U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation

Transforming Maternal Health (TMaH) Model

Notice of Funding Opportunity Type: New

Funding Opportunity Award Type: Cooperative Agreement

Notice of Funding Opportunity Number: CMS-2N2-25-001

Federal Assistance Listings Number (CFDA): 93.869

Notice of Funding Opportunity Posting Date: June 26, 2024

Applicable Dates:

Letter of Intent to Apply Due Date: August 8, 2024, 11:59 pm Eastern Standard Time

Electronic Application Due Date: September 20, 2024, 11:59 pm Eastern Standard Time

Anticipated Issuance Notice(s) of Award: January 13, 2025

Anticipated Period of Performance: January 20, 2025 through January 19, 2035

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EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS), through its Center for Medicare and Medicaid Innovation, is soliciting applications for the Transforming Maternal Health (TMaH) Model. This is a voluntary, 10-year service delivery and payment model designed to improve maternal health care outcomes for people enrolled in Medicaid and the Children's Health Insurance Program (CHIP).

The TMaH Model will test whether targeted technical (TA) assistance, coupled with payment and delivery system reforms, can drive a whole-person care-delivery approach to pregnancy, childbirth, and postpartum care while reducing Medicaid and CHIP program expenditures.

CMS will select up to 15 state Medicaid agencies (SMAs or Recipients) to participate in the TMaH Model. Up to $17 million dollars in Cooperative Agreement Awards will be available to each selected Recipient over the course of the 10-year period of performance for a total of up to $225M investment.

CMS will evaluate the following: the TMaH Model's impact on rates of low-risk cesarean section (c-section), severe maternal morbidity (SMM), incidence of low birthweight infants, changes in experience of care for those who are pregnant, giving birth, or postpartum, and changes in Medicaid and CHIP program expenditures. The TMaH Model aims to improve maternal and child health outcomes while reducing Medicaid and CHIP program expenditures for maternal care through reduced spending on high-cost procedures such as c-sections for low-risk beneficiaries.

TABLE 1 EXECUTIVE SUMMARY

Item	Description
HHS Awarding Agency	Centers for Medicare & Medicaid Services (CMS)
CMS Awarding Center	Center for Medicare and Medicaid Innovation
Notice of Funding Opportunity Title	Transforming Maternal Health (TMaH) Model
Authorization	Section 1115A of the Social Security Act (the Act), as added by Section 3021 of the Patient Protection and Affordable Care Act
Federal Assistance Listings Number (CFDA)	93.869

Funding Opportunity Type	New
Funding Opportunity Number	CMS-2N2-25-001
Type of Award	Cooperative Agreement
Type of Competition	Competitive
Letter of Intent	CMS recommends a letter of intent to apply for this funding opportunity. These are optional. See Section C.3 Letter of Intent for more information.
Application Due Date and Time	September 20, 2024, by 11:59 pm EST (Baltimore, MD)
Anticipated Issuance Notice(s) of Award	January 13, 2025
Period of Performance Start Date	January 20, 2025
Period of Performance End Date	January 19, 2035
Anticipated Total Available Funding	$255 million (Subject to availability of funds)
Estimated Maximum Award Amount	$17 million per Recipient
Estimated Maximum Number of Awards	15

A. Program Description

A.1 Purpose

This Notice of Funding Opportunity (NOFO) provides details and instructions on how to apply to the Transforming Maternal Health (TMaH) Model.

Poor maternal outcomes result from many factors that may be addressed with different interventions. The TMaH Model will test whether effective implementation of a package of evidence-informed interventions, sustained by a value-based payment model, can improve maternal outcomes, and reduce Medicaid and CHIP program expenditures.

The goals for the TMaH Model include the following:

- Reduced rates of low-risk c-sections.
- Reduced incidence of severe maternal morbidity.
- Reduced rates of low-birthweight infants.
- Improved experience of perinatal care.
- Reduced Medicaid and CHIP program expenditures for maternity and infant care.

TMaH Model consists of two distinct phases:

- a three-year Pre-Implementation Period
- a seven-year Implementation Period.

Pre-Implementation Period funding and technical assistance will help the Recipient build critical skills and capacity to successfully launch a value-based payment model that supports delivery of whole-person care during the seven-year Implementation Period. Participation in the TMaH Model will require significant effort, collaboration and staff time from the Recipient to set the foundation for success, given the historic underinvestment in maternal health care.

Recipients will be expected to define one or more geographic areas in which to implement the TMaH Model. Recipients are expected to include their CHIP population if pregnant individuals[i] receive services through CHIP in their state. Recipients in states that have implemented managed care in their Medicaid and/or CHIP programs are required to collaborate with at least one risk-based managed care plan (MCP)[ii] to implement the model.

Recipients will work with:

- Partner Providers (e.g. obstetricians, midwives and other clinical and support staff such as doulas; see Appendix VII Glossary for additional details)
- Partner Care Delivery Locations (e.g. hospitals, birth centers, FQHCs and other sites of care; see Appendix VII Glossary for additional details) and
- Partner Organizations (e.g. MCPs, state public health departments, community-based organizations and other non-clinical partners; see Appendix VII Glossary for additional details) to implement the model.

All Recipients must adhere to the TMaH payment model timeline set forth in this paragraph and detailed further in Section A.4.3.

- In the first two years of the Pre-Implementation Period (Model Years 1-2), Recipients will work with CMS to develop and implement a detailed technical assistance and tailored work plan with defined tasks, timelines and benchmarks that will support achievement of model elements.

[i] Throughout this document, we use the term “pregnant women” when aligning with cited literature.
[ii] In this document, the term “managed care plan” refers to managed care organizations, prepaid inpatient health plans and prepaid ambulatory health plans with a risk-contract with the State as defined in 42 CFR § 438.2.

- Beginning no later than the final year of the Pre-Implementation Period (Model Year 3), Recipient will use a portion of their Cooperative Agreement Awards to provide financial assistance to providers for care delivery transformation activities; these payments are called Provider Infrastructure Payments.
- In Model Year 4, providers may receive, from State funds (and not using the Cooperative Agreement Awards), retrospective performance payments on a set of quality and cost measures.
- In Model Year 5, Recipients will transition to a new value-based payment model to be finalized during the Pre-Implementation Period. The design of the value-based payment model will be led by CMS in partnership with the Recipients and other stakeholders; these design discussions will begin in Model Year 1.

The requirements and expectations for the TMaH Model are detailed throughout this NOFO. Specific information regarding TMaH Model requirements are detailed in Section A.4 Program Requirements. For key terms and definitions used throughout this NOFO, see Appendix VII. Glossary.

A.2 AUTHORITY

Section 1115A of the Social Security Act (the Act), as added by Section 3021 of the Affordable Care Act, authorizes the Secretary of the Department of Health and Human Services to test innovative payment and service delivery models to reduce Medicare, Medicaid, and CHIP expenditures while preserving or enhancing the quality of care.

A.3 BACKGROUND

Despite spending more per capita for maternity care than any other nation, the U.S. has higher rates of adverse pregnancy outcomes than any other high-income country.[1] In 2022, the U.S. maternal mortality rate was 22.3 deaths per 100,000 live births. The Centers for Disease Control and Prevention (CDC) reports that more than 80 percent of pregnancy-related deaths are preventable.[2] Mortality is a relatively rare event, but the rate of severe maternal morbidity is also unacceptably high (rate = 88.2/10,000 delivery hospitalizations in 2020, the latest year for which national data are available).[3] Moreover, with 53 percent of pregnancy-related deaths occurring 7 days to a year after delivery, there is an urgent need to address the chronic conditions and mental health needs that are driving maternal morbidity and mortality in the postpartum period.[4] Maternal morbidities may be treatable and controlled if detected early, preventing catastrophic outcomes. For example, treatment of mild chronic hypertension before the twenty-third week of pregnancy is associated with reduced risk of preeclampsia, a pregnancy-related hypertensive disorder.[5] Extension of Medicaid and CHIP eligibility to 12 months postpartum in a majority of states creates opportunities to effectively address these postpartum risks.[6,7]

In 2022, Medicaid financed 41.3 percent of all U.S. births.[8] In 2021, Medicaid financed 64 percent of births to non-Hispanic Black mothers and 58.1 percent of those to Hispanic mothers.[9] In 2018, Medicaid financed about half of births in rural areas.[10] Medicaid beneficiaries have a greater risk of significant disparities in cost, quality, care, and outcomes compared with those who are commercially insured.[11]In 2021, non-Hispanic Black women had SMM rates nearly twice as high as those among non-Hispanic White women (156.8 per 10,000 deliveries vs. 83.4

per 10,000 deliveries).[12] Moreover, preventive care to detect, treat and manage chronic conditions such as hypertension and diabetes, as well as mental health conditions and substance use disorders, is essential to mitigate pregnancy-related complications, but research shows that Black persons are less likely to receive preventive health care, in part due to poorer access to prenatal and postpartum care.[13]

Factors Contributing to Current Outcomes

Below, we describe key issue areas that affect maternal health outcomes, including the following: 1) access, infrastructure, and workforce; 2) quality improvement and patient safety; and 3) whole-person care. Section A.4 Program Requirements will detail how Recipients must use this funding opportunity to address these issues.

Access, Infrastructure and Workforce

Adequate coverage and provider capacity are critical to access to care along the prenatal, pregnancy, and postpartum continuum. As the 2022 HRSA State of the Maternal Health Workforce Brief highlighted, several clinical specialties provide pregnancy-related care.[14] Nonetheless, with a ratio of just 11 obstetricians (OBs) and four midwives for every 1,000 live births,[15] pregnant women who attempt to access high-quality maternity care may face serious challenges. The integration of midwives and doulas into the perinatal workforce is an important strategy to build the workforce while improving access to risk-appropriate care.[16, 17, 18, 19, 20 21, 22, 23, 24]

Social context and poverty also play a big part in maternal health and outcome disparities. Pregnant women with low socioeconomic status have higher rates of maternal mortality,[25] and those living in areas with limited access to nutritious food have higher odds of at least one comorbid condition in pregnancy such as preeclampsia, gestational hypertension, gestational diabetes, and preterm labor than people who do not live in food deserts.[26] Studies consistently find that predominantly Black neighborhoods have fewer supermarkets compared with predominantly White neighborhoods and that a lower proportion of stores in Black neighborhoods carry fresh produce.[27] Rural communities are at increased risk of food insecurity.[28] After controlling for sociodemographic and clinical factors, rural women have a 9 percent higher probability of SMM, compared with their urban counterparts.[29,30] Enrollment in Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) has been shown to significantly reduce preterm birth and infant mortality among Medicaid beneficiaries,[31] but only about half of WIC-eligible people are enrolled in the program.[32] Many state Medicaid agencies do not regularly participate in data matching with other benefits programs such as WIC that would increase cross-enrollment and decrease administrative burden on beneficiaries.

