CLERICAL ERRORS AND NON-WAIVER.

18.1. Clerical error. Notwithstanding Clause 19.1, STATE reserves the right to unilaterally fix clerical errors contained in the CONTRACT without executing an amendment. GRANTEE will be informed of errors that have been fixed pursuant to this paragraph.

18.2. Non-waiver. If STATE fails to enforce any provision of this CONTRACT, that failure does not waive the provision or STATE's right to enforce it.

19. AMENDMENT, ASSIGNMENT, SEVERABILITY, ENTIRE AGREEMENT, AND DRAFTING PARTY.

19.1. Amendments. Any amendments to this CONTRACT shall be in writing and shall be executed by the same parties who executed the original CONTRACT, or their successors in office.

19.2. Assignment. GRANTEE shall neither assign nor transfer any rights or obligations under this CONTRACT without the prior written consent of STATE.

19.3. Entire Agreement.

- **a.** If any provision of this CONTRACT is held to be invalid or unenforceable in any respect, the validity and enforceability of the remaining terms and provisions of this CONTRACT shall not in any way be affected or impaired. The parties will attempt in good faith to agree upon a valid and enforceable provision that is a reasonable substitute and will incorporate the substitute provision in this CONTRACT according to clause 19.1.
- **b.** This CONTRACT contains all negotiations and agreements between STATE and GRANTEE. No other understanding regarding this CONTRACT, whether written or oral may be used to bind either party.

19.4. Drafting party. The parties agree that each party has individually had an opportunity to review with a legal representative, negotiate and draft this CONTRACT, and that, in the event of a dispute, the CONTRACT shall not be construed against either party.

20. PROCURING GOODS AND CONTRACTED SERVICES.

20.1. Contracting and bidding requirements.

a. Any services and/or materials that are expected to cost $100,000 or more must undergo a formal notice and bidding process.

b. Services and/or materials that are expected to cost between $25,000 and $99,999 must be competitively awarded based on a minimum of three (3) verbal quotes or bids.

c. Services and/or materials that are expected to cost between $10,000 and $24,999 must be competitively awarded based on a minimum of two (2) verbal quotes or bids or awarded to a targeted vendor.

d. GRANTEE must take all necessary affirmative steps to assure that targeted vendors from businesses with active certifications through these entities are used when possible:

i. State Department of Administration's Certified Targeted Group, Economically Disadvantaged and Veteran-Owned Vendor List.

ii. Metropolitan Council Underutilized Business Program: MCUB: Metropolitan Council Underutilized Business Program.

iii. Small Business Certification Program through Hennepin County, Ramsey County, and City of St. Paul: Central Certification Directory.

e. GRANTEE must maintain written standards of conduct covering conflicts of interest and governing the actions of its employees engaged in the selection, award and administration of contracts.

f. GRANTEE must maintain support documentation of the purchasing or bidding process used to contract services in their financial records, including support documentation justifying a single/sole source bid, if applicable.

g. Notwithstanding (a) - (d) above, the STATE may waive bidding process requirements when:

i. Vendors/subgrantees included in response to competitive grant request for proposal process were approved and incorporated as an approved work plan for the grant; or

ii. It is determined there is only one legitimate or practical source for such materials or services and that the vendor/subgrantee has established a fair and reasonable price.

20.2. Prevailing wage. For projects that include construction work of $25,000 or more, prevailing wage rules apply per Minn. Stat. §§ 177.41 through 177.44; consequently, the bid request must state the project is subject to *prevailing wage*. These rules require that the wages of laborers and workers should be comparable to wages paid for similar work in the community as a whole. Vendors should submit a prevailing wage form along with their bids.

20.3. Debarred vendors. In the provision of goods or services under this CONTRACT, GRANTEE must not contract with vendors or subgrantees who are suspended or debarred in Minnesota or under federal law. Before entering into a subcontract, GRANTEE must check if vendors are suspended or debarred by referencing the web page link in subclause 15.4 of this CONTRACT. A link to vendors debarred by Federal agencies is provided at the bottom of the web page.

21. SUBCONTRACTS AND SUBCONTRACT PAYMENT.

21.1. GRANTEE, as an awardee organization, is legally and financially responsible for all aspects of this award that are subcontracted, including funds provided to subgrantees and subcontractors (hereinafter "subgrantees"). GRANTEE shall ensure that the material obligations, borne by the GRANTEE in this CONTRACT, apply as between GRANTEE and subgrantees, in all subcontracts, to the same extent that the material obligations apply as between the STATE and GRANTEE.

21.2. Subgrantee. A subgrantee is a person or entity that has been awarded a portion of the work authorized by this CONTRACT by GRANTEE. GRANTEE must document any subaward through a formal legal agreement. GRANTEE must provide timely notice to the STATE of any subgrantee(s) prior to the subgrantee(s) performing work under this CONTRACT.

21.3. Subgrantee Monitoring. GRANTEE must monitor the activities of subgrantee(s) to ensure the subaward is used for authorized purposes and is in compliance with:

a. the terms and conditions of this CONTRACT and the subaward;

b. required Grants Management Policies and procedures as specified in Minn. Stat. § 16B.97, subd. 4(a)(1) and other relevant statutes and regulations; and

c. that subaward performance goals are achieved.

21.4. Subgrantee performance. If a subgrantee is determined to be performing unsatisfactorily by the State's Authorized Representative, the GRANTEE will receive written notification that the subgrantee can no longer be used for this CONTRACT.

21.5. GRANTEE responsibility. No subaward shall serve to terminate or in any way affect the primary legal responsibility of the GRANTEE for timely and satisfactory performances of the obligations contemplated by this CONTRACT.

21.5. Payment. GRANTEE must pay any subgrantee in accordance with subclause 4.2 of this CONTRACT.

22. LEGAL COMPLIANCE.

22.1. General compliance. All performance under this CONTRACT must be in compliance with state and federal law and regulations, and local ordinances. Allegations that STATE deems reasonable, in its sole discretion, of violations of state or federal law or regulations, or of local ordinances, may result in CONTRACT termination and/or reporting to local authorities by STATE.

22.2. Nondiscrimination. GRANTEE will not discriminate against any person on the basis of the person's race, color, creed, religion, national origin, sex, marital status, gender identity or expression, disability, public assistance status, sexual orientation, age, familial status, membership or activity in a local commission, or status as a member of the uniformed services. GRANTEE must refrain from such discrimination as a matter of its contract with STATE. "Person" includes, without limitation, a STATE employee, GRANTEE's employee, a program participant, and a member of the public. "Discriminate" means, without limitation, to fail or refuse to hire, discharge, or otherwise discriminate against any person with respect to the compensation, terms, conditions, or privileges of employment, or; exclude from participation in, deny the benefits of, or subject to discrimination under any GRANTEE program or activity.

GRANTEE will ensure that all of its employees and agents comply with Minnesota Management and Budget Policy #1329 (Sexual Harassment Prohibited) and #1436 (Harassment and Discrimination Prohibited).

22.3. Grants management policies. GRANTEE must comply with required Grants Management Policies and procedures as specified in Minn. Stat. § 16B.97, subd. 4(a)(1). Compliance under this paragraph includes, but is not limited to, participating in monitoring and financial reconciliation as required by the Office of Grants Management (OGM) Policy 08-10.

22.4. Conflict of interest. GRANTEE certifies that it does not have any conflicts of interest related to this CONTRACT, as defined by OGM Policy 08-01. GRANTEE shall immediately notify STATE if a conflict of interest arises.

23. OTHER PROVISIONS

23.1. No Religious Based Counseling. GRANTEE agrees that no religious based counseling shall take place under the auspices of this CONTRACT.

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Signature Page Follows

By signing below, the parties agree to the terms and conditions contained in this CONTRACT.

APPROVED:

1. **STATE ENCUMBRANCE VERIFICATION** *Individual certifies that funds have been encumbered as required by Minnesota Statutes, chapter 16A and section 16C.05 or Department of Administration Policy 21-01.*

By:_____

Date:_____

Contract No:_____

2. **GRANTEE**

Signatory certifies that Grantee's articles of incorporation, by-laws, or corporate resolutions authorize Signatory both to sign on behalf of and bind the Grantee to the terms of this Agreement. Grantee and Signatory agree that the State Agency relies on the Signatory's certification herein.

By:_____

Title:_____

Date:_____

3. **STATE AGENCY**

By (with delegated authority):_____

Title:_____

Date:_____

Distribution: (fully executed contract to each)

Contracts and Legal Compliance Division

Grantee

State Authorized Representative

The CMS Transforming Maternal Health (TMaH) Model

TMaH Value-Based Payment Design Session II

February 11, 2026

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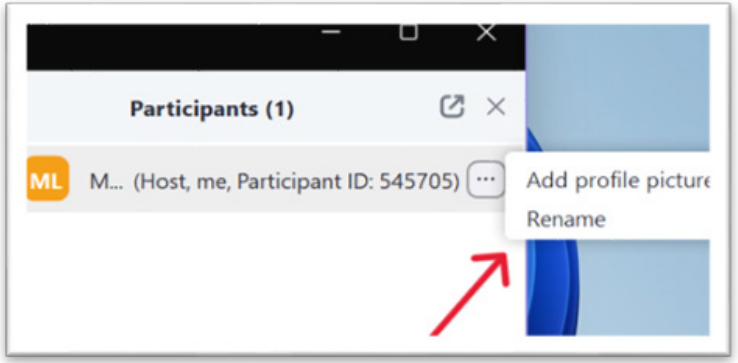

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Agenda

1. Introduction and Overview
2. Value-Based Payment (VBP) Design
   - Accountable Entity
   - Safety Net Providers
   - Inclusion / Exclusion Criteria
   - Risk Adjustment
   - Quality Measures
3. Questions and Breakout Sessions
4. Closing

Meeting Objectives

State Medicaid agencies (SMAs) will learn more about:

- The **Accountable Entity** structure within the TMaH VBP Model
- Potential pathways for **Safety Net Providers**, like Federally Qualified Health Centers (FQHCs) and Tribal Health Providers, to participate in the TMaH VBP Model
- **Inclusion and exclusion criteria** for the prospective and retrospective payments
- Preliminary concept for **risk adjustment**
- **Quality measure concepts** that may be used in the TMaH VBP Model for accountability

Disclaimer

The information provided in workshops is subject to change based on SMA feedback and additional testing/analysis.

