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.