In addition, valuable data about patient conditions and treatment remain locked in paper charts or electronic health records that are not shared between providers, with community-based organizations (CBOs) or across agencies that could address health and health-related social needs (HRSNs). For example, the comprehensive individual and population-level health picture that could emerge from linkage of parents and infants in Medicaid, vital records, and hospital discharge data remains incomplete in most states. Furthermore, hospital discharge data in state and regional Health Information Exchanges (HIE) may not share the same information at the same level of detail or in the same format. For example, continuity of care information may be

entered into online forms or stored as portable document files (pdf). Lack of interoperability and linkage among state administrative data and federal programs such as WIC may be a barrier to enrollment for eligible people. State and federal privacy laws may further limit data sharing absent explicit written permission to do so.

Recipients and MCPs use a variety of approaches to manage cost and utilization of maternal health services. Obstetrics and midwifery providers are paid a professional fee for their services and often receive global reimbursement for a package of services, which may be unconnected to performance or outcomes.[33] In addition, a facility fee is paid separately to the delivery site. Hospital facility payments for cesarean sections are often higher than for vaginal births due to the use of operating rooms and hospital-based labor and supplies. However, it is important to note this fee is not paid to the delivering provider.[34] One study found that the average Medicaid Fee-for-Service (FFS) hospital facility payment for cesarean delivery can be more than 40 percent higher than for vaginal delivery.[35] Neither FFS payments nor the use of global payments adequately incentivizes team-based care or coordination across the pregnancy episode.[36]

Quality Improvement and Patient Safety

Not all evidence-informed safety practices are used consistently across birthing facilities.[37,38,39] This contributes to poor maternal health outcomes. The Alliance for Innovation on Maternal Health (AIM) is a quality improvement initiative supported by the Health Resources & Services Administration. AIM has developed evidence-informed protocols called "patient safety bundles." Currently, there are eight core AIM patient safety bundles designed to be implemented at the hospital-level: Obstetric Hemorrhage, Severe Hypertension in Pregnancy, Safe Reduction of Primary Cesarean Birth, Cardiac Conditions in Obstetric Care, Care for Pregnant and Postpartum People with Substance Use Disorder, Perinatal Mental Health Conditions, Postpartum Discharge Transition, and Sepsis in Obstetrical Care. These patient safety bundles are often implemented with the assistance of Perinatal Quality Collaboratives (PQCs)[iii]. For more information visit the AIM website.

CMS created a "Birthing-Friendly" hospital designation to recognize high-quality care at hospitals eligible for the Hospital Inpatient Quality Reporting (IQR) Program.[40] The "Birthing-Friendly" hospital designation and the AIM initiative are complementary. To earn the "Birthing-Friendly" hospital designation, eligible facilities must (1) participate in a statewide or national perinatal quality improvement collaborative program and (2) implement evidence-based quality interventions in hospital settings to improve maternal health. Implementing AIM safety bundles through participation in a state PQC would satisfy the current requirements for the Birthing-Friendly hospital designation. As the Birthing-Friendly hospital designation requirements evolve through the Hospital IQR Program and/or other CMS quality programs, Recipients would be expected to encourage and support hospitals that are Partner Care Delivery Locations to maintain the designation.

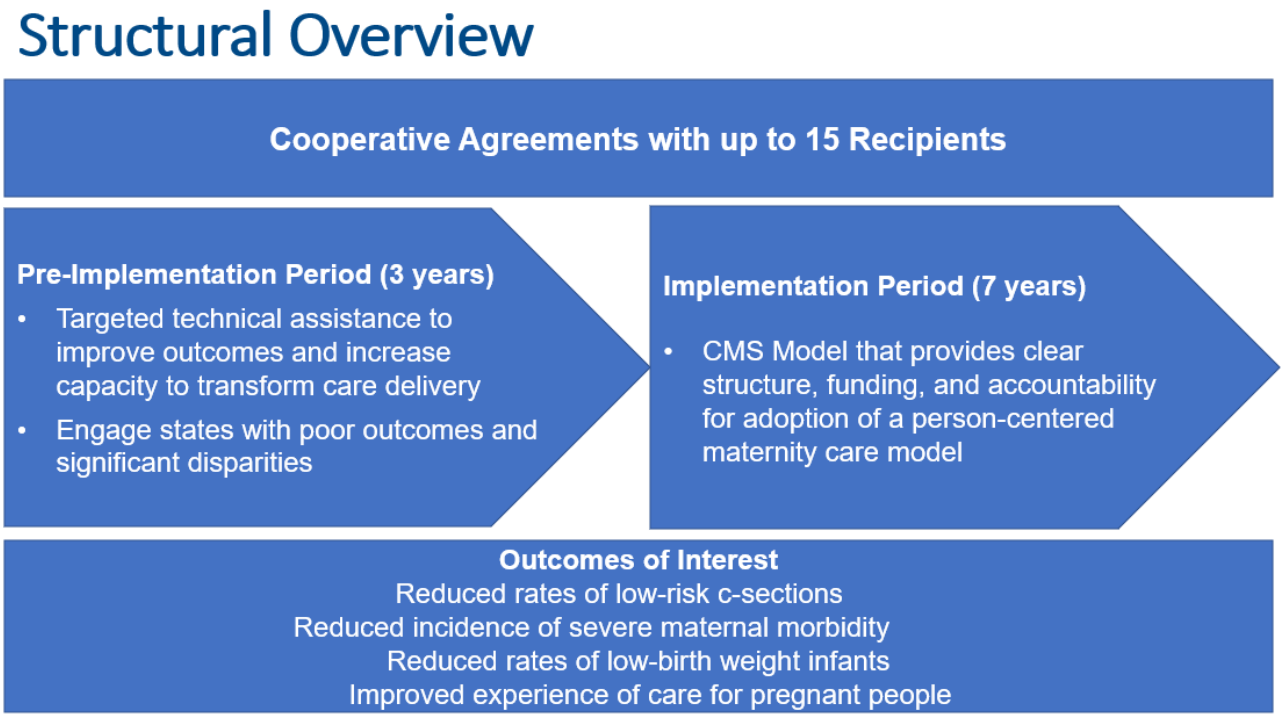
Whole-Person Care Delivery

[iii] The Centers for Disease Control and Prevention defines PQCs as "state or multistate networks of teams working to improve the quality of care for mothers and babies. PQC members identify health care processes that need to be improved and use the best available methods to make changes as quickly as possible."

Currently, most pregnant people receive the same "one size fits all" approach to care that is designed to respond to medical complications, rather than to optimize overall health and wellness for the patient.[41] Proper risk-stratification of pregnant people to determine what prenatal care models best meet their physical and behavioral needs and health-related social needs (HRSNs) helps to avoid overmedicalization of maternity care that can lead to complications and worse outcomes.[42] Consistent, comprehensive screening is central to risk assessment. Screening for HRSNs has been less consistently or comprehensively incorporated into routine risk assessment. Insufficient resources and a lack of protocols often do not support effective referral and follow-up, further compounding the problem.[43,44,45]

Many pregnant women, including Black, Indigenous, People of Color and those with disabilities report a negative perinatal care experience, including feeling that their concerns are unheard or dismissed by overstretched providers who do not have adequate time or culturally competent training.[46,47,48,49] Approximately one in five pregnant women overall, and approximately 30 percent of those who are Black, Hispanic, and multiracial, reported mistreatment (e.g., violations of physical privacy or verbal abuse) during maternity care. Approximately 40 percent of Black, Hispanic, and multiracial pregnant women reported discrimination during maternity care, and 45 percent of all pregnant women reported holding back from asking questions or discussing concerns with their provider.[50]

FIGURE 1 STRUCTURAL OVERVIEW



Previous efforts to improve care and outcomes have usually reinforced the medical model of maternity care. In the United States, the medical model tends to focus on testing, monitoring, and procedure-based management of problems and complications. Common criticisms of the medical model, especially for patients experiencing socioeconomic challenges, include: disrespectful treatment;[51,52,53] racial, ethnic, and cultural discordance between providers and patients;[54] poor

continuity of care between providers;[55,56] insufficient time for patient education and questions;[57] historical medical mistreatment and current distrust, particularly for Black and American Indian and Alaska Native (AI/AN) populations;[58] insufficient attention to behavioral health and social drivers of health;[59,60] siloed care that impedes information-sharing and team-based care;[61] and overuse of certain medical interventions.[62]

During a three-year Pre- implementation Period, Recipients, managed-care entities and Partner Providers and Partner Care Delivery Locations will receive intensive TA and funding designed to build critical skills and capacity to successfully implement the TMaH Model elements. CMS and its contractors will support the Recipients in using Medicaid and CHIP authorities to establish coverage for Medicaid and CHIP benefits that are required under the TMaH Model, such as coverage and sustainable payment for Doula Services. CMS will offer TA regarding how to reimburse and support these benefits at sufficient scale to successfully implement the TMaH Model's team-based approach. During the seven-year Implementation Period, Recipients will implement value-based payment approaches that support the model of care.