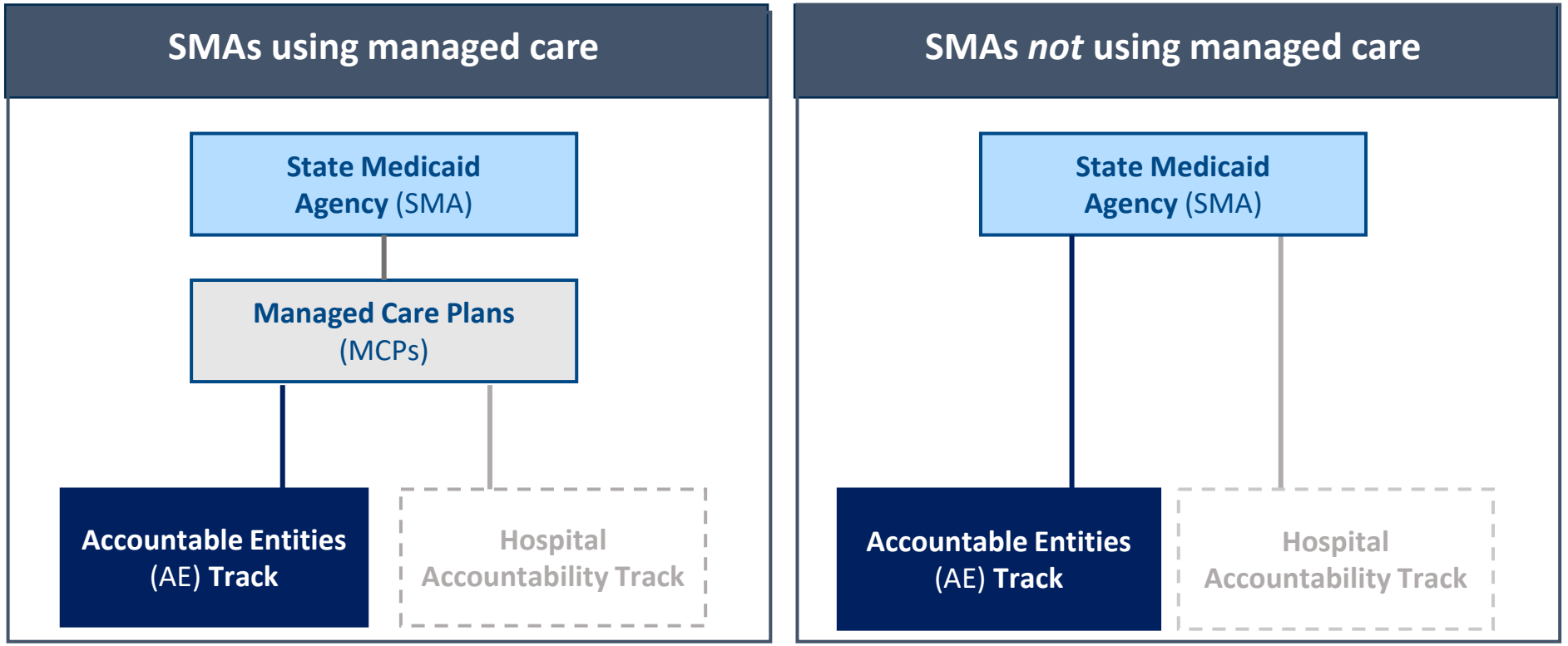
Opening Remarks from CMS

Overview of TMaH Model VBP Strategy

TMaH VBP Model includes two tracks with implementation varying based on the role of managed care in each state.

AE Track refers to the payment mechanisms by which the SMA holds the AEs accountable for their attributed patients' perinatal journey.

Hospital Accountability Track refers to the mechanism by which the SMA holds the sites of delivery accountable for outcomes.



Today, we will focus on the Accountable Entity Track.

VBP Design: Review from October 2025 VBP Workshop

Why Providers Will Benefit from Participating in the TMaH VBP Model

The TMaH VBP Model is designed to:

- **Provide maternal health providers with upfront funds** and predictable revenue to invest in prevention
- **Improve patient outcomes by incenting screening, identifying of, and providing continuous care for high-risk** patients across the spectrum of physical and behavioral health
- **Reward maternal health providers for improved outcomes** and resultant cost savings

Outcomes of interest

Reduced rates of low-risk caesarean deliveries

Reduced incidence of severe maternal morbidity

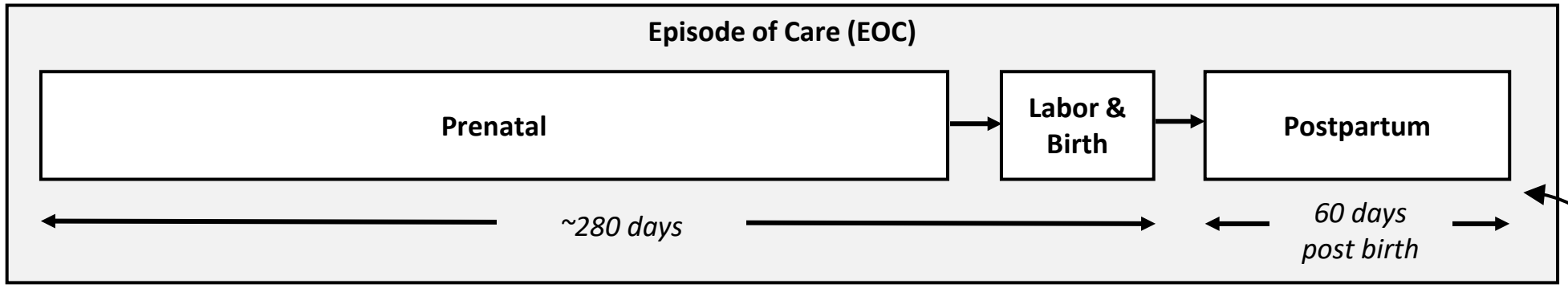
Reduced rates of low-birth weight infants

Improved experience of care for pregnant women

Accountable Entity (AE): Definition and Requirements

- Accountable Entities are the entities accountable for care in the TMaH Model, **primarily practices**, with some exceptions for hospitals, providing prenatal, labor/delivery, and/or postpartum care (perinatal)
  - Targeting obstetric and midwifery practices because these practices often focus on providing prenatal and postpartum care
  - Participating AEs must be identified by a tax identification number (TIN)
  - The AE may be one practice, or multiple practices that join together
- AEs are **accountable** through upside and downside risk (shared savings and losses) for:
  - **Cost** and **quality outcomes**
  - Ensuring all practices (if the AE comprises more than one practice) adhere to the **terms and conditions** of participation
  - **Distributing** shared savings **or recouping** phased in shared losses

Prospective Monthly Payments



Newborn costs are excluded from the EOC given neonatal and pediatric influence out of AE's control

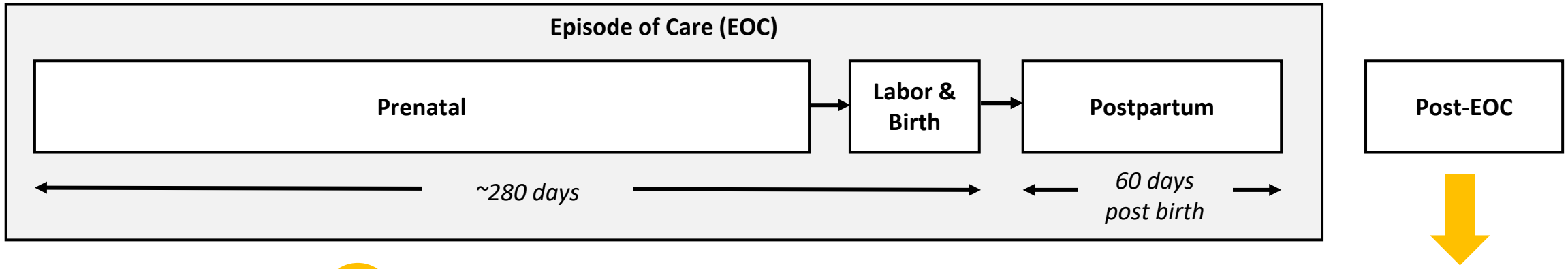
Prospective monthly payments triggered by prenatal appointment in the second trimester

1

SMA/Managed Care Plan (MCP) will pay AEs a <u>prospective monthly payment (the case rate)</u> starting in the second trimester until 60 days postpartum that provide consistent and steady funding to support professional services and care coordination.

Case rate will be calculated individually for each AE based on historic professional claims costs and re-calculated annually based on costs from the prior year

Retrospective Shared Savings



2

Retrospective shared savings (or phased-in losses)

Reconciliation of EOC × **Quality Adjustment** = **Shared Savings** (phased-in losses)

The total cost of completed perinatal EOCs are **reconciled against the target price and adjusted for quality performance.** Total cost includes professional and facility claims.

VBP Support Available to Practices: Provider Infrastructure Payments (PIPs)

- VBP participation is an opportunity for practices to participate in care delivery transformation activities and readiness for the TMaH VBP Model
- The model included the PIP to aid practice transformation activities and build readiness to implement the TMaH VBP Model
- All SMAs will be making PIP payments in 2027 to ready practices to participate in the TMaH VBP Model in 2028 and beyond*
- CMS will share additional guidance in the spring of 2026 and hold the PIP Workshop Session II in Q3 2026
- State coaching teams will support SMAs in understanding guidance and planning efforts