A.4 Program Requirements

A.4.1 Model Pillars and Elements

The TMaH Model is organized into three pillars designed to address the key issue areas that affect maternal health outcomes:

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

The TMaH Model consists of ten required elements and eight optional elements that have been shown to improve maternal health outcomes. These elements are organized by pillar in Table 2 and further described below. Recipients shall implement the ten required elements, subject to their approved Project Narrative (see Section D.3 Program Requirements and Expectations and Section E Application Review Information). In addition, applicants may propose to implement one or more of the eight optional elements with the help of technical assistance (TA) and Cooperative Agreement funding provided by CMS, subject to CMS approval. Election of optional elements may not be desired by all applicants and will depend on the current maternal and perinatal health care system in each state as well as each applicant's individual objectives, among other state-specific factors. There is no cap on the number of optional elements that may be selected by an applicant. However, except for the extension of postpartum eligibility to 12 months, Recipients will not be allowed to add additional elements to the project scope after award without explicit CMS prior approval. No funding above the annual maximums set by CMS will be awarded based on the applicant's election of optional elements.

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
▪ Increase access to the midwifery workforce ▪ Increase access to birth centers ▪ Cover[iv] Doula Services ▪ Improve data infrastructure ▪ Develop payment model	▪ Support implementation of AIM patient safety bundles ▪ Support "Birthing-Friendly" hospital designation	▪ Increase risk assessments, screenings, referrals and follow-up for perinatal depression, anxiety, tobacco use, substance use disorder, and HRSN ▪ Increase home monitoring of diabetes and hypertension ▪ Develop Health Equity 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[v] certified midwives (CMs) and certified professional midwives (CPMs) ▪ Cover[vi] 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

[iv] Include Doula Services among those eligible for Medicaid payment

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

[vi] Include perinatal community health worker services among those eligible for Medicaid payment

A.4.2 Care Delivery Model and Milestones

The TMaH Model will test a new paradigm of maternity care by increasing access to and expanding the maternal health workforce while also increasing the use of comprehensive clinical and social screenings, risk-appropriate care, safety practices and home monitoring.

Table 3 summarizes each element, the supporting technical assistance activities provided by CMS (see Section A.4.5 Technical Assistance and Information for Prospective Applicants for additional details) and the Pre-Implementation Period milestones Recipients need to complete by the end of Model Year 3. Most of the technical assistance will be provided to the Recipients. However, depending on the model element, and at the direction of the Recipient, technical assistance may be provided to Partner Providers, Partner Care Delivery Locations and Partner Organizations to reach Pre-Implementation Period milestones. Recipients are required to ensure that they or their collaborating MCPs and/or Partner Providers and Partner Care Delivery Locations, as appropriate, reach all Pre-Implementation Period milestones no later than the end of the Pre-Implementation Period (Model Year 3).

CMS will develop state-specific milestones for Model Years 4-10, including the implementation of the payment model and advancing model elements (see Section F.6.1.2 Programmatic Reporting for additional information). CMS and Recipient will collaborate to conduct a needs assessment and create a detailed technical assistance plan as part of the initial model activities. TA will assist Recipients in progressing toward the model's objectives, while helping to ensure that milestones are met in a timely manner.

TABLE 3 ELEMENTS, TA, AND MILESTONES

Element	Technical Assistance Activities	Pre Implementation Period Milestones to Complete by the End of Model Year 3
State Medicaid Agencies and Model Participants		
Pillar 1 — Access, Infrastructure and Workforce		
Increase access to the midwifery workforce	• Guidance for assessing the state's midwifery workforce capacity, including by type of midwife and options for covering additional types of midwives licensed in the state • Guidance for payment analyses that compares the reimbursement rate for midwives as a proportion of a benchmark rate for determining fee schedule updates, as appropriate[vii] • Guidance to create a billing pathway for midwives (and obstetricians) to consult with	• Completed an assessment of midwifery workforce capacity in the state and options for covering additional types of midwives licensed in the state • Assessed and created a billing pathway for interprofessional consultations between midwives and other providers, including maternal fetal medicine specialists, as appropriate and needed • Completed payment analysis that compares the reimbursement rate for midwives as a proportion of a benchmark rate (for fee schedule updates as appropriate), and has a process in place for completing an annual analysis thereafter

[vii] A benchmark rate could include commercial or other plan rates or reimbursement rates for other clinicians or sites of care performing similar services, as appropriate based on each Recipient's state context.

Element	Technical Assistance Activities	Pre Implementation Period Milestones to Complete by the End of Model Year 3
	maternal fetal medicine specialists without a direct patient encounter (e.g., eConsults). • Guidance to connect with local and state resources, including CBOs, community colleges, training organizations and others to expand recruitment, training opportunities, and patient communications around the use and availability of midwives • Guidance to cover childbirth preparation education classes through state plan amendment (SPA) or waiver and develop a childbirth education class referral process	
Increase access to birth centers	• Guidance for payment analyses that compares the reimbursement rate for birth center facility fees as proportion of a benchmark rate for determining fee schedule updates, as appropriate • Guidance for establishing more sustainable reimbursement rates for birth centers	• Completed 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 • Created a plan for providing information to beneficiaries on birth centers, if licensed, accredited and operating in the state • Completed an implementation plan for establishing more sustainable reimbursement rates for birth centers
Cover Doula Services	• Guidance to cover all Doula Services through Medicaid authorities, including defining Doula Services • Guidance for rate development and payment analyses, as appropriate, that compares the reimbursement rate for Doula Services as a proportion of a relevant benchmark rate, for determining fee schedule updates, as appropriate • Guidance to establish a State Doula Support Council, if no such group currently exists • Guidance to connect with local and state resources, including	• Completed workplan for initial payment analysis • Completed a payment analysis that compares the reimbursement rate for Doula Services as a proportion of a relevant benchmark rate, and has a process in place for completing an annual analysis thereafter • Submitted, or has a timeline and process in place, for submitting and implementing a State Plan Amendment (SPA)/waiver to cover Doula Services if not already covered • Convened a State Doula Support Council, if such council is newly established

Element	Technical Assistance Activities	Pre Implementation Period Milestones to Complete by the End of Model Year 3
	CBOs, community colleges, historically black colleges and universities, doula training organizations and others to expand recruitment, training opportunities, and communications around the use and availability of Doula Services • Guidance and trainings for nonclinical trained professionals performing Doula Services to help them enroll in Medicaid and learn about reimbursement structures and billing procedures • Provider awareness and education to create more supportive care environments for Doula Services to be furnished • Information to Medicaid beneficiaries about the availability of Doula Services and benefits of doula service care	
Improve data infrastructure	• Guidance to develop IT infrastructure and data use agreements to link Medicaid data with vital records, to link parents and their infants in Medicaid claims and other administrative data sets •Guidance to Partner Providers, Partner Care Delivery Locations, and other stakeholders, as needed, around data privacy, permitted use and disclosures • Guidance to improve the collection and stratification of demographic data, including race and ethnicity data as aligned with the Office of the National Coordinator for Health Information Technology (ONC) United States Core Data for Interoperability (USCDI) and	• Established a timeline and plan for linking Medicaid data and vital records, if the data have not yet been linked by the end of the Pre-Implementation Period. Plans should include the execution of necessary data-sharing and related agreements for linking Medicaid and vital records. Note: Recipient will identify any state laws and regulations that restrict vital records data-sharing and linkage as required in this NOFO, and should propose solutions for obtaining vital records data elements in their application, if needed. See Section F.6.1.2 Evaluation • With TA contractor assistance, Recipient has completed data needs assessment and draft work plan with Partner Providers and Partner Care Delivery Locations to stratify demographic data, and has identified challenges and has a clear timeline and process for resolution • With TA contractor assistance, Recipient has completed data needs assessment and draft work plan to identify Model beneficiaries who are also utilizing social service and benefit programs such as WIC/SNAP,

Element	Technical Assistance Activities	Pre Implementation Period Milestones to Complete by the End of Model Year 3
	CMS Office of Minority Health recommendations • Guidance to Partner Providers about how to improve the collection, exchange, and use of other data important for maternal health as aligned with the USCDI and the USCDI+ Maternal Health data set where appropriate and applicable.[viii,ix] • Guidance for data-matching across social service and benefit programs such as WIC/SNAP and Medicaid to measure and address cross-program enrollment gaps and facilitate auto enrollment, as appropriate • Guidance to Recipients in understanding allowable uses of the 90 percent enhanced match for various activities related to Medicaid Information Technology (IT) in both Medicaid Management Information Systems (MMIS) and Medicaid Eligibility and Enrollment (E&E) Systems, including the use of Commercial Off-the-Shelf (COTS) software • Guidance for improving data flow, consistency and use in state Health Information Exchanges • Guidance for Partner Providers and Partner Care Delivery Locations to implement new data processes, including revising workflows and ensuring staff	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

[viii] USCDI+ is an initiative to identify and harmonize data elements that go beyond the USCDI to address needs in specific domains. The USCDI+ Maternal Health data set is available here.

[ix] Recipients and partner providers can also refer to HHS ONC Informational Resources for maternity health care, NAS, and pediatrics that outline relevant standards (such as the USCDI) and certification criteria that are relevant to maternal health use cases.

Element	Technical Assistance Activities	Pre Implementation Period Milestones to Complete by the End of Model Year 3
	training, e.g. related to collected patient reported experience data[x]	
Develop Payment Model	• While CMS will lead the design of the payment model approaches for MY3-5, guidance will be provided to engage in discussions with Recipients including which Medicaid authority to use to implement the payment model approaches • Analytic guidance to forecast the impact of potential MY4-MY5 payment model parameters on utilization, cost, and quality outcomes, using historic data • Guidance to calculate MY4-MY5 payment model benchmarks and risk adjustment measures, in addition to other specifications • Guidance to consider how to foster multi-payer alignment • Guidance to engage with and communicate the payment model implementation plan to providers and other stakeholders • Guidance to include maternal health policy priorities in the Medicaid managed care procurement process • Guidance to Recipients to gain expertise in the use of managed care contracts as a tool for maternal health quality and access improvement using requirement language, QI conditions, benefit standards, and health outcome expectations	With policy and analytic guidance, created a plan, process and timeline for implementing the MY4 and MY5 payment requirements, including: • Using the appropriate Medicaid authority to implement the payment model • Listed personnel necessary to implement the payment model, including description of roles and responsibilities and budget to support efforts • Stakeholder engagement plan for ongoing conversations with providers and MCP, where applicable • Quarterly meeting cadence established with CMS staff and contractors • Draft payment model implementation workplan submitted to CMS • Final payment model implementation workplan submitted to CMS, including MCP engagement plan, and MCP contracting timeline • Establish payment model benchmarks in partnership with CMS, including cost and quality thresholds

[x] Recipients and Partner Providers can also refer to HHS ONC Informational Resources for maternity health care, NAS, and pediatrics that outline relevant standards (such as the USCDI) and certification criteria that are relevant to maternal health use cases.