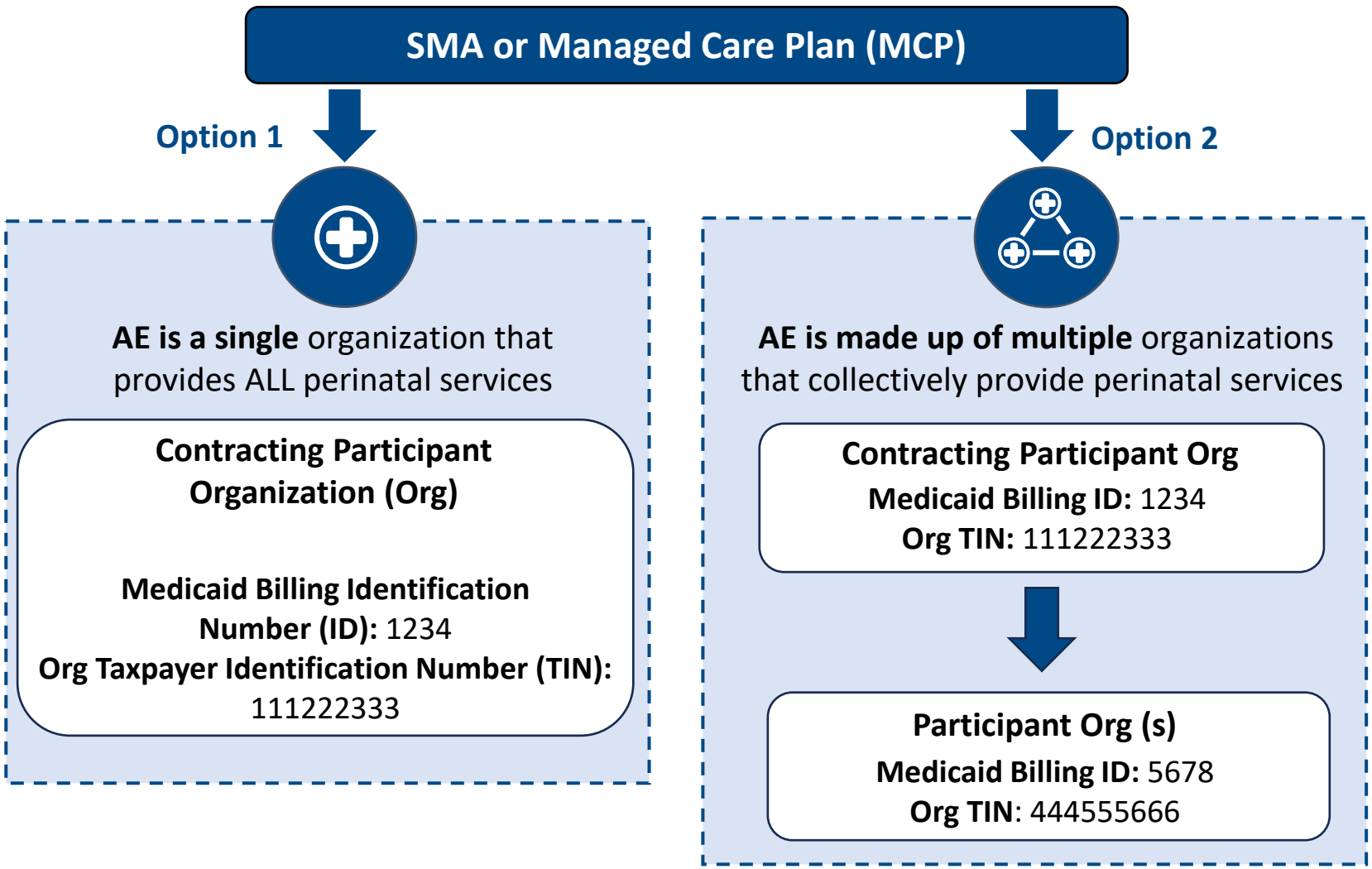
PIP Payments Can Be Used For:

- ☐ Patient safety initiatives and maternal care assessments
- ☐ Quality measure reporting and value-based payment
- ☐ Data integration
- ☐ Team-based care
- ☐ Enhanced access to care
- ☐ Connections to community-based organizations (CBOs)

*Three SMAs will implement PIPs in 2026.

VBP Design: Accountable Entity (AE)

Accountable Entity (AE) Structure



Even if multiple organizations come together, there must be a primary **single TIN** forming a business relationship with the SMA or MCP.

AE may enter **downstream contractual arrangements** with Participant Organizations to meet delivery requirements.

AE Eligibility Criteria

Legal Requirements	❑ **Be a legal entity** formed under applicable state, federal, or Tribal law and authorized to conduct business in the state in which it operates ❑ **Be Medicaid-enrolled** with an active TIN and organizational Medicaid Billing ID (and appropriate CHIP enrollment and billing identifier, if required by the state)
Service Provision Requirements	❑ Provides the **full range of perinatal care** - prenatal, delivery, and postpartum care - which could be provided among different organizations within the AE ❑ Employ or contract with providers who bill for **prenatal, postpartum, and delivery services** (demonstrated by submitting claims with the appropriate codes*) ❑ **Bill under qualifying maternity care specialty types*** ❑ Collectively perform a **minimum number of deliveries** (between 30-50 births per year, further details forthcoming) annually for Medicaid patients
Contractual Requirements Between AEs and Other Participant Organizations	❑ Comply with **applicable model requirements**, such as data and reporting requirements, and participate in performance measurement and financial reconciliation ❑ **Agree to directly receive a case rate for perinatal services** provided to attributed patients in lieu of certain Medicaid FFS payments

*Examples of codes that are used to identify prenatal visits to start the case rate payments and/or show administration of those services, as well as provider types who qualify to receive case rate payments are provided in Appendix A.

Hospital Participation in AEs

- While hospitals may serve as Participant Organizations, they are restricted from serving as the AE ***unless*** they provide:
  - The **full range of perinatal care** (prenatal, delivery, and postpartum)
  - Provide **contractual assurances** that at least 80% of the AE's portion of the shared savings payment will be dispersed to the individuals who provided a majority of the prenatal and postpartum care
- The TMaH Model allows hospital participation subject to these requirements to ensure increased accountability for all primary actors involved with perinatal care

Example of a hospital AE: A hospital in a rural or underserved area that provides perinatal care services but does not have an OB-GYN practice

Note: This slide is about hospitals participation in AEs. It is not about the separate Hospital Accountability Track for which there will be more information in the future.

What Can an AE Look Like?

The following slides contain examples of what it might look like when an AE is comprised of:

- A **single organization** provides all perinatal care
- **More than one practice** that collectively provides all perinatal care

Example 1: Single Organization as the AE

SMA or MCP

SMA or MCP contracts with AE

Contracting Participant Org: OB/GYN Practice or Midwifery Practice

Employs clinicians providing delivery, prenatal, and postpartum*

Patient Perspective

Patients receive prenatal, postpartum, and delivery care from **one organization**

*Minimum delivery volume threshold between 30-50 births per year, further details forthcoming

Why this is an AE

An organization operating under a single TIN that:

- Provides the full continuum of perinatal care (prenatal, delivery, and postpartum care) and
- Contracts with the SMA or MCP to be accountable for cost and quality under the TMaH VBP Model

How it Operates

The practice:

- Employs all clinicians needed to deliver comprehensive perinatal care
- May operate at multiple sites of care
- Receives PIP funding to prepare for the TMaH VBP Model, including, for example: hiring a staff member to support VBP administration, financial oversight and claims submissions

Example 2: Two or More Organizations as the AE

SMA or Subrecipient (MCP)

SMA or MCP contracts with AE

Contracting Participant Org: FQHC

Employs clinicians providing prenatal and postpartum care

AE contracts with Participant Organization

Participant Org: Hospital or Hospital Owned OB/GYN Practice

Employs clinicians providing delivery and postpartum care

Patient Perspective

Patients receive prenatal, postpartum, and delivery care from **multiple organizations**

Why this is an AE

Two Participant Organizations coordinate to collectively provide the full continuum of perinatal services.

One organization contracts with the SMA or MCP as the AE which contracts downstream with a Participant Organization to meet eligibility requirements.

How it Operates

- The two organizations collectively employ all clinicians needed for the full perinatal episode
- AE receives PIP funding to, for example: formalize patient and provider workflows between both organizations and hire a staff member to support VBP administrative and financial oversight

Who Cannot be an AE

Entities that do not alone meet the eligibility criteria include:

- ✖ Individual clinicians without organizational infrastructure
- ✖ Hospitals that do not provide prenatal or postpartum services
- ✖ AEs below minimum delivery volume threshold*
- ✖ Practices/FQHCs where providers do not perform labor/delivery cannot be AEs on their own

*Minimum delivery volume threshold between 30-50 births per year, further details forthcoming

VBP Design: Safety Net Providers

Safety Net Provider Participation

- Safety net providers* (SNPs) provide critical maternal health care services
- Unique SNP reimbursement structures require flexibility related to phased-in downside risk and potentially the case rate payment
  - **FQHCs:** The Medicaid Prospective Payment System (PPS) is the single required rate that states must pay FQHCs in a single visit. Many SMAs pay an alternative rate either equal to or greater than the PPS rate, known as an Alternative Payment Methodology (APM) rate
  - **Tribal Health Providers**: The Indian Health Service (IHS) All-Inclusive Rate (AIR) is the U.S. Office of Personnel Management-determined payment methodology for Medicaid or Medicare services furnished in IHS-operated or Tribally operated (Section 638) facilities
- The TMaH VBP Model will phase in downside risk over time
- SNP dynamics in your state will be discussed in follow-up TA calls

*This workshop focuses on FQHC and Tribal Health providers, we will discuss other types of SNPs providing perinatal care services in your state.

Optional Pathways for FQHC Participation

1. ACO Approach

Multiple FQHCs form a joint entity to pool volume, coordinate quality efforts, and share accountability.

2. AE Umbrella Model

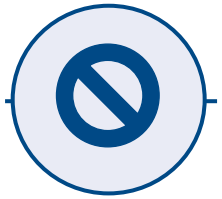
FQHCs join a larger AE—such as a health system or integrated OB group—that holds the financial risk and redistributes incentives.

3. Limited Risk/Reward

FQHCs participate as AEs but are exposed only to minimal shared risk/reward to a proportion of payments above PPS*.

SMAs with an APM can put a portion of their existing APM at risk.

SMAs without an APM would need to create a new APM and put the amount above the PPS at risk.



4. No Risk/Reward

FQHCs participate without upside/downside risk through care delivery requirements, quality reporting, and access measures. Under this approach, FQHCs would not be eligible for provider infrastructure payments. Over time, FQHCs could participate in Options 1-3.

*Payments above PPS are designed to ensure cost coverage, rather than incentive payments.

Optional Pathways for Tribal Health Participation

1. AE Umbrella Model

Tribal providers join an AE that takes on downside risk on behalf of the Tribal provider(s).

2. No Risk

Tribal providers are eligible for shared savings if they reduce costs and improve quality, but downside risk is not required.

Recruiting for the TMaH VBP Model

- The TMaH VBP Model is focused on practice-led maternity care to maximize the benefits of the VBP model and improve outcomes
- State and regional maternal health care delivery structures vary in:
  - Use of integrated health systems
  - Experience with independent hospital-based outpatient obstetric practices
  - Types of care provided by safety net providers
- **CMS will work with each SMA** to help identify and recruit AEs for the TMaH VBP Model

VBP Design: Payment Rate Inclusion/Exclusion Criteria

Included Services for Prospective and Retrospective Payment

	Service
Professional Services	• Labor & Delivery (L&D) Professional* • Outpatient Professional* • Inpatient Professional (codes unrelated to L&D Professional)
Facility & Diagnostic Services	• Ultrasounds • Inpatient Facility • Outpatient Facility • Outpatient Laboratory • Outpatient Radiology
Other	• Certain Durable Medical Equipment (DME) • Pharmacy • Emergency Department & Observation Stay • Other Services (uncategorized claims that are determined to be included services)

Rationale

Included services are intended to incent use of standard services and disincentivize overutilization of unnecessary services.

Except for L&D and outpatient professional services, other services are included in the retrospective episode but excluded from the prospective monthly payment to ensure that providers are not discouraged from ordering clinically appropriate services.