Element	Technical Assistance Activities	Pre Implementation Period Milestones to Complete by the End of Model Year 3
Pillar 2 — Quality Improvement and Patient Safety		
Support implementation of AIM patient safety bundles	• CMS will collaborate with CDC and HRSA to help Recipients foster connections with a PQC to facilitate provider progress toward implementation of relevant AIM patient safety bundles •Where possible, provide guidance on implementing AIM patient safety bundles into standards-based clinical decision supports (CDS) in electronic health records (EHRs) via Agency for Healthcare Research and Quality's CDS Connect tools	• Established partnership (regularly participate in meetings, share information and action items) with PQC or entity leading AIM patient safety bundles to support selection and rollout of AIM patient safety bundles across state, particularly in facilities where no bundles have been implemented • Designed implementation plan to build capacity for participating in AIM patient safety bundles • Developed data collection and monitoring plan to support state safety bundle activity • Work with AIM and PQC convenors to expand database to systematically collect relevant quality, process or structure and outcomes measures data
Support "Birthing-Friendly" hospital designation	• Guidance to help Recipients understand "Birthing-Friendly" hospital designation requirements and to help hospitals and Critical Access Hospitals, which are not required to report data to the Inpatient Quality Reporting program, overcome challenges to achieving this designation • Guidance to display the "Birthing-Friendly" hospital designation in provider directories, where applicable	• Completed analysis of hospitals and Critical Access Hospitals with birthing facilities to identify challenges in attaining the "Birthing-Friendly" designation and actions that can be taken so that any remaining hospitals achieve the birthing-friendly designation • Attest that the "Birthing-Friendly" hospital designation is displayed in provider directories, where applicable
Pillar 3 – Whole-Person Care Delivery		
Increase risk assessments screenings, referrals and follow-up for perinatal depression, anxiety, tobacco use, substance use disorder, and HRSNs	**Risk Assessment** • Review of current risk assessment tools in use. Plan to implement medical and social risk assessments for risk appropriate care and/or plan to collect information on risk assessments already in use at the practice level • Guidance to evaluate prenatal to postpartum care delivery patterns and utilization to guide risk assessment design • Guidance on developing, defining, and implementing	**Risk Assessment** • Identification and selection of risk assessment tools, as appropriate • Plan to implement medical and social risk assessments for risk appropriate care **Screening/Referral for Behavioral Health Needs** • Drafted a process/journey map of existing screening and referral processes for perinatal beneficiaries with behavioral health needs • Identified workflows and data collection processes for related quality measures • Selected specific screening tools

Element	Technical Assistance Activities	Pre Implementation Period Milestones to Complete by the End of Model Year 3
	medical and social risk assessments to drive risk appropriate care **Screening/Referral for Behavioral Health Needs** • Guidance to analyze gaps in resources to meet behavioral health needs of pregnant and postpartum people in communities within the model test region • Education on recommended behavioral health screenings and follow up for maternal depression and anxiety or managing existing behavioral health conditions during and after pregnancy • Guidance to ensure that workflows and quality measures include recommended screening and follow up for maternal depression and anxiety **Screening/Referral for SUD and Tobacco Use** • Guidance to ensure that workflows and quality measures include recommended screening and follow up for tobacco use and substance use disorder. • Education on recommended screenings and follow-up practices for tobacco use and substance use disorder, including use of the Office of the National Coordinator Neonatal Abstinence Syndrome Informational Resource[63] **Screening/Referral for HRSNs** • Guidance to analyze gaps in community resources to meet HRSNs of pregnant and postpartum people • Guidance to establish reliable bi-directional referral pathways to	• Identified areas of improvement through completed process map • Drafted implementation plan to address identified gaps • Trained hospital and provider staff, as appropriate, on selected screening tools • Established specific follow-up protocol for positive behavioral health screens and behavioral health workforce linkages made **Screening/Referral for SUD and Tobacco Use** • Drafted a process/journey map of existing screening and referral processes for perinatal beneficiaries with SUD or tobacco use • Identified workflows and data collection processes for quality measures • Selected specific screening tools • Identified areas of improvement through completed process map • Drafted implementation plan to address identified gaps • Trained hospital and provider staff, as appropriate, on specific screening tools • Established specific follow-up protocol for positive SUD or tobacco-use screens and behavioral health workforce linkages made, where needed **Screening/Referral for HRSNs** • Drafted implementation plan to address identified gaps • Identified workflows and data collection processes for quality measures • Selected specific screening tools • Established bi-directional referral pathways such that providers can connect beneficiaries to CBOs and receive notification when the CBO is engaged • Trained staff on specific screening tools • Established specific follow-up protocols for identified needs

Element	Technical Assistance Activities	Pre Implementation Period Milestones to Complete by the End of Model Year 3
	CBOs to address and resolve HRSNs • Guidance on HRSN tools that utilize health IT enabled instruments that support interoperability	
Increase home monitoring for diabetes and hypertension	• Guidance to analyze and examine Medicaid coverage and reimbursement for home monitoring to ensure Partner Providers can track and monitor chronic conditions remotely • Guidance to operationalize the implementation of home monitoring and use of Cooperative Agreement funding to cover the cost of telehealth platforms or data integration platforms on an ongoing basis, home monitoring, training for self-monitored blood pressure and associated data submission, blood pressure cuffs and/or glucose monitors for Medicaid beneficiaries, as appropriate • Guidance in partnering with the state's Public Health Department, MCP or other organization (e.g. university) in the design and implementation of home monitoring and creating a partnership plan • Home monitoring implementation support (e.g. provider and/or patient education)	• Determined whether a SPA or waiver is needed for Medicaid coverage of home monitoring • Created a draft partnership plan between the Recipient and public health department, MCP and/or other organization (e.g. university) on the design and implementation of home monitoring, as appropriate • Completed draft SPA/waiver documents, as needed, and submitted for internal review, as required • Met with partners, such as the state public health department, MCP and/or other organization (e.g. university) and updated partnership plan, as appropriate • Drafted 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 so that this intervention can be implemented in the implementation phase
Develop Health Equity Plan (HEP)	• Provide guidance on the development of the HEP for the model test region through the following activities: o Analyses to better understand maternal health disparities	• HEP completed and approved by CMS. At a minimum, the HEP should answer the following questions: o What are the features, obstacles, and demographics of the test region population? o What is the state of health equity in this region?

Element	Technical Assistance Activities	Pre Implementation Period Milestones to Complete by the End of Model Year 3
	○ Identification of specific improvement goals ○ Tracking progress toward the goals ○ Expanding on existing health equity-related activities ○ Addressing data collection/ infrastructure and quality issues • Assessing state's compliance with Translation and Non-Emergency Medical Transport (NEMT) requirements in section 1902(a)(4)(A) of the Social Security Act promulgated in 42 C.F.R. § 431.53 and section 1905(a)(31) of the Social Security Act and promulgated in 42 CFR § 440.170(a)	○ Which health disparities will be addressed? ○ What are the health equity goals to be attained by December 2029? ○ What are the health equity goals to be attained by December 2034? ○ What strategies will Recipient use to overcome obstacles to equitable care? ○ How are leaders in the Recipient and other relevant organizations held accountable for equitable outcomes? • Submitted a plan to CMS to comply with NEMT requirements, if needed • Submitted a plan to CMS to comply with translation requirements, if needed • Established a process for measuring and tracking stratified outcomes in state or sub-state region of interest for conditions with identified disparities
Optional Pillar 1		
Cover certified midwives and certified professional midwives	• Guidance to cover certified midwives and certified professional midwives licensed in the state through Medicaid authorities • Guidance for completing rate development and payment analyses, as appropriate, that compare the reimbursement rate for all professional midwives, as a proportion of a relevant benchmark rate, for determining fee schedule updates, as appropriate • Guidance to connect with local and state resources, including CBOs, community colleges, midwifery training organizations and others to expand recruitment, training opportunities, and marketing around the use and availability of CMs and CPMs	To be established during Model Year 1

Element	Technical Assistance Activities	Pre Implementation Period Milestones to Complete by the End of Model Year 3
	• Guidance and trainings for all professional midwives to help them enroll in Medicaid and learn about reimbursement structures and billing procedures • Provider awareness and education on appropriate scope of practice and to create more supportive care environments for CMs and CPMs to furnish services	
Cover perinatal CHWs	• Guidance to cover perinatal CHWs through Medicaid authorities • Guidance for completing rate development and payment analyses, as appropriate, that compares the reimbursement rate for perinatal CHWs, as a proportion of a relevant benchmark rate, for determining fee schedule updates, as appropriate • Guidance to connect with local and state resources, including CBOs, community colleges, HRSA-funded Area Health Education Centers, perinatal CHW training organizations and others to expand recruitment, training opportunities, and marketing around the use and availability of perinatal CHWs • Guidance and trainings for perinatal CHWs to help them enroll in Medicaid and learn about reimbursement structures and billing procedures • Provider awareness and education to create more supportive care environments for perinatal CHWs to furnish services	To be established during Model Year 1