*Services in blue font with * are included in basis for prospective and retrospective payment

All services in black font are included in the basis for retrospective payment but not in the prospective monthly payment

Excluded Services for Prospective and Retrospective Payment

	Service
Professional Services	• Pediatric professional services • Behavioral Health and Substance Use Disorder (SUD) services*
Facility & Care Services	• Neonatal care/NICU • Hospital costs and non-pregnancy related care
Medications & Devices	• Pharmacy claims with excluded medications/high-cost drugs • Durable Medical Equipment (DME)**, including home monitoring equipment
Other	• Non-emergency transportation • Flu and TdAP vaccines • Pregnancy-related care (e.g., doula, dental, lactation) that is cost-effective and important for improving health outcomes • Header-paid inpatient claims with excluded services (e.g., appendectomy, hip replacement, hernia procedure) • Contraceptive services and procedures

Rationale

Certain services such as behavioral health, SUD, home monitoring, doula, dental and lactation care are intentionally excluded to incent providers to use them.

Other services such as pediatric and neonatal care are excluded because they are beyond the control of the provider.

*Services related to screenings for behavioral health and substance use disorder are included in the episode cost as part of pregnancy-related care that may occur during the perinatal window, and to incentivize providers to care for pregnant individuals with behavioral/SUD conditions. Services related to treatment would subsequently be excluded.

**Certain DME is excluded from both the prospective and retrospective payments

Non-Attributable Patients or Events

The following patients or events will be excluded from reconciliation

- Dual eligible patients
- Out of age range (<12 and >55)
- Miscarriages
- Stillbirth
- Left care against medical advice
- High-cost outliers and conditions
- Switched or transferred providers in third trimester

VBP Design: Risk Adjustment

Risk Adjustment

A process used to account for differences in the health status and expected medical costs of patients when comparing outcomes, setting payments, or evaluating performance.

Why is risk adjustment necessary?

- Ensures the TMaH Model target price fairly reflects the underlying health risk of the pregnant population attributed to each AE and therefore does not unfairly penalize providers serving sicker populations
- It helps compare spending across patients with different risk levels

How Will the TMaH Model Implement Risk Adjustment?

CMS is considering using the **Chronic Illness and Disability Payment System (CDPS), a risk adjustment system** that is widely used in Medicaid programs and can be applied to a maternal health population.

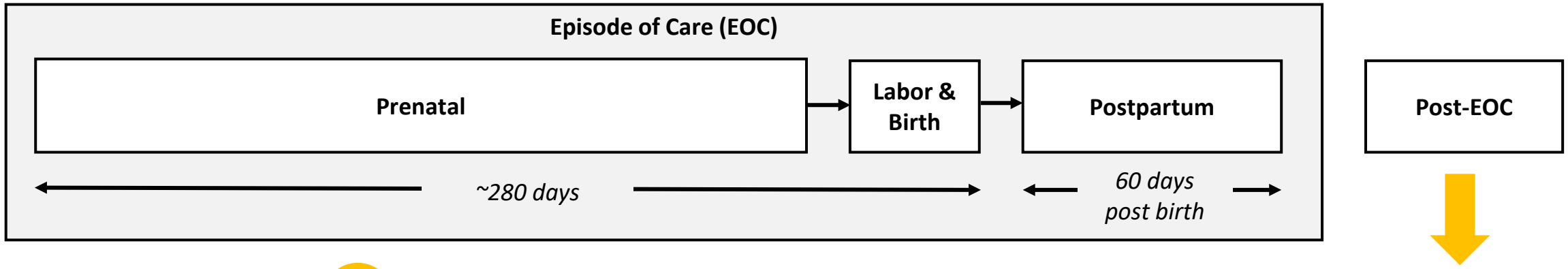
Risk-Adjusted Target Prices:

- Constructed using historic claims, encounters, and eligibility data from an established **historical baseline** period to create relative risk scores
- **Reassessed** after the performance period

CMS is continuing to test and refine risk adjustment methodology and additional details will be forthcoming. Additionally, TMaH will consider risk adjustment for relevant quality measures.

VBP Design: Quality Measures

The Role of Quality in the TMaH VBP Model



2

Retrospective shared savings (or phased-in losses)

Reconciliation of EOC × **Quality Adjustment** = **Shared Savings** (phased-in losses)

Annually, the total cost of completed perinatal EOCs are **reconciled against the target price and adjusted for quality performance.** Total cost includes professional and facility claims.

Quality measures are a core part of VBP because they align provider incentives with better care and ensure that cost savings are achieved through improved outcomes.

TMaH VBP Model Quality Concepts

Inclusion	AE Track	Hospital Accountability Track
Likely	• Timeliness of prenatal and postpartum care • Depression screening and follow up • Substance use disorder screening • Maternal hypertension control • Maternal morbidity (e.g., complications) • Low-risk cesarean delivery	• Low-risk cesarean delivery • Maternal morbidity, including obstetrical complications
Under Discussion	• Low birthweight • Upstream drivers of health risk screening • Patient experience measure	• Early elective delivery (EED)

The timing of reporting or tying these measures to payment needs are to be determined. We do not expect that all measures will be used in the first phase of implementation.

Q&A

Breakout Discussions

Breakout Rooms

- Each of the 4 breakout rooms will share reflections from the list of questions on the next slide
- After the session, each group will share one key finding from their discussion
- Please designate a spokesperson to briefly summarize your group's insight
- We'll reconvene in the main session to hear from:
  - **Room 1**: AL, DC, MN, OK
  - **Room 2**: AR, LA, MS, NJ
  - **Room 3**: CA, IL, KS, WI
  - **Room 4**: ME, SC, WV

Breakout Room Questions

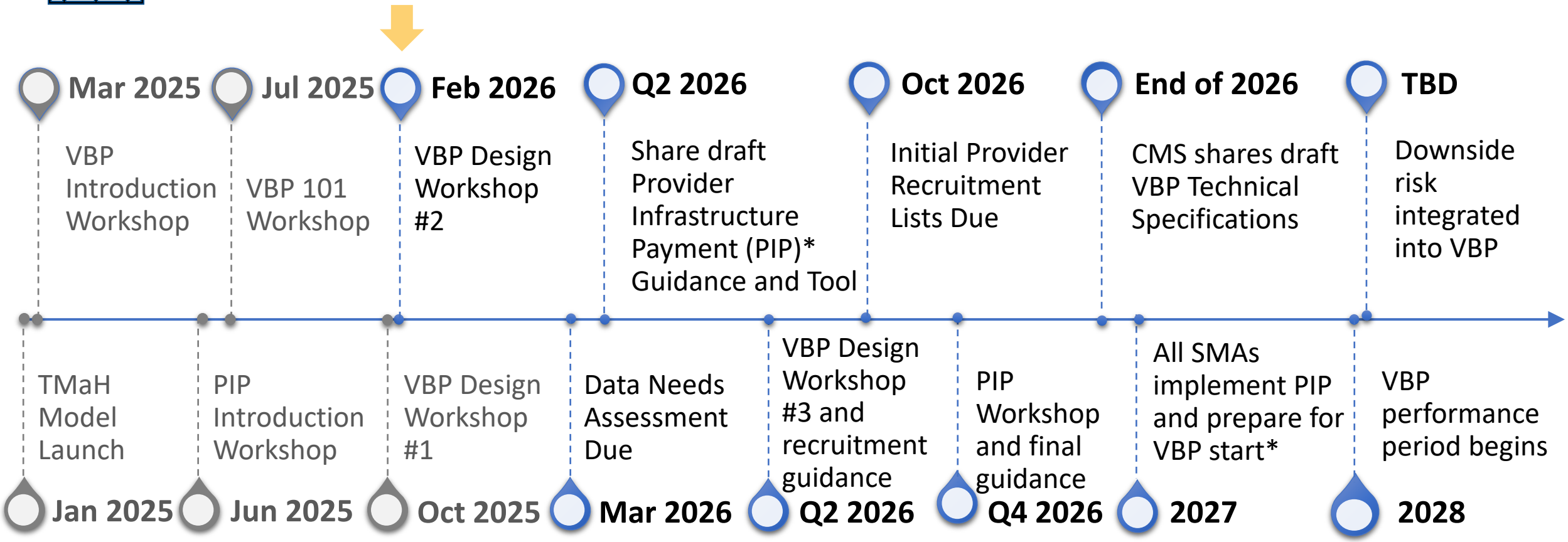
1. **Accountable Entities:** Which practice and/or hospital types do you want to recruit to participate in the TMaH VBP Model in your state?
   - Would they be a single or multiple organization AE?
   - What provider types will be most interested in the TMaH VBP Model?
   - What provider types will be more complex to recruit?
2. **Safety Net Providers (SNPs):** Which SNP (FQHC/RHC/Tribal) risk options would work best in your state?
   - What additional information does your state need to recruit SNP participants?
3. **Quality Measures for VBP:**
   - Are these the right measures for your state?
   - Any reactions on feasibility?

Report Out

- Please share:
  - Your group's main insights or recommendations in each of the three topic areas
  - Any emerging themes or questions?
- Report Out Order
  - **Room 1**: AL, DC, MN, OK
  - **Room 2**: AR, LA, MS, NJ
  - **Room 3**: CA, IL, KS, WI
  - **Room 4**: ME, SC, WV

Closing

TMaH VBP Timeline



Ongoing VBP Feedback from SMAs and VBP TA to SMAs

*Three SMAs will implement PIPs in 2026

Upcoming Workshops

Topic	Date	Description
Data Infrastructure	Q2 2026	• Overview of data needs assessment • Technical assistance for VBP data needs
VBP Design Workshop Session III	Q2 2026	• Additional TMaH VBP Model technical specifications: AE recruitment, attribution logic and quality measures
PIP Workshop Session II	Fall 2026	• Updated guidance on recruiting and executing contracts with AEs for PIP funding dispersal • Lessons learned from SMAs implementing PIPs in 2026 • PIP tool (questionnaire) • Operationalizing the tool and PIP payments

Additional Information and Resources

For more information and to stay up to date on upcoming TMaH Model events and resources:

- TMaH Model Website: www.cms.gov/priorities/innovation/innovation-models/transforming-maternal-health-tmah-model
- Overview Factsheet: www.cms.gov/files/document/tmah-fact-sheet.pdf
- Patient Journey Map: www.cms.gov/files/document/tmah-journey-map.pdf

Thank you for your time!

Please take the survey following this webinar so we can learn how to make our events better.

Questions? Please email your TMaH PO.