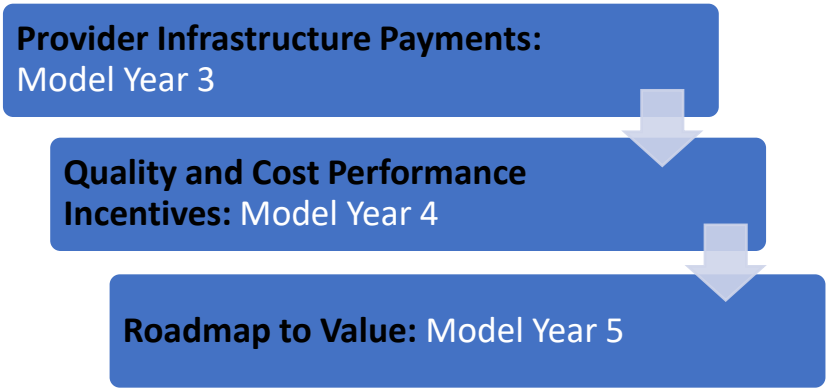
Element	Technical Assistance Activities	Pre Implementation Period Milestones to Complete by the End of Model Year 3
	• Information to Medicaid beneficiaries about the availability of perinatal CHWs, and benefits of perinatal CHW care	
Create regional partnerships in rural areas	• Guidance to bolster regional partnerships in rural areas among health centers, Rural Health Clinics (RHCs), birth centers, community hospitals and larger hospitals/health systems for risk management • Guidance on assessing and verifying risk-appropriate care standards for different maternity care provider types for low- and high-risk patients • Guidance to Federally Qualified Health Centers (FQHCs) that participate in the Health Resources and Services Administration (HRSA) Health Center Program to submit Change in Scope requests to include new outreach clinics in rural communities • Guidance on setting up telehealth services, especially with RHCs or FQHCs as the originating sites	To be established during Model Year 1
Extend Medicaid eligibility to 12 months postpartum	• Guidance to amend state plans to extend Medicaid eligibility to 12 months postpartum (may include CHIP, if separate CHIP exists in the state)	To be established during Model Year 1
Optional Pillar 2		
Promote shared decision-making	• Guidance to Recipients to develop and/or implement patient decision aid resources to enhance shared decision-making, including effective training materials • Promote shared decision aids across beneficiary population to	To be established during Model Year 1

Element	Technical Assistance Activities	Pre Implementation Period Milestones to Complete by the End of Model Year 3
	improve appropriate use, avoid misuse, and decrease underuse of evidence based, high-value care	
Expand group perinatal care	• Guidance to Recipients to amend state plans to include coverage of group care • Guidance to Recipients and partnered care settings on designing a group care curriculum, including potentially group care sessions to address specific health issues (e.g. smoking cessation, at-risk for gestational diabetes), and training facilitators • Guidance to develop payment mechanisms and reimbursement rates that support group care models including reporting of reimbursement rates for such enhanced care services	To be established during Model Year 1
Optional Pillar 3		
Increase use of home visits, mobile health, and telehealth	• Guidance to Recipients to amend state plans, if needed, in connection with home visits for prenatal and postpartum care • Guidance to support contracting and payment analyses for enhanced-care community-based programs	To be established during Model Year 1
Expand oral health care	• Education to providers regarding optimal oral health screening and care during the prenatal and postpartum period • Guidance to Recipients in payment analysis that compares the reimbursement rates for oral health care as a proportion of a benchmark rate, and has a process in place for completing an annual analysis thereafter	To be established during Model Year 1

A.4.3 Medicaid Payment Model

The TMaH Model payment model will be implemented using appropriate authorities under Medicaid and CHIP, and Federal Medical Assistance Percentage-eligible services provided in the TMaH Model will be covered accordingly. Recipients may implement the payment model directly in a FFS program and/or via risk-based MCPs.

FIGURE 2 PAYMENT MODEL YEAR 3-5



In Model Years 1 and 2, Recipients will receive Cooperative Agreement funding for infrastructure needs, including to hire and retain staff, perform data analytics and build critical skills and capacity necessary to implement the payment model.

Starting no later than Quarter 1 of Model Year 3, Recipients must use a portion of their Cooperative Agreement funding to pay Partner Providers and Partner Care Delivery Locations for care delivery transformation activities outlined in Section A.4.3.1 Provider Infrastructure Payments – Model Year 3.

Although CMS will be responsible for the design of the payment model, some parameters may vary based on state laws and regulations as well as regional and local labor pools and other variables. CMS will design a payment model that aligns with existing federal Medicaid and CHIP requirements. Recipients will have the opportunity to provide feedback on the payment model as it is developed. However, as a condition of participation in TMaH Model, all Recipients must agree to implement the payment model, consistent with the parameters outlined in this NOFO.

A.4.3.1 Provider Infrastructure Payments – Model Year 3

The TMaH Model payment model will start with Provider Infrastructure Payments to support the implementation of the care delivery transformation no later than the first quarter of Model Year 3.

Provider Infrastructure Payments will be adjusted for medical, and potentially non-medical, risk factors (also known as risk-adjusted payments) and will be awarded to Recipients who have qualified for non-competing continuation Cooperative Agreement funding. Recipients will be responsible for regularly dispersing to Partner Providers and Partner Care Delivery Locations to support the activities through subrecipient agreements as detailed below. The Provider Infrastructure Payments will be based on the number of TMaH Model-eligible Medicaid beneficiaries cared for by the provider, when appropriate. The Provider Infrastructure Payment is triggered by an attributed beneficiary's first prenatal encounter and continues through the last

day of the calendar month of the 60th day postpartum. Provider Infrastructure Payments must not duplicate or supplant existing federal, state or local funds available for the same activities.

The Provider Infrastructure Payments may only be used by providers for the following activities and must be detailed in the Recipient's Project 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 HRSA, 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 social risk assessments to drive risk-appropriate care.
- **Quality Measure Reporting:**
  - Data reporting on mandatory quality measures (see Section A.4.3.2 Quality and Cost Performance Incentive for additional details), 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 Section A.4.6 Measures and Reporting)
- **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.[xi]
  - 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 member HSRN 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 CHWs, midwives, physician assistants and behavioral health providers, as appropriate.
- **Enhanced Access to Care:**

[xi] Provider Partners are encouraged to partner with HIEs and other networks that support nationwide exchange under the Trusted Exchange Framework and Common Agreement (TEFCA).

- 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 HRSNs and behavioral health needs:**
  - Identification of local entities that can help address social and 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.

Recipients must execute a legal agreement (subaward) with a subrecipient(s) for the purpose of administering Provider Infrastructure Payments. Such subrecipients may include a managed-care entity, foundations, or another entity dispersing payments to providers and Partner Care Delivery Locations. All subawards must be in accordance with 45 CFR § 75.351, 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 entity pursuant to 42 CFR Part 438.

Such agreement must require that the entity cooperate with all CMS monitoring requests and activities and provide CMS with access to records, data and information necessary to comply with such monitoring requests and activities. CMS will work with each Recipient to conduct data analyses to determine the risk-adjusted payment amount, subject to CMS approval.

A.4.3.2 Quality and Cost Incentive Performance Payments – Model Year 4

In Model Year 4, Partner Providers and Partner Care Delivery Locations will become eligible for upside-only performance payments to be paid by Recipient using the appropriate Medicaid authority and following CMS review processes. **Cooperative Agreement funding cannot be used for these payments.** 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 Quality- and Cost-Performance Incentive Payments (PIP), respectively, based on Model Year 4 performance. Payment methodologies for the PIP will be finalized during the Pre-Implementation Period. Performance Incentive Payments will be added to existing provider reimbursement structures.

Partner Providers and Partner Care Delivery Locations may earn a percentage of a provider's total Medicaid payments for pregnancy-related services for TMaH Model-attributed beneficiaries. The percentage for the PIP will be proposed by the Recipient, subject to CMS approval. The Performance Incentive Payment amount will be based on an aggregate score for quality performance, worth 80 percent of the total Performance Incentive Payment, and cost performance, worth 20 percent of the total Performance Incentive Payment during MY4 and paid retrospectively. CMS will finalize the Performance Incentive Payment methodology and implementation plan during the Pre-Implementation Period.

The quality and cost measures are outlined below and further specified in Section A.4.6 Measures and Reporting.

A.4.3.3 Quality Measures

- **Quality Measures:** The following quality measure concepts will be used to determine Performance Incentive Payments in MY4 (see below). These measures will be finalized by the end of MY3. Additional details can be found in Table 4.
    - 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 participating in financial and quality-focused meetings with CMS.

A.4.3.4 Roadmap to Value – Model Year 5

By the end of Model Year 5, Recipients will transition from the current payment methodology in each state to a value-based payment model. The value-based payment model will transition from the status quo payments (e.g., FFS and, where applicable, OB global payments and facility fees), inclusive of the preceding TMaH Model payment streams (Provider Infrastructure Payments and Performance Incentive Payments), to one that reduces unnecessary Medicaid and CHIP program expenditures as a result of poor maternity care, through a replicable and sustainable whole-person care delivery approach to pregnancy and childbirth that reduces low-risk cesarean sections, severe maternal morbidity and low birthweight infants, and improves patient experience.

CMS will lead the design of the MY5 value-based payment approach, in collaboration with Recipients and other key stakeholders. As part of the MY5 value-based payment design process, CMS will develop a process for engaging Recipients and key stakeholders in structured discussions to outline and then detail the MY5 value-based payment approach. The purpose of these conversations will be to share information with Recipients on CMS' approach to value-based payment design, and to gain insights from Recipients and other stakeholders on key features. Topics of these discussions 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

A.4.4 Measure Reporting

CMS will use several measures to monitor and evaluate Recipient performance in the TMaH Model and the quality of care furnished by Partner Providers and Partner Care Delivery Locations. Recipients will be required to report the quality measures in Table 4. CMS reserves the right, in its sole discretion, to suspend, suppress, substitute or remove any quality measure from TMaH Model, including substitution of equivalent digital measures and/or measures that are currently in development. CMS will communicate any such change to Recipients no later than four months prior to such change.

A.4.5 Availability of Technical Assistance to Recipients

Separate from Cooperative Agreement funding, TA will be provided to help all Recipients prepare to implement the TMaH Model. CMS and its contractors will comprise a multidisciplinary TA team to assist as needed with:

- Maternal health care and maternal health policy
- Identifying and addressing health disparities
- Developing partnerships among and between MCPs, providers and CBOs
- Designing and implementing Value-Based Payment models
- Health care quality improvement
- Medicaid data linkage and data sharing
- Medicaid claims data analytics and financial modeling

A Project Officer and a TA coach will be assigned to each Recipient to help make progress toward program milestones and to implement the TMaH Model.

CMS and its contractors will work with Recipients and Partner Providers to prioritize action items and timelines during the Pre-Implementation Period to meet the required and optional elements, including providing assistance in analyzing Medicaid data to assess root causes of poor maternal health outcomes and disparities.

During the first quarter of the Pre-Implementation Period, CMS and Recipient will collaborate to draft a TA plan. The plan will identify workstreams, goals, entities to participate in TA, and team leads. It will estimate the time required per month by Recipient and other team members. The plan will specify group or tandem topics to be covered together, and a timeline of milestone activities to be accomplished during Pre-Implementation Period. The TA plan will be revised as needed throughout the Pre-Implementation Period.

Recipients are expected to be actively involved in TA activities, including attending regularly scheduled calls; providing input and working on portions of documents, as appropriate; reviewing documents and completing awardee action items per the TA work plan. Guidelines for the types of activities to be conducted by the Recipient are listed below:

- Recipients are expected to swiftly execute the necessary data sharing agreements in order to support the exchange of data and information related to the TA activities and completion of milestones.
- Recipients are expected to provide CMS and contractors the necessary information and data to support the development of documents to help reach milestones.

- Recipients are expected to use their Medicaid authority and state government agency position to meet model milestones. For example:
    - Recipients are expected to draft SPA language, with guidance provided on examples of language and data points for the SPA, as needed.
    - Recipients are expected to actively contribute to the design of the Health Equity Plan and implement the Health Equity Plan, with guidance from CMS and contractors.
    - Recipients are expected to implement the State Doula Support Council, as appropriate.

CMS will provide different forms of TA based on need, including:

Peer-to-peer collaborative learning opportunities: This may include model-wide education or education by interest area. Topics may include: assistance with environmental scans and analyses relevant to required and optional elements; assistance with identification of all parties necessary to implement the model; collection and use of data for quality measure reporting; partnerships with statewide PQCs for supporting the implementation of AIM patient safety bundles; improvement of prenatal and postpartum care; feedback on payment model designed by CMS; increasing access to midwifery care, doula care and birth centers; Medicaid managed care procurement and Medicaid contracting; and best practices to support maternal and infant health with extended Medicaid eligibility to 12-month postpartum.

One-on-One assistance: This may include: expertly crafted communications materials to recruit MCPs and providers to participate in TMaH Model; strategic advice and guidance around selection of Medicaid and CHIP authorities to achieve TMaH Model's payment and delivery reforms; care delivery process improvement strategies; data matching and outreach efforts across Medicaid, SNAP and WIC to streamline and increase enrollment in benefit programs; linkage of mother and infant Medicaid claims data; linkages of Medicaid claims with vital records; improvement of the collection and stratification of racial/ethnic data; data analysis and financial modeling to support the payment model, including risk-adjustment methodologies, benchmarking, specification development and implementation guidance and support.

A.4.6 Measures and Reporting

TABLE 4 MY4 QUALITY MEASURES TIED TO PERFORMANCE PAYMENTS*

Concept	Proposed Measure Name	Steward	Specifications
Low-Risk Cesarean Delivery (provider and/or hospital-level)	Cesarean Birth (ePC-02)	The Joint Commission (TJC)	P4QM Specifications
Screening for Maternal Depression and Follow-Up (provider level)	Screening for Clinical Depression and Follow-Up (CDF or 0418)	CMS	P4QM Specifications

Concept	Proposed Measure Name	Steward	Specifications
Severe Obstetric Complications (hospital level)	Severe Obstetric Complications (ePC-07)	TJC	P4QM Specifications
Timeliness of Prenatal and Postpartum Care (provider level)	Prenatal and Postpartum Care (PPC)	TBD	TBD

*Measures subject to change.

The measures below may be used for monitoring and/or evaluation but will not affect the MY4 Performance Incentive Payments. CMS intends to measure the concepts listed below as proxies for healthcare quality. Specific measures will be chosen and specified by the end of MY3. Depending on the measures chosen, providers may be required to collect and report patient-level data to CMS, either for program monitoring or for evaluation purposes. If this is the case, TA will be provided to enable the most efficient collection and reporting strategies. Specific measures selected based on the measure concepts listed below may also be included in the MY5 payment model.

- Low Birthweight
- Contraceptive Care for Postpartum Women
- Blood Pressure Control
- Pre-Term Birth < 37 Weeks Gestational Age
- NICU Rate
- Emergency Department Utilization among Postpartum Beneficiaries
- Screening for Perinatal Anxiety
- Tobacco Use Screening
- Substance Use Screening
- Health-Related Social Needs Screening
- Patient-Reported Experience Measure (Survey)

A.4.7 Medicaid and CHIP Authorities

Recipients will use available Medicaid and CHIP authorities as needed to support model implementation. Individual states may need to work with CMCS to submit and gain approval through existing CMCS pathways for SPAs, 1115 demonstrations, managed care contracts (including state-directed payments) and/or any other Medicaid authority. **Information included in a TMaH Model application will be used solely for the purpose of application review and does not represent a formal request for the use of any Medicaid authorities, nor a commitment to approval on the part of CMS.** Rather, for successful applicants, the identification of current and planned Medicaid authority will help federal and state planning efforts for transitions to a sustainable payment methodology, in compliance with applicable Medicaid statutory and regulatory requirements, beyond the Cooperative Agreement period of performance.

A.4.8 Cooperation with Evaluation

Applicants are required to devise a strategy to ensure that collaborating MCPs, Partner Providers and Partner Care Delivery Locations with whom the Recipient forms agreements comply with and participate in the independent model evaluation that will be conducted by CMS. The applicant must demonstrate its capacity to participate in and help facilitate patient- and program-level data provision and qualitative evaluation tasks, which may include:

- arranging site visits and
- observations, interviews, surveys and focus groups with providers and patients as well as program staff.

A.5 Technical Assistance and Information for Prospective Applicants

Prior to the application deadline, CMS will host one or more webinars to provide details about the TMaH Model and to answer questions from potential applicants regarding this NOFO. Questions should be submitted in writing in advance for CMS to consider. Information about the webinars and where to send questions will be posted on the TMaH Model website. A list of frequently asked questions may also be posted to the website.

B. Federal Award Information

B.1 Total Funding

TABLE 5 TOTAL FUNDING (AMOUNTS NOT GUARANTEED)

Total Funding	Up to $255 million
Award Amount	Up to $17 million to each Recipient Up to $8 million during the Pre-Implementation Period (model years 1-3), and Up to $9 million during the Implementation Period (model years 4-10).
Anticipated Award Dates	December 15, 2024
Period of Performance	January 20, 2025 – January 19, 2035
Number of Awards	Up to 15 awards
Type of Award	Cooperative Agreement Statutes, regulations, and policies, that apply to grants also apply to cooperative agreements, unless the award itself provides otherwise. References throughout this NOFO to grants also apply to cooperative agreements unless this NOFO states otherwise. Please refer to Section F.4. Cooperative Agreement Terms and Conditions of Award.
Type of Competition	Open to All Eligible Applicants

Award amounts may vary based on factors such as the size and needs of Medicaid and CHIP populations to be served by the Model, as well as the overall scope of project as described in the application. All awards are subject to availability of funds. Annual budgets are subject to negotiation, and the maximum funding amounts listed in the table below are not guaranteed.

B.2 Cooperative Agreement Funding Per Recipient

TABLE 6 COOPERATIVE AGREEMENT FUNDING PER RECIPIENT

Model Year	Maximum Annual Cooperative Agreement Funding (Amounts Not Guaranteed)
Pre Implementation Period	
Model Year 1	$1M
Model Year 2	$2M
Model Year 3	$5M
Subtotal	**$8M**
Implementation Period	
Model Year 4	$3.5M
Model Year 5	$2.5M
Model Year 6	$1.25M
Model Year 7	$1.0M
Model Year 8	$0.25M
Model Year 9	$0.25M
Model Year 10	$0.25M
Subtotal	**$9M**
Total	**$17M**

The period of performance will consist of 10 one-year budget periods. Each budget period covers one Model Year. Recipients may request prior approval from CMS to carryover unobligated funds remaining from a current budget period to a subsequent budget period.

TABLE 7 MODEL YEAR AND BUDGET PERIODS

Model Year	Budget Period	
	Start	End
1	January 20, 2025	January 19, 2026
2	January 20, 2026	January 19, 2027
3	January 20, 2027	January 19, 2028
4	January 20, 2028	January 19, 2029
5	January 20, 2029	January 19, 2030
6	January 20, 2030	January 19, 2031
7	January 20, 2031	January 19, 2032
8	January 20, 2032	January 19, 2033
9	January 20, 2033	January 19, 2034
10	January 20, 2034	January 19, 2035

CMS will award, by competitive process, Cooperative Agreements up to $17 million each to a maximum of 15 successful applicants. Funding for each year after Model Year 1 will be issued via non-competing continuation awards, contingent on each Recipient's progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all Terms and Conditions of award. Recipient must request funds for the next budget period via submission of a non-competing continuation application. Additional details on this process will be included in the Terms and Conditions of award as well as subsequent post-award communications from CMS.

Recipients are required to recruit Partner Providers and Partner Care Delivery Locations. Recipients may decide whether Medicaid and CHIP providers in the test region will be required to participate in the TMaH Model and the associated payment model or whether providers can participate on a voluntary basis. However, CMS requires that in the test region, the average number of combined annual Medicaid- and CHIP-covered births between calendar years 2015-2020 must be no less than 1,000. Therefore, it is incumbent on Recipients to consider the number and size of providers and practices participating in the model. Data for all beneficiaries attributed to these practices will be part of analyses for payment, monitoring, and evaluation. Recipients in states that have implemented managed care in their Medicaid and CHIP programs must collaborate with managed care plans (MCPs) such as Prepaid Ambulatory Health Plans (PAHPs), Prepaid Inpatient Health Plans (PIHPs), and Managed Care Organizations (MCOs).

All initial awards and non-competing continuation awards are subject to availability of funds.

C. Eligibility Information

C.1 Eligible Applicants

State Medicaid Agencies (SMAs) for the 50 states, District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands are eligible to apply. Applicants must propose either to implement the model statewide or to implement the model in a sub-state region specified by ZIP codes. Regardless of the size of the chosen implementation area, the average number of combined Medicaid- and CHIP-covered births between calendar years 2015-2020 must be no less than 1,000 per year for the region. Sub-state implementation is strongly preferred for evaluation purposes (see Section F.6.1.2 Evaluation). **CMS understands that in some states and territories the minimum number of births may not occur in any substate region and therefore certain states or territories may need to implement the model state- or territory-wide to meet the 1,000 birth a year minimum. In addition, CMS encourages applicants to include rural, underserved, and Tribal areas in its proposed test region, where appropriate.**

C.2 Cost Sharing or Matching

Cost sharing or matching is not applicable for this program.