Appendix A: Prenatal Care and Delivery Services Code List and Qualifying Maternal Health Providers

Code List Under Consideration for TMaH Prenatal Care and Delivery Services Included in VBP Payments

Prenatal Care Codes	• Trigger diagnosis codes indicating pregnancy (ICD-10 codes to be specified in the technical specifications), **AND** • Qualifying Evaluation & Management (E&M) codes: 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

Delivery Procedure Codes or Delivery-Related Diagnosis Codes*	• Delivery procedure codes:
	  • Vaginal delivery: 59400, 59409, 59410
	  • Cesarean delivery: 59510, 59514, 59515
	  • VBAC and related delivery codes: 59610, 59612, 59614, 59618, 59620, 59622

Qualifying POS Codes	11 (Office), 19 (Off-campus outpatient hospital), 21 (Inpatient hospital; delivery only), 22 (On-campus outpatient hospital), 23 (Emergency room—hospital; delivery only), 50 (FQHC), 72 (RHC), Tribal POS codes

*This list of procedure codes does not represent the complete list that will be included in forthcoming technical specifications.

TMaH Qualifying Maternal Health Providers

The following types of providers/practices could participate in the TMaH Model as Accountable Entities if they meet other criteria*:

- Obstetrics and Gynecology (OB/GYN)
- Maternal-Fetal Medicine (MFM)
- Certified Nurse Midwife (CNM)
- Obstetric Nurse Practitioner
- Women's Health Nurse Practitioner
- Primary Care Providers (Family Medicine, Internal Medicine, General Practice)
- Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes providing perinatal services
- Tribal Health Centers and Indian Health Service (IHS) facilities providing perinatal services
- Hospitals are eligible to participate as Participant Organizations if they employ eligible clinicians who provide perinatal care services and bill under the hospital's TIN

*This list is subject to change.

Transforming Maternal Health (TMaH) Model

Value-Based Payment Glossary

Overview

This glossary offers a common set of definitions for terminology specific to the Transforming Maternal Health (TMaH) Value-Based Payment (VBP) Model to provide State Medicaid Agencies (SMA) and other stakeholders with a clear, consistent reference for shared definitions and orientation.

Note: All definitions are subject to revision based on analysis and stakeholder input. If changes are made, this glossary will be updated

Term	Definition
Accountable Entity (AE)	Provider organization(s) that deliver prenatal, labor and delivery, and postpartum ("perinatal") care and agree to be accountable for cost and quality outcomes as part of the TMaH VBP Model. An AE is identified based on the taxpayer identification number (TIN) of a Participant Organization, which serves as the single legal entity that forms a business relationship with the SMA or a managed care plan (MCP) for purposes of participation in the TMaH VBP Model. An AE may be structured as a single organization or multiple organizations that formally join together under a contracting participant organization's TIN to meet model requirements. Even if multiple organizations join together, one primary TIN must contract with the SMA or MCP and downstream with other Participant Organizations to meet AE requirements. Examples of entities that can become an AE include, but are not limited to: obstetrics and gynecology (OB/GYN) practice, hospital-based OB/GYN practice, family medicine practice, federally qualified health center (FQHC), midwifery practice, or birth center.
Attribution	The method used to assign patients and their health care outcomes to specific providers. Patient attribution in the TMaH VBP Model establishes the patient panel for which an AE is accountable for cost and quality outcome.
Delivery Setting	The site of care where a patient delivers a baby (e.g., hospital, birth center, etc.).
Excluded Services	Services that are not included in calculations for the purposes of determining prospective monthly payments or retrospective reconciliation under the TMaH VBP Model.
Included Services	The services included in calculations for the purposes of determining prospective monthly payments or retrospective reconciliation under the TMaH VBP Model, such as professional services and certain facility and diagnostic services.
Prospective Monthly Payment (Case Rate)	Fixed monthly payments, also called a case rate, paid to an AE for the cost of providing care to patients attributed to that AE. In the TMaH VBP Model, prospective monthly payments will begin when a prenatal visit occurs in the second trimester and continue monthly through 60 days postpartum. Prospective monthly payments are calculated individually for each AE based on historic professional claims costs of included services and re-calculated annually based on costs from the prior year.

Term	Definition
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA.
Non-Attributable Delivery	A scenario where an AE-attributed patient receives labor/delivery services from a practice that is not a participating AE in the TMaH VBP Model.
Participant Organization	An organization that may on its own be an AE, if it meets all AE criteria, or partners with one or more additional Participant Organizations to form an AE. Participant organizations, either individually or collectively, provide the basis for shared savings and shared losses determinations through financial reconciliation.
Partner Organization	A non-clinical organizations that will partner with the SMA or AE to implement the model, including but not limited to state public health departments, Perinatal Quality Collaboratives, maternal mortality review committees, managed care plans, community-based organizations, universities and other non-clinical organizations.
Perinatal Episode of Care (Perinatal EOC)	The full course of maternal care during the perinatal period (prenatal, labor and delivery, and postpartum) for which the VBP is based.
Prenatal	The period before birth (~280 days prior).
Postpartum	For the purposes of TMaH Model VBP calculations, the 60-day period post birth.
Prenatal Care Setting	The FQHCs, OB/GYN clinics, family medicine practices, birth centers, and other maternal health settings, including the delivery of telehealth, where prenatal care is delivered. The prospective monthly payment is triggered by submission and receipt or a prenatal visit claims code in this setting.
Provider Infrastructure Payment (PIP)	Time-limited payments made by the SMA or a subrecipient to TMaH-participating providers or other entities on behalf of providers, primarily during the Pre-Implementation Period to support health care delivery transformation activities within six approved domains: patient safety initiatives and maternal care assessment, quality measure reporting, data integration, team-based care, enhanced access to care, and connections to community-based organizations (CBOs).
Quality Measures (Value-Based Payment)	Measures used to track and link value-based payments to quality of care. The measures that will partially affect payment are still being finalized.
Retrospective Reconciliation	A comparison of the total cost of maternal health care services provided by the AE included in the episode of care to a risk-adjusted target price, adjusted based on quality measures, to determine the shared savings payment (or losses).
Risk Adjustment	A process used to account for differences in the health status and expected medical costs of patients when comparing outcomes, setting payments, or evaluating performance. Risk adjustment can be used to adjust the target price and/or quality benchmarks in VBP models.

Term	Definition
Safety Net Provider	A community health services entity providing services on a sliding payment scale, including: 1. All Federally Qualified Health Centers (FQHCs), including those reimbursed via the Federal prospective payment system (PPS) rate or bill at the Tribal/Indian Health Service All Inclusive Rate (AIR) 2. Rural Health Clinics 3. American Indian and Alaska Native (AI/AN) Healthcare service sites operated by: a. Indian Health Service (IHS) b. Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act (ISDEAA), and c. Urban Indian organizations under title V of the Indian Health Care Improvement Act (IHCIA) 4. Safety Net Hospitals a. Hospitals receiving Disproportionate Share Hospital (DSH) payments or meeting federal DSH criteria b. Critical Access Hospitals c. Rural Emergency Hospitals.
Shared Losses	Repayment owed by the AE if average costs for attributed TMaH episodes are above the risk-adjusted target price.
Shared Savings	Incentive payment earned by the AE if average costs for attributed TMaH episodes are below the risk-adjusted target price and quality requirements are met.
Subrecipient	Entities who administer and/or distribute PIPs and VBPs to AE. Subrecipients may include managed care plans, foundations, or entities with experience dispersing similar payments.
Switch	When a patient receives care from more than one AE during the perinatal period.
Target Price	The expected cost for maternity care services based on an AE's historical costs for the included services in TMaH's episode of care. CMS will risk adjust the target price to account for variation in the average risk profile of an AE's patient panel.
Tax Identification Number (TIN)	A unique number assigned by the Internal Revenue Service to identify a legal entity for tax and billing purposes.
Transfer	When a patient moves into a different level of care based on clinical need.
Value-Based Payment (VBP)	A way of paying for care that links payment to quality and cost performance rather than the quantity of services provided.
Transforming Maternal Health Value-Based Payment Model (TMAH VBP Model)	Refers to the set of payment and quality requirements that apply to an AE participating in the model. It includes the components used to determine both prospective monthly payments and retrospective reconciliation.

DEPARTMENT OF HUMAN SERVICES

DATA SHARING AND BUSINESS ASSOCIATE AGREEMENT TERMS AND CONDITIONS

This Data Sharing and Business Associate Agreement, and amendments and supplements thereto ("Agreement"), is between the State of Minnesota, acting through its Department of Human Services, Click here to enter Division, ("STATE") and Click here to enter name of party ("DATA SHARING PARTNER").

RECITALS

This Agreement sets forth the terms and conditions in which STATE will share data with and permit DATA SHARING PARTNER to Use or Disclose Protected Information that the parties are legally required to safeguard pursuant to the Minnesota Government Data Practices Act ("MGDPA") under Minnesota Statutes, chapter 13, the Health Insurance Portability and Accountability Act rules and regulations codified at 45 C.F.R. Parts 160, 162, and 164 ("HIPAA"), and other Applicable Safeguards.

The parties agree to comply with all applicable provisions of the MGDPA, HIPAA, and any other Applicable Safeguard that applies to the Protected Information.

General Description of Protected Information That Will Be Shared: EXAMPLE: "Minnesota Health Programs claims data for fiscal years 2013 through 2014". Identify data to be shared.

Purpose for Sharing Protected Information and Expected Outcomes: EXAMPLE: "Review Minnesota Health Programs to program integrity, quality, and effectiveness." Briefly describe reason for sharing.

STATE is permitted to share the Protected Information with DATA SHARING PARTNER pursuant to: Cite legal authority that permits sharing.

It is expressly agreed that DATA SHARING PARTNER is a "business associate" of STATE, as defined by HIPAA under 45 C.F.R. § 160.103, "Definitions." The Disclosure of Protected Health Information to DATA SHARING PARTNER that is subject to the Health Insurance Portability Accountability Act (HIPAA) is permitted by 45 C.F.R. § 164.502(e)(1)(i), "Standard: Disclosures to Business Associates."

It is understood by DATA SHARING PARTNER that, as a business associate under HIPAA, DATA SHARING PARTNER is directly liable under the HIPAA Rules and subject to civil and, in some cases, criminal penalties for making Uses and Disclosures of Protected Health Information that are not authorized by contract or permitted by law. DATA SHARING PARTNER is also directly liable and subject to civil penalties for failing to safeguard electronic Protected Health Information in accordance with the HIPAA Security Rule, Subpart C of 45 C.F.R. Part 164, "Security and Privacy."

DEFINITIONS

A. "Agent" means DATA SHARING PARTNER'S employees, contractors, subcontractors, and other non-employees and representatives.

B. “Applicable Safeguards” means the state and federal safeguards listed in subsection 2.1.A of this Agreement.

C. “Breach” means the acquisition, access, Use, or Disclosure of unsecured Protected Health Information in a manner not permitted by HIPAA, which compromises the security or privacy of Protected Health Information.

D. “Business Associate” shall generally have the same meaning as the term “business associate” found in 45 C.F.R. § 160.103, and in reference to the party in the Agreement, shall mean DATA SHARING PARTNER.

E. “Disclose” or “Disclosure” means the release, transfer, provision of access to, or divulging in any manner of information by the entity in possession of the Protected Information.