C.3 Letter of Intent

CMS requests that interested applicants submit Letters of Intent (LOIs); this is optional and will not impact application scoring. Applicants may email LOIs to the following address: tmahmodel@cms.hhs.gov . Letters of Intent must include:

1. An expression of interest, including the proposed regions of participation.
2. A brief description of the interested organization.
3. Contact information, including the organization's street address and a contact person's name, position, email, and phone number.

LOIs are due August 8, 2024.

C.4 Ineligibility Criteria

The table below provides information on allowable overlaps with other ongoing CMS models. Recipients that currently or in the future are implementing or considering CMS models not listed in Table 8 should carefully consider potential duplication of funding or services, as well as Recipient administrative capacity. Potential conflicts must be detailed in the required Program Duplication Assessment in Section D.3.5.

TABLE 8 ALLOWABLE CMS MODEL OVERLAPS

Other CMS Models	TMaH Model
States Advancing All-Payer Health Equity Approaches and Development (AHEAD)	A state can apply for both models as long as there is no geographic overlap and no providers or beneficiaries participating in both models.
Cell and Gene Therapy	A state can apply for both models, and geographic, provider and beneficiary overlaps are permitted.
Innovation in Behavioral Health	A state can apply for both models and geographic and beneficiary overlaps are permitted, but providers may not participate in both models.
Making Care Primary	A state can apply for both models and geographic, provider and beneficiary overlaps are permitted.

C.5 Single Application Requirement

Applicants may submit only one application.

C.6 Continued Eligibility

Continued funding is contingent on satisfactory progress, compliance with the Terms and Conditions, and the availability of funds. After the initial award for Budget Year 1, which is synonymous with Model Year 1, Recipients must meet reporting and certification requirements

as specified in Section F.4 Cooperative Agreement Terms and Conditions to be eligible for non-competing continuation awards in Budget Years/Model Years 2-10. Non-competing continuation awards will help Recipients retain staff and build critical skills and capacity necessary to implement the TMaH Model.

Recipients are expected to participate in the full 10 years of the TMaH Model.

Satisfactory progress is determined by the Recipient's adherence to the CMS-approved TA plan and timeline, including timely achievement of TMaH Model milestones for each element as described in Table 3 in accordance with the Terms and Conditions at the time of the award.

All Recipients will be required to cooperate with CMS efforts to conduct independent, federally funded evaluations of the TMaH Model, which may include completion of surveys and participation in interviews, site visits, and other activities that CMS determines necessary to conduct comprehensive evaluations. Evaluation results will be used to meet CMS' statutory requirement to analyze the quality of care furnished under the model, including measurement of patient-level outcomes and changes in federal spending on Medicaid and CHIP beneficiaries by reason of the model. Failure to cooperate with evaluation efforts may result in termination from the model.

At any time in the period of performance, Recipients could receive decreased funding, or their award could be terminated in accordance with 45 CFR § 75.372 "Termination" if they fail to perform the requirements of the award.

C.7 EIN, UEI, AND SAM REGULATIONS

All applicants must have the following to submit an application to Grants.gov:

- A valid Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN)
- A Unique Entity Identifier (UEI)
- A Login.gov account
- Active registration in the System for Award Management (SAM) database

See Appendix II. Application and Submission Information on how to get registered.

C.8 FAITH-BASED ORGANIZATIONS

This grant opportunity is available for State participants of the TMaH Model only. Faith-based organizations are not eligible to apply.

C.9 OTHER ELIGIBILITY REQUIREMENTS

Not applicable.

D. APPLICATION AND SUBMISSION INFORMATION

During the application period, the TMaH Model team will host informational events (e.g., webinars and "office hours" open forums). These events will enable CMS to engage interested and potentially affected parties, introduce key concepts, and initiate action planning by

applicants. Prospective applicants are encouraged, but not required, to participate in these informational events to gain a better understanding of how to apply for and participate in the model.

D.1 Address to Request Application Package

You must submit your application through Grants.gov. Grants.gov has information about the online application process. See "How to Apply for Grants" at Grants.gov for electronic submission instructions. Refer to Appendix II. Application and Submission Information for additional requirements and instructions.

D.2 Content and Form of Application Submission

Application Format

Disqualifying Factors.

Applications determined to be ineligible, incomplete, and/or nonresponsive will not move forward.

CMS will not consider an application that:

- Is from an organization that does not meet eligibility conditions.
- Requests funding above the award ceiling shown in the funding range.
- Is not submitted through Grants.gov.
- Is incomplete based on the initial screening

However, the CMS, Division of Grants Management Director/Deputy Director may continue the review process for an ineligible application if it is in the best interests of the government to meet the objectives of the program.

Each application must include all contents of the application package, in the order indicated, and conform to the following formatting specifications:

a. The required page size is 8.5" x 11" letter-size pages (one side only) with 1" margins (top, bottom, and sides). CMS does not accept other paper sizes.

b. All pages of the project and budget narratives as well as other required narrative documents must be paginated in a single sequence.

c. Font size must be at least 12-point with an average of 14 characters per inch (CPI).

d. The Project Narrative must be double-spaced. The page limit for this document is 60 pages.

e. The Budget Narrative may be single-spaced. The page limit for this document is 10 pages.

f. The Business Assessment of Applicant Organization may be single spaced. The page limit for this document is 12 pages.

g. The Program Duplication Assessment may be Single spaced. The limit for this document is 10 pages.

h. Tables included within any portion of the application must have a font size of at least 12-point with a 14 CPI and may be single-spaced. Tables are counted toward the applicable page limits.

i. The project abstract is restricted to a one-page summary that may be single-spaced.

j. The following required application documents are **excluded** from the page limitations described previously:
   - Standard Forms, (SF-424, SF-424A, SF-LLL)
   - Application Cover Letter/Cover Page (if applicable)
   - Project/Performance Site Location(s) Form
   - Cost Allocation Plan/Indirect Cost Rates
   - Copy of the Letter of Intent, if applicable

k. The total number of additional appendices per application may be no more than 20 pages to include, optional letters of support from government officials such as state governors, ranking members of state congress and chairs of relevant committees such as health and human services, insurance, and social services or the statewide perinatal quality collaborative. Additionally, applicants may choose to provide required resumes and/or curriculum vitaes, job descriptions, and organization chart as part of its Project Narrative submission (D.3.1.2(a)-(d), or alternatively, include these documents as appendices. If choosing to include some of the required Project Narrative information as an Appendix, the Project Narrative should cross-reference to the Appendix.

D.2.1 STANDARD FORMS

You must complete the five standard forms identified below. You can also view them and see their instructions at Grants.gov Forms.

1. Project Abstract Summary **(required)**

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

   Include:

   - Goals of the project
   - Total budget
   - Description of how funds will be used.

2. SF-424: Official Application for Federal Assistance **(required)**

   You must complete all sections of the SF-424. Special instructions include:

   ☐ **In Item 15 "Descriptive Title of Applicant's Project**,":

   HHS awarding agencies must establish detailed and accurate award descriptions at the time they make a federal financial assistance award. Award descriptions are:

   • critical to ensuring accountability and transparency and

• a primary means to inform the public of the purpose of the federal funding that is distinct from the programmatic level information in the Assistance Listings.

Elements of a Strong Award Description

Robust award descriptions provide an understanding of the award's purpose and include a description of award-specific activities and purpose. A strong award description will have all the following elements:

• Specifics about the award purpose
• Activities to be performed
• Expected deliverables and outcomes
• Intended beneficiary(ies) or recipients
• Subrecipient activities, (if known)

Characteristics of a Strong Award Description

A strong award description will have the following characteristics:

• Uses plain language an average reader can fully understand
• Is brief and succinct
• Is unique on USA Spending
• Does not use or limits abbreviations or acronyms

Examples of Strong Award Descriptions:

The Council of Inspectors General on Integrity and Efficiency's Pandemic Response Accountability Committee (PRAC) shared the following examples of effective award descriptions. These, or other agency-specific examples, can be shared with applicants to assist them in developing their award descriptions.

• **Example One**: Construction of pedestrian & bicycle facilities on the Broadway corridor. Broadway @ St. James St- Foxhall Ave. Streetscape improvements & enhancements include sidewalks, curbing, bike lanes, ped bump-outs, and lighting.

• **Example Two**: Levittown Beauty Academy, LLC is creating distance education for students affected by Covid-19. Schools cannot use physical location and students are now doing their schoolwork online.

☐ Check "No" to item 19c. as Review by State Executive Order 12372 does not apply.

☐ **The Authorized Organizational Representative (AOR) completes and electronically signs this form.**

<u>Note</u>: The signature of the individual that submits the application to Grants.gov populates throughout the application. The signature must match the name of the AOR. Other signatures will not be accepted.

Authorized Organization Representative (AOR), the AOR is the applicant's designated representative, who can make legally binding commitments for your organization. When the AOR authorizes an application, they agree that the organization will assume all award obligations.

3. SF-424A: Budget Information Non-Construction **(required)**

4. SF-LLL: Disclosure of Lobbying Activities **(required)**

   You must submit the SF-LLL form. If you do not engage in lobbying, please insert "Non-Applicable" on the form (fields 10a and 10b) and include the required AOR name, contact information, and signature.

   Please note that the application kit available online on the Grants.gov website is used for many programs and therefore Grants.gov may designate this form as optional to allow for flexibility amongst programs. **However, this form is required as part of the application package and must be submitted for the application to be considered eligible for review**.

5. Project Site Location Form(s) **(required)**

   All applicants must submit this Project Site Location form. Please note that the application kit available online in Grants.gov is utilized for many programs and therefore Grants.gov may designate this form as optional to allow for flexibility among programs. However, this form is **required** as part of the application package and must be submitted for the application to be considered eligible for review.