F. “HIPAA” means the rules and regulations codified at 45 C.F.R. Parts 160, 162, and 164.

G. “Individual” means the person who is the subject of protected information.

H. “Privacy Incident” means a violation of an information privacy provision of any applicable state and federal law, statute, regulation, rule, or standard, including those listed in the Agreement.

I. “Protected Information” means any information, regardless of form or format, which is or will be Used by STATE or DATA SHARING PARTNER under the Agreement that is protected by federal or state privacy laws, statutes, regulations, policies, or standards, including those listed in this Agreement. This includes, but is not limited to, individually identifiable information about a State, county or tribal human services agency client or a client’s family member. Protected Information also includes, but is not limited to, Protected Health Information, as defined below, and Protected Information maintained within or accessed via a State information management system, including a State “legacy system” and other State application.

J. “Protected Health Information” is a subset of Protected Information (defined above) and has the same meaning as the term “protected health information” found in 45 C.F.R. § 160.103. For the purposes of this Agreement, it refers only to that information that is received, created, maintained, or transmitted by DATA SHARING PARTNER as a Business Associate on behalf of STATE.

K. “Security Incident” means the attempted or successful unauthorized accessing, Use, or interference with system operations in an information management system or application. “Security Incident” does not include pings and other broadcast attacks on a system’s firewall, port scans, unsuccessful log-on attempts, denials of service, and any combination of the above, provided that such activities do not result in the unauthorized exposure, viewing, obtaining, accessing, or Use of Protected Information.

L. “Use” or “Used” means any activity involving Protected Information including its creation, collection, access, acquisition, modification, employment, application, utilization, examination,

analysis, manipulation, maintenance, dissemination, sharing, Disclosure, transmission, or destruction. "Use" includes any of these activities whether conducted manually or by electronic or computerized means.

1. TERM OF AGREEMENT.

1.1 Effective date. The effective date of this Agreement is Click here to enter effective date, or the date this Agreement is signed by both parties, whichever is later.

1.2 Expiration date. The expiration date of this Agreement is Click here to enter expiration date, or until all obligations set forth in this Agreement have been satisfactorily fulfilled, whichever occurs first.

2. DUTIES.

2.1 STATE will disclose the following information to DATA SHARING PARTNER: Identify and describe data to be shared.

A. The data exchanged under the Agreement is provided to DATA SHARING PARTNER for DATA SHARING PARTNER to: Reason for sharing data.

B. STATE is permitted to share the Protected Information with DATA SHARING PARTNER pursuant to: Legal authority permitting sharing.

C. STATE will share the Protected Information by Click here to describe how STATE will share data.

2.2 DATA SHARING PARTNER shall: Click here to describe duties that are expected from the DATA SHARING PARTNER under the Agreement and specifically state how the data will be used to accomplish those tasks.

3. TIME.

The parties will perform their duties within the time limits established in this Agreement unless prior written approval is obtained from the other party.

4. CONSIDERATION AND PAYMENT.

There will be no funds obligated by either party under this Agreement. Each party will be responsible for its own costs in performing its stated duties.

5. AUTHORIZED REPRESENTATIVES AND RESPONSIBLE AUTHORITY.

5.1 State. STATE's authorized representative is Click here to enter Name, Title, and Contact Information**,** or successor. DATA SHARING PARTNER shall make any notice or contact to STATE required by this Agreement to STATE's authorized representative.

5.2 Data Sharing Partner. DATA SHARING PARTNER's Authorized Representative is Click here to enter Name, Title, and Contact Information or successor.

5.3 Information Privacy and Security. STATE's responsible party for the purposes of complying with the Applicable Safeguards in this Agreement is STATE's authorized representative. DATA SHARING PARTNER's responsible party for the purposes of complying with the Applicable Safeguards this Agreement is Click here to enter Name, Title, and Contact Information or successor.

6. INFORMATION PRIVACY AND SECURITY

DATA SHARING PARTNER and STATE must comply with the MGDPA, HIPAA, and all other Applicable Safeguards as they apply to all data provided by STATE under the Agreement, and as they apply to all data created, collected, received, stored, Used, maintained, or disseminated by DATA SHARING PARTNER under the Agreement. The civil remedies of Minn. Stat. § 13.08, "Civil Remedies," apply to DATA SHARING PARTNER and STATE. Additionally, the remedies of HIPAA apply to the release of data governed by HIPAA.

6.1 Compliance with Applicable Safeguards.

A. State and Federal Safeguards. The parties acknowledge that the Protected Information to be shared under the terms of the Agreement may be subject to one or more of the laws, statutes, regulations, rules, policies, and standards, as applicable and as amended or revised ("Applicable Safeguards"), listed below, and agree to abide by the same.

1. Health Insurance Portability and Accountability Act rules and regulations codified at 45 C.F.R. Parts 160, 162, and 164 ("HIPAA");
2. Minnesota Government Data Practices Act (Minn. Stat. Chapter 13);
3. Minnesota Health Records Act (Minn. Stat. § 144.291–144.34);
4. Confidentiality of Alcohol and Drug Abuse Patient Records (42 U.S.C. § 290dd-2, "Confidentiality of Records," and 42 C.F.R. Part 2, "Confidentiality of Substance Use Disorder Patient Records");
5. Tax Information Security Guidelines for Federal, State and Local Agencies (26 U.S.C. § 6103, "Confidentiality and Disclosure of Returns and Return Information," and Internal Revenue Service Publication 1075;
6. U.S. Privacy Act of 1974;
7. Computer Matching Requirements (5 U.S.C. § 552a, "Records Maintained on Individuals");
8. Social Security Data Disclosure (section 1106 of the Social Security Act: 42 USC § 1306, "Disclosure of information in Possession of Social Security Administration or Department of Health and Human Services");
9. Disclosure of Information to Federal, State and Local Agencies (DIFSLA Handbook, Internal Revenue Service Publication 3373);
10. Final Exchange Privacy Rule of the Affordable Care Act (45 C.F.R. § 155.260, "Privacy and Security of Personally Identifiable Information,");
11. NIST Special Publication 800-53, "Security and Privacy Controls for Federal Information Systems and Organizations," Revision 4 (NIST.SP.800-53r4); and,
12. All state of Minnesota "Enterprise Information Security Policies and Standards."[1]

The parties further agree to comply with all other laws, statutes, regulations, rules, and standards, as amended or revised, applicable to the exchange, Use and Disclosure of data under the Agreement.

B. Statutory Amendments and Other Changes to Applicable Safeguards. The Parties agree to take such action as is necessary to amend the Agreement from time to time as is necessary to ensure, current, ongoing compliance with the requirements of the laws listed in this Section or in any other applicable law.

[1] *See* https://mn.gov/mnit/government/policies/security/

6.2 DATA SHARING PARTNER Data Responsibilities

A. Use Limitation.

1. Restrictions on Use and Disclosure of Protected Information. Except as otherwise authorized in the Agreement, DATA SHARING PARTNER may only Use or Disclose Protected Information as minimally necessary to provide the services to STATE as described in the Agreement, or as otherwise required by law, provided that such Use or Disclosure of Protected Information, if performed by STATE, would not violate the Agreement, HIPAA, or state and federal statutes or regulations that apply to the Protected Information.

2. Federal tax information. To the extent that Protected Information Used under the Agreement constitutes "federal tax information" (FTI), DATA SHARING PARTNER shall ensure that this data only be Used as authorized under the Patient Protection and Affordable Care Act, the Internal Revenue Code, 26 U.S.C. § 6103(C), and IRS Publication 1075.

B. Individual Privacy Rights. DATA SHARING PARTNER shall ensure Individuals are able to exercise their privacy rights regarding Protected Information, including but not limited to the following:

1. Complaints. DATA SHARING PARTNER shall work cooperatively and proactively with STATE to resolve complaints received from an Individual; from an authorized representative; or from a state, federal, or other health oversight agency.

2. Amendments to Protected Information Requested by Data Subject Generally. Within three (3) business days, DATA SHARING PARTNER must forward to STATE any request to make any amendment(s) to Protected Information in order for STATE to satisfy its obligations under Minn. Stat. § 13.04, "Rights of Subjects of Data," subd. 4. If the request to amend Protected Information pertains to Protected Health Information, then DATA SHARING PARTNER must also make any amendment(s) to Protected Health Information as directed or agreed to by STATE pursuant to 45 C.F.R. § 164.526, "Amendment of Protected Health Information," or otherwise act as necessary to satisfy STATE or DATA SHARING PARTNER's obligations under 45 CF.R. § 164.526 (including, as applicable, Protected Health Information in a designated record set).

C. Background Review and Reasonable Assurances of Agents.

1. Criminal Background Check Required. DATA SHARING PARTNER and employees of DATA SHARING PARTNER accessing STATE's Protected Information must submit to STATE or provide evidence of a computerized criminal history system background check (hereinafter "CCH background check") performed within the last six (6) months before work can begin under the Agreement. "CCH background check" is defined as a background check including search of the computerized criminal history system of the Minnesota Department of Public Safety's Bureau of Criminal Apprehension.

2. Reasonable Assurances. DATA SHARING PARTNER represents that, before any Agent is allowed to Use or Disclose Protected Information, DATA SHARING

PARTNER has conducted and documented a background review of the Agent sufficient to provide DATA SHARING PARTNER with reasonable assurances that the Agent will fully comply with the terms of the Agreement and Applicable Safeguards.

3. **Documentation.** DATA SHARING PARTNER shall make available documentation required by this Section upon request by STATE.

D. Ongoing Responsibilities to Safeguard Protected Information.

1. **Privacy and Security Safeguards.** DATA SHARING PARTNER shall develop, maintain, and enforce policies, procedures, and administrative, technical, and physical safeguards that comply with the Applicable Safeguards to ensure the privacy and security of the Protected Information, and to prevent the Use or Disclosure of Protected Information, except as expressly permitted by the Agreement.

2 **Electronic Protected Information.** DATA SHARING PARTNER shall implement and maintain appropriate safeguards with respect to electronic Protected Information, and comply with Subpart C of 45 C.F.R. Part 164 (HIPAA Security Rule) with respect to prevent the Use or Disclosure other than as provided for by the Agreement.

3. **Monitoring Agents.** DATA SHARING PARTNER shall ensure that any Agent to whom DATA SHARING PARTNER Discloses Protected Information on behalf of STATE, or whom DATA SHARING PARTNER employs or retains to create, receive, Use, store, Disclose, or transmit Protected Information on behalf of STATE, agrees in writing to the same restrictions and conditions that apply to DATA SHARING PARTNER under the Agreement with respect to such Protected Information, and in accordance with 45 C.F.R. §§ 164.502, "Use and Disclosure of Protected Health Information: General Rules," subpart (e)1)(ii) and 164.308, "Administrative Safeguards," subpart (b)(2).

4. **Encryption**. According to the state of Minnesota's "Enterprise Information Security Policies and Standards,"[2] DATA SHARING PARTNER must use encryption to store, transport, or transmit Protected Information and must not use unencrypted email to transmit Protected Information.

5. **Minimum Necessary Access to Protected Information.** DATA SHARING PARTNER shall ensure that its Agents acquire, access, Use, and Disclose only the minimum necessary Protected Information needed to complete an authorized and legally permitted activity.

6. **Training and Oversight.** DATA SHARING PARTNER shall ensure that Agents are properly trained and comply with all Applicable Safeguards and the terms of the Agreement.

E. Responding to Privacy Incidents, Security Incidents, and Breaches. DATA SHARING PARTNER will comply with this Section for all Protected Information shared under the Agreement. Additional obligations for specific kinds of Protected Information shared under the Agreement are addressed in subsection 6.2.F, "Reporting Privacy Incidents,

[2] https://mn.gov/mnit/government/policies/security/

Security Incidents, and Breaches."

1. **Mitigation of harmful effects.** Upon discovery of any actual or suspected Privacy Incident, Security Incident, and/or Breach, DATA SHARING PARTNER will mitigate, to the extent practicable, any harmful effect of the Privacy Incident, Security Incident, and/or Breach. Mitigation may include, but is not limited to, notifying and providing credit monitoring to affected Individuals.

2. **Investigation.** Upon discovery of any actual or suspected Privacy Incident, Security Incident, and/or Breach, DATA SHARING PARTNER will investigate to (1) determine the root cause of the incident, (2) identify Individuals affected, (3) determine the specific Protected Information impacted, and (4) comply with notification and reporting provisions of the Agreement, this Agreement, and applicable law.

3. **Corrective action.** Upon identifying the root cause of any Privacy Incident, Security Incident, and/or Breach, DATA SHARING PARTNER will take corrective action to prevent, or reduce to the extent practicable, any possibility of recurrence. Corrective action may include, but is not limited to, patching information system security vulnerabilities, sanctioning Agents, and/or revising policies and procedures.

4. **Notification to Individuals and others; costs incurred.**

    a. **Protected Information.** DATA SHARING PARTNER will determine whether notice to data subjects and/or any other external parties regarding any Privacy Incident or Security Incident is required by law. If such notice is required, DATA SHARING PARTNER will fulfill the STATE's and DATA SHARING PARTNER's obligations under any applicable law requiring notification, including, but not limited to, Minn. Stat. §§ 13.05, "Duties of Responsible Authority," and 13.055, "Disclosure of Breach in Security."

    b. **Protected Health Information.** If a Privacy Incident or Security Incident results in a Breach of Protected Health Information, as these terms are defined in this Agreement and under HIPAA, then DATA SHARING PARTNER will provide notice to Individual data subjects under any applicable law requiring notification, including but not limited to providing notice as outlined in 45 C.F.R. § 164.404, "Notification to Individuals."

    c. **Failure to notify.** If DATA SHARING PARTNER fails to timely and appropriately notify Individual data subjects or other external parties under subparagraph (a), then DATA SHARING PARTNER will reimburse STATE for any costs, fines, or penalties incurred as a result of DATA SHARING PARTNER's failure to timely provide appropriate notification.

5. **Obligation to report to STATE.** Upon discovery of a Privacy Incident, Security Incident, and/or Breach, DATA SHARING PARTNER will report to STATE in writing as further specified in subsection 6.2.F.

    a. **Communication with authorized representative.** DATA SHARING PARTNER will send any written reports to, and communicate and coordinate as necessary with, STATE's authorized representative or designee.

b. **Cooperation of response.** DATA SHARING PARTNER will cooperate with requests and instructions received from STATE regarding activities related to investigation, containment, mitigation, and eradication of conditions that led to, or resulted from, the Security Incident, Privacy Incident, and/or Breach, and all matters pertaining to reporting and notification of a Security Incident, Privacy Incident, and/or Breach.

c. **Information to respond to inquiries about an investigation.** DATA SHARING PARTNER will, as soon as possible, but not later than forty-eight (48) hours after a request from STATE, provide STATE with any reports or information requested by STATE related to an investigation of a Security Incident, Privacy Incident, and/or Breach.

6. **Documentation.** DATA SHARING PARTNER will document actions taken under paragraphs 1 through 5 of this subsection, and retain this documentation for a minimum of six (6) years from the date it discovered the Privacy Incident, Security Incident, and/or Breach or the time period required by subsection 6.2.I, whichever is longer. DATA SHARING PARTNER shall provide such documentation to STATE upon request.

F. **Reporting Privacy Incidents, Security Incidents, and Breaches.** DATA SHARING PARTNER will comply with the reporting obligations of this Section as they apply to the kind of Protected Information involved. DATA SHARING PARTNER will also comply with subsection 6.2.E, "Responding to Privacy Incidents, Security Incidents, and Breaches," above in responding to any Privacy Incident, Security Incident, and/or Breach.

1. . **Social Security Administration Data.** DATA SHARING PARTNER will report all actual or suspected unauthorized Uses or Disclosures of Social Security Administration (SSA) data. SSA data is information protected by section 1106 of the Social Security Act.

a. **Initial report.** DATA SHARING PARTNER will, in writing, immediately report all actual or suspected unauthorized Uses or Disclosures of SSA data to STATE. DATA SHARING PARTNER will include in its initial report to STATE all information under subsections 6.2.E(1)–(4), of this Agreement that is available to DATA SHARING PARTNER at the time of the initial report, and provide updated reports as additional information becomes available.

b. **Final report.** DATA SHARING PARTNER will, upon completion of its investigation of and response to any actual or suspected unauthorized Uses or Disclosures of SSA data, or upon STATE's request in accordance with subsection 6.2.E(5), promptly submit a written report to STATE documenting all actions taken under subsections 6.2.E(1)–(4), of this Agreement.

3. . **Protected Health Information.** DATA SHARING PARTNER will report Privacy Incidents, Security Incidents, and/or Breaches involving Protected Health Information as follows:

a. **Reporting Breaches to STATE.** DATA SHARING PARTNER will report, in writing, any Breach involving Protected Health Information to STATE within five (5) calendar days of discovery, as defined in 45 C.F.R. § 164.410,

"Notification by a Business Associate," subpart (a)(2), for all Breaches involving fewer than 500 Individuals, and immediately for all Breaches involving 500 or more Individuals. These reports shall include, at a minimum, the following information:

1. Identity of each Individual whose unsecured Protected Health Information has been, or is reasonably believed by DATA SHARING PARTNER, to have been accessed, acquired, Used, or Disclosed during the incident or Breach.
2. Description of the compromised Protected Health Information.
3. Date of the Breach.
4. Date of the Breach's discovery.
5. Description of the steps taken to investigate the Breach, mitigate its impact, and prevent future Breaches.
6. Sanctions imposed on DATA SHARING PARTNER's Agents involved in the Breach.
7. All other information that must be included in notification to the Individual under 45 C.F.R. § 164.404(c).
8. Statement that DATA SHARING PARTNER has notified, or will notify, impacted Individuals in accordance with 45 C.F.R. § 164.404 and, upon the completion of said notifications, provide through documentation of the recipients, date, content, and manner of the notifications.

b. Reporting Breaches to external parties. DATA SHARING PARTNER shall timely report all Breaches involving Protected Health Information to the impacted Individuals (as specified in 45 C.F.R. § 164.404), the U.S. Department of Health and Human Services (as specified in 45 C.F.R § 164.408, "Notification to the Secretary"), and, for Breaches involving 501 or more Individuals, to the media (as specified in 45 C.F.R. § 164.406, "Notification to the Media"). As soon as possible and no later than 10 (ten) business days prior to any report to the media required by 45 C.F.R. § 164.406, DATA SHARING PARTNER shall draft and provide to STATE for its review and approval all Breach-related reports or statements intended for the media.

c. Reporting Security Incidents that do not result in a Breach to STATE. DATA SHARING PARTNER will report, in writing, all Security Incidents that do not result in a Breach, but involve systems maintaining Protected Health Information created, received, maintained, or transmitted by DATA SHARING PARTNER or its Agents on behalf of STATE, to STATE on a monthly basis, in accordance with 45 C.F.R § 164.314, "Organizational Requirements."

d. Reporting other violations to STATE. DATA SHARING PARTNER will report, in writing, any other Privacy Incident and/or violation of an Individual's privacy rights as it pertains to Protected Health Information to STATE within five (5) calendar days of discovery as defined in 45 C.F.R. § 164.410(a)(2). This includes, but is not limited to, any violation of Subpart E of 45 C.F.R. Part 164.

4. **Other Protected Information.** DATA SHARING PARTNER will report all other Privacy Incidents, Security Incidents, and/or Breaches to STATE.

   a. **Initial report.** DATA SHARING PARTNER will report all other Privacy Incidents, Security Incidents, and/or Breaches to STATE, in writing, within five (5) calendar days of discovery. If DATA SHARING PARTNER is unable to complete its investigation of, and response to, a Privacy Incident, Security Incident, and/or Breach within five (5) calendar days of discovery, then DATA SHARING PARTNER will provide STATE with all information under subsections 6.2.E(1)–(4), of this Agreement that are available to DATA SHARING PARTNER at the time of the initial report, and provide updated reports as additional information becomes available.

   b. **Final report.** DATA SHARING PARTNER will, upon completion of its investigation of and response to a Privacy Incident, Security Incident, and/or Breach, or upon STATE's request in accordance with subsection 6.2.E(5) submit in writing a report to STATE documenting all actions taken under subsections 6.2.E(1)–(4), of this Agreement.

G. **Designated Record Set—Protected Health Information.** If, on behalf of STATE, DATA SHARING PARTNER maintains a complete or partial designated record set, as defined in 45 C.F.R. § 164.501, "Definitions," upon request by STATE, DATA SHARING PARTNER shall, in a time and manner that complies with HIPAA or as otherwise directed by STATE:

1. Provide the means for an Individual to access, inspect, or receive copies of the Individual's Protected Health Information.

2. Provide the means for an Individual to make an amendment to the Individual's Protected Health Information.

H. **Access to Books and Records, Security Audits, and Remediation.** DATA SHARING PARTNER shall conduct and submit to audits and necessary remediation as required by this Section to ensure compliance with all Applicable Safeguards and the terms of the Agreement.

1. DATA SHARING PARTNER represents that it has audited and will continue to regularly audit the security of the systems and processes used to provide services under the Agreement, including, as applicable, all data centers and cloud computing or hosting services under contract with DATA SHARING PARTNER. DATA SHARING PARTNER will conduct such audits in a manner sufficient to ensure compliance with the security standards referenced in this Agreement.

2. This security audit required above will be documented in a written audit report which will, to the extent permitted by applicable law, be deemed confidential security information and not public data under the Minnesota Government Data Practices Act, Minn. Stat. § 13.37, "General Nonpublic Data," subd. 1(a) and 2(a).

3. DATA SHARING PARTNER agrees to make its internal practices, books, audits, and records related to its obligations under the Agreement available to STATE or a STATE designee upon STATE's request for purposes of conducting a financial or security audit, investigation, or assessment, or to determine DATA SHARING PARTNER's or STATE's compliance with Applicable Safeguards, the terms of this Agreement and accounting standards. For purposes of this provision, other

authorized government officials includes, but is not limited to, the Secretary of the United States Department of Health and Human Services.

4. DATA SHARING PARTNER will make and document best efforts to remediate any control deficiencies identified during the course of its own audit(s), or upon request by STATE or other authorized government official(s), in a commercially reasonable timeframe.

I. Documentation Required. Any documentation required by this Agreement, or by applicable laws, standards, or policies, of activities including the fulfillment of requirements by DATA SHARING PARTNER, or of other matters pertinent to the execution of the Agreement, must be securely maintained and retained by DATA SHARING PARTNER for a period of six years from the date of expiration or termination of the Agreement, or longer if required by applicable law, after which the documentation must be disposed of consistent with subsection 6.6 of this Agreement.

DATA SHARING PARTNER shall document Disclosures of Protected Health Information made by DATA SHARING PARTNER that are subject to the accounting of disclosure requirement described in 45 C.R.F. 164.528, "Accounting of Disclosures of Protected Health Information," and shall provide to STATE such documentation in a time and manner designated by STATE at the time of the request.

J. Requests for Disclosure of Protected Information. If DATA SHARING PARTNER or one of its Agents receives a request to Disclose Protected Information, DATA SHARING PARTNER shall inform STATE of the request and coordinate the appropriate response with STATE. If DATA SHARING PARTNER Discloses Protected Information after coordination of a response with STATE, it shall document the authority used to authorize the Disclosure, the information Disclosed, the name of the receiving party, and the date of Disclosure. All such documentation shall be maintained for the term of the Agreement or six years after the date of the Disclosure, whichever is later, and shall be produced upon demand by STATE.

K. Conflicting Provisions. DATA SHARING PARTNER shall comply with all applicable provisions of HIPAA and with the Agreement. To extent that the parties determine, following consultation, that the terms of this Agreement are less stringent than the Applicable Safeguards, DATA SHARING PARTNER must comply with the Applicable Safeguards. In the event of any conflict in the requirements of the Applicable Safeguards, DATA SHARING PARTNER must comply with the most stringent Applicable Safeguard.

L. Data Availability. DATA SHARING PARTNER, or any entity with legal control of any Protected Information provided by STATE, shall make any and all Protected Information under the Agreement available to STATE upon request within a reasonable time as is necessary for STATE to comply with applicable law.

6.3 Data Security.

A. STATE Information Management System Access. If STATE grants DATA SHARING PARTNER access to Protected Information maintained in a STATE information management system (including a STATE "legacy" system) or in any other STATE application, computer, or storage device of any kind, then DATA SHARING PARTNER agrees to comply with any additional system- or application-specific requirements as

directed by STATE.

B. **Electronic Transmission.** The parties agree to encrypt electronically transmitted Protected Information in a manner that complies with NIST Special Publications 800-52, "Guidelines for the Selection and Use of Transport Layer Security (TLS) Implementations"; 800-77, "Guide to IPsec VPNs"; 800-113, "Guide to SSL VPNs," or other methods validated under Federal Information Processing Standards (FIPS) 140-2, "Security Requirements for Cryptographic Modules." As part of its compliance with the NIST publications, and the State of Minnesota's "Enterprise Information Security Policies and Standards," DATA SHARING PARTNER must use encryption to store, transport, or transmit any Protected Information. DATA SHARING PARTNER must not use unencrypted email to send any Protected Information to anyone, including STATE.

C. **Portable Media and Devices.** The parties agree to encrypt Protected Information written to or stored on portable electronic media or computing devices in a manner that complies with NIST SP 800-111, "Guide to Storage Encryption Technologies for End User Devices."

6.4 DATA SHARING PARTNER Permitted Uses and Responsibilities.

A. **Management and Administration.** Except as otherwise limited in the Agreement, DATA SHARING PARTNER may:

1. Use Protected Health Information for the proper management and administration of DATA SHARING PARTNER or to carry out the legal responsibilities of DATA SHARING PARTNER.

2. Disclose Protected Health Information for the proper management and administration of DATA SHARING PARTNER, provided that:

    a. The Disclosure is required by law; or

    b. The Disclosure is required to perform the services provided to or on behalf of STATE or the Disclosure is otherwise authorized by STATE, and DATA SHARING PARTNER:

        i. Obtains reasonable assurances from the entity to whom the Protected Health Information will be Disclosed that the Protected Health Information will remain confidential and Used or further Disclosed only as required by law or for the purposes for which it was Disclosed to the entity; and

        ii. Requires the entity to whom Protected Health Information is Disclosed to notify DATA SHARING PARTNER of any instances of which it is aware in which the confidentiality of Protected Health Information has been Breached or otherwise compromised.

B. **Notice of Privacy Practices.** If DATA SHARING PARTNER's duties and responsibilities require it, on behalf of STATE, to obtain individually identifiable health information from Individual(s), then DATA SHARING PARTNER shall, before obtaining the information, confer with STATE to ensure that any required Notice of Privacy Practices includes the appropriate terms and provisions.

C. **De-identify Protected Health Information.** DATA SHARING PARTNER may use Protected

Health Information to create de-identified Protected Health Information provided that DATA SHARING PARTNER complies with the de-identification methods specified in 45 C.F.R. § 164.514, "Other Requirements Relating to Uses and Disclosures of Protected Health Information." De-identified Protected Health Information remains the sole property of STATE and can only be Used or Disclosed by DATA SHARING PARTNER on behalf of STATE and pursuant to the Agreement or by prior written approval of STATE.

D. Aggregate Protected Health Information. DATA SHARING PARTNER may use Protected Health Information to perform data aggregation services for STATE, and any such aggregated data remains the sole property of STATE. The DATA SHARING PARTNER must have the written approval of STATE prior to using Protected Health Information to perform data analysis or aggregation for parties other than STATE.

6.5 STATE Data Responsibilities

A. STATE shall Disclose Protected Information to DATA SHARING PARTNER only as authorized by law to DATA SHARING PARTNER.

B. STATE shall obtain any consents or authorizations that may be necessary for it to Disclose Protected Information with DATA SHARING PARTNER.

C. STATE shall notify DATA SHARING PARTNER of any limitations that apply to STATE's Use and Disclosure of Protected Information—including any restrictions on certain Disclosures of Protected Health Information requested under 45 C.F.R. § 164.522, "Rights to Request Privacy Protection for Protected Health Information," subpart (a), to which STATE has agreed and that would also limit the Use or Disclosure of Protected Information by DATA SHARING PARTNER.

D. STATE shall refrain from requesting DATA SHARING PARTNER to Use or Disclose Protected Information in a manner that would violate applicable law or would be impermissible if the Use or Disclosure were performed by STATE.

6.6 Obligations of DATA SHARING PARTNER Upon Expiration or Cancellation of the Agreement. Upon expiration or termination of the Agreement for any reason:

A. In compliance with the procedures found in the Applicable Safeguards listed in subsection 6.1.A, or as otherwise required by applicable industry standards, or directed by STATE, DATA SHARING PARTNER shall immediately destroy or sanitize (permanently de-identify without the possibility of re-identification), or return in a secure manner to STATE all Protected Information that it still maintains.

B. DATA SHARING PARTNER shall ensure and document that the same action is taken for all Protected Information shared by STATE that may be in the possession of its Agents. DATA SHARING PARTNER and its Agents shall not retain copies of any Protected Information.

C. In the event that DATA SHARING PARTNER determines that returning or destroying the Protected Information is not feasible or would interfere with its ability to carry out its legal responsibilities, maintain appropriate safeguards, and/or comply with Subpart C of 45 C.F.R. Part 164, it shall notify STATE of the specific laws, rules, policies, or other circumstances that make return or destruction not feasible or otherwise inadvisable. Upon mutual agreement of the Parties that return or destruction of Protected Information is not feasible or otherwise inadvisable, DATA SHARING PARTNER will

continue to extend the protections of the Agreement to the Protected Information and take all measures possible to limit further Uses and Disclosures of the Protected Information for so long as it is maintained by DATA SHARING PARTNER or its Agents.

D. DATA SHARING PARTNER shall document and verify in a written report to STATE the disposition of Protected Information. The report shall include at a minimum the following information:

1. A description of all Protected Information that has been sanitized or destroyed, whether performed internally or by a service provider;

2. The method by which, and the date when, the Protected Data were destroyed, sanitized, or securely returned to STATE; and

3. The identity of organization name (if different than DATA SHARING PARTNER), and name, address, and phone number, and signature of Individual, that performed the activities required by this Section.

E. Documentation required by this Section shall be made available upon demand by STATE.

F. Any costs incurred by DATA SHARING PARTNER in fulfilling its obligations under this Section will be the sole responsibility of DATA SHARING PARTNER.

7. INSURANCE REQUIREMENTS

7.1 Network Security and Privacy Liability Insurance. DATA SHARING PARTNER shall, at all times during the term of the Agreement, keep in force a network security and privacy liability insurance policy. The coverage may be endorsed on another form of liability coverage or written on a standalone policy.

DATA SHARING PARTNER shall maintain insurance to cover claims which may arise from failure of DATA SHARING PARTNER's security or privacy practices resulting in, but not limited to, computer attacks, unauthorized access, Disclosure of not public data including but not limited to confidential or private information or Protected Health Information, transmission of a computer virus, or denial of service. DATA SHARING PARTNER is required to carry the following **minimum** limits:

$2,000,000 per occurrence

$2,000,000 annual aggregate

8. INTERPRETATION

8.1 Any ambiguity in this Agreement shall be interpreted to permit compliance with all Applicable Safeguards.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK.

By signing below, the parties agree to the terms and conditions contained in this AGREEMENT.

APPROVED:

1. **DATA SHARING PARTNER**

DATA SHARING PARTNER certifies that the appropriate person(s) have executed the Agreement on behalf of DATA SHARING PARTNER as required by applicable articles, by-laws resolutions or ordinances.

By:
Printed Name:
Title:
Date:

2. **STATE AGENCY**
By (with delegated authority):
Printed Name:
Title:
Date:

Distribution: (copy of fully executed contract to each)
Contracting and Legal Compliance Division
Data Sharing Partner
State Authorized Representative