D.2.2 Application cover letter or cover page (Optional)

The applicant may choose to include a cover letter to detail interest in participation in TMaH Model.

The cover letter will not be used as part of the application evaluation nor considered for scoring purposes. The cover letter will not count against the overall page limit of the application as described in Section D.2 Content and Form of Application Submission.

D.3 Program Requirements and Expectations

D.3.1 Project Narrative

The project narrative should give a clear and concise description of your project. Articulate in detail the proposed goals, measurable objectives, and milestones in accordance with the instructions and content requirements provided below, consistent with the criteria described in Section A4. Program Requirements and Section E1. Criteria. Review these sections carefully to make sure you answer all questions and cover all topics the reviewers will look at.

Below are the required and optional elements of the project narrative including a brief description of the type of information required within each specific section. The project narrative is double-spaced and cannot exceed 60 pages in length.

Include the title "Project Narrative" at the beginning of the Project Narrative and include in bold the name of each numbered section below before responding to the prompt. If an applicant believes a prompt does not apply, the applicant should not skip the prompt but rather state that it is not applicable with a brief explanation. If an applicant believes that a specific required model

element would prove to be an unreasonable hardship or barrier to participation, the applicant should indicate as such and provide rationale and justification in the project narrative.

1. **Maternal Health Policy Priorities (required):** Clearly articulate how participation in the TMaH Model and achievement of model elements will advance and align with the state's maternal health policy priorities.
2. **Organization, Administration, and Capacity (required):** Applicants must demonstrate their capacity to organize and manage the model and to work collaboratively with other interested parties to implement the model. Applicants **must** provide a description of their organization including:
    a. An organizational chart that names the Authorized Organizational Representative (AOR) and identifies the lines of authority.
    b. Identification of the individual(s) who will have management authority over the Model and a resume or CV as an appendix for each identified manager.
    c. Identification of the individual who will be the Project Director (primary liaison to CMS for the TMaH Model) and a resume or CV for that person.
    d. Additional staff capacity (e.g., job descriptions including positions that may be currently vacant for key staff that will be involved in the TMaH Model).
    e. Description of the anticipated role of any subrecipients or contractors that may be engaged to help implement the TMaH Model such as model partners, MCPs, or contractors.
    f. Any maternal health-related partnerships with other governmental agencies (federal, state, local) or non-governmental organizations (e.g., nonprofits, coalitions or collaboratives, universities etc.).
    g. The applicant's experience, as applicable, with each of the following:
        i. Prior efforts and known challenges to improving maternal care across different programmatic areas such as coverage and benefits, care delivery transformation, and data collection, as well as oversight of these efforts.
        ii. Participation in CMS models, regardless of whether such models are or were related to maternal or infant health.
3. **Payment Environment (required):** The applicant must respond to the following:
    a. Describe existing statewide value-based payment models that include Medicaid and/or CHIP beneficiaries, including any maternal health-related value-based payment approaches and other information the applicant deems relevant.
    b. Describe your state's commitment to implementing the TMaH payment model in the selected region, including (if relevant) how existing payment efforts will be phased out or incorporated into the TMaH payment model approaches listed in A.4.3.1-A.4.3.4.
    c. Describe all enabling factors and/or potential barriers to implementing or aligning with the TMaH payment approaches listed in A.4.3.1-A.4.3.4.

d. Indicate whether the TMaH Model will be implemented in a fee-for-service program, managed care program or both.
e. Provide existing language related to maternal health policies and priorities in procurement materials and contracts with each MCP in the proposed test area and, if applicable, in the sub-state comparison area.

4. **Regional Plan (required):** Applicants must respond to the following:

a. Indicate whether the TMaH Model will be implemented statewide or limited to a sub-state region. Regardless of the size of the chosen test region, the average number of combined annual Medicaid- and CHIP-covered births between calendar years 2015-2020 must be no less than 1,000 for the region.
b. Propose both a test and comparison region per requirements in Section F.6.1.2 Evaluation.
c. Provide a rationale for the region chosen or for proposed statewide implementation by submitting the information requested in Section D.3.1.4a, 4b and 4c.
d. Provide a list of counties or ZIP codes where the model will be tested, if the TMaH Model will be limited to a sub-state region.
e. Provide the following information for the proposed test region, and if the state is seeking to implement the model at a sub-state level, please also provide the below information for the proposed sub-state comparison region:
    i. Provide the most recent summary information available on the number of Medicaid and CHIP beneficiaries in the proposed model test region(s) between the ages of 15-45 years by gender, and by race and ethnicity, if possible.
    ii. Provide summary information about health care providers contracted to care for Medicaid and CHIP beneficiaries in the chosen region including:
        1) A list of hospitals that have a licensed obstetrical unit along with the level of maternal care on the unit, if known. For each hospital listed, also include the average number of Medicaid/CHIP-financed births over the three most recent calendar years for which data are available.
        2) A list of hospitals that provide only emergency department services to pregnant people because there is no designated obstetrical unit.
        3) A list of freestanding birth centers that deliver babies. For each freestanding birth center listed, the average number of Medicaid/CHIP-financed births over the three most recent calendar years for which data are available.
        4) A list of FWHCs providing prenatal care

5) The number of obstetric professionals by licensure type – i.e., physicians, certified nurse midwives, and other midwives where applicable – who provide prenatal, perinatal and postpartum care.

6) Description of need for the region selected for implementation. Narrative should include any observed health disparities, relevant health outcome trends, population-specific needs that are unmet or any additional context that highlights a need for the model in the selected region. In addition to the information requested in (f.) below, useful metrics include the rate of maternal deaths per 100,000 live births for the most recent year(s) available; the per-capita rate of perinatal deaths from suicide or substance overdose, if available; a summary of any findings with respect to patient-reported experience of maternal care measures, if available.

f. Provide detailed information about the following health outcomes for the most recent year available and, if possible, by race/ethnicity in the region where the model will be implemented:

i. Rate of ICU admission per 1000 pregnancies.

ii. Percentage of cesarean section delivery; and if available, the percentage of cesarean deliveries in which birth parent and infant were deemed low-risk (nulliparous, term, singleton, vertex).

iii. Rate of live births weighing less than 2500 grams.

5. **Model Pillars (required):** The applicant must provide detailed information about the status of the following <u>required</u> TMaH Model elements. CMS will evaluate applications based on clarity and completeness. For each element below, please provide information on potential barriers to achieving the milestones listed in Table 3.

a. **Pillar 1 – Access, Infrastructure and Workforce**

i. Midwives:

1) What midwife classification(s) are currently licensed in the state?
2) What midwife classification(s) are currently covered under the Medicaid and CHIP State Plan?
3) Describe the current payment scheme for midwives, including payment amounts.

ii. Birth Centers: Are free-standing birth centers licensed (or do they have deemed licensure) in the state? If so, please, describe applicable reimbursement policies and any limitations on care in such settings.

iii. Doula Services - Coverage:

1) Are Doula Services covered by the Medicaid State Plan? If not, please affirm that you will take necessary action to add coverage and provide detailed steps and a timeline for adding Doula

Services as a new Medicaid benefit. In so doing, describe any potential obstacles such as legislative calendars, staff capacity, etc.

2) Doula Services: Does the state have an established independent group to advise the state on policies related to advancing Doula Services reimbursement and coverage, expanding recruitment and training opportunities, and developing resources to aid nonclinical trained professionals performing Doula Services in enrolling as state Medicaid providers? If no such group exists, please affirm that you will take the necessary action to establish a State Doula Support Council and a timeline for doing so.

iv. Improve data infrastructure:

1) Is reporting to a state or regional health information exchange (HIE) mandatory or voluntary?

2) Are Medicaid providers able to send and receive information to a health information exchange (HIE)? If so, please describe the capabilities of such HIE to meaningfully exchange health care information such as medical records, orders, referrals, HRSN screenings, etc.

3) Are Medicaid claims data and birth certificates linked to vital records?

4) Is data-matching performed across social service and benefit programs such as Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Medicaid to measure and address cross-program enrollment gaps? If so, who performs the data-matching? Please describe how it is used. If not, please describe efforts to date to perform data-matching and any obstacles to success.

5) Please describe the extent to which individual-level demographic data such as race, ethnicity, preferred language, sexual orientation, and gender identity data are collected in alignment with the ONC USCDI and CMS' health equity data strategy outlined in The Path Forward: Improving Data to Advance Health Equity Solutions. Please describe any obstacles to the collection of these data.

b. **Pillar 2 – Quality Improvement and Patient Safety**

i. Does the applicant have an existing partnership with the state's PQC or other entity supporting the implementation of AIM patient safety bundles?

1) If so, please list which bundles have been or will be implemented, and the month and year in which actual or planned implementation began or will begin at each relevant facility in the implementation region.

2) If known, please list which bundles are high priority. Applicants are encouraged to contact their PQC or lead entity that implements AIM patient safety bundles in the state to better understand which bundles may be high priority in the implementation region.

ii. Please describe existing efforts, if any, to support hospital achievement of the "Birthing-Friendly" hospital designation. Include efforts spearheaded by state and local governments, PQCs, MCPs, and individual hospitals within the proposed TMaH Model implementation region or regions.

c. **Pillar 3 – Whole-Person Care Delivery**

i. Does the applicant require payors or providers to use a standardized HRSN screening tool? If so, please indicate which tool or tools are used and attach a copy of the tool or tools as an appendix to this application.

ii. Describe existing required screening and referral processes for perinatal beneficiaries with behavioral or mental health conditions or substance use disorders, if any. Summarize how these processes may be improved under this model.

iii. Does the applicant require the use of Z codes for health-related social needs? Please describe strategies the applicant has deployed that may increase the use of Z codes.

iv. Is patient home monitoring covered by the Medicaid State Plan? Please describe reimbursement policies, including any restrictions, and the reimbursement amount. The applicant should take care to highlight any policies specifically related to perinatal care. If home monitoring is not already covered, the applicant must state how home monitoring will be covered. Please detail the steps required to add home monitoring for perinatal conditions, including but not limited to gestational diabetes and hypertension, as a new Medicaid benefit in your state. Describe any obstacles, including legislative calendars if applicable, staff capacity, or others. In addition, the applicant should describe any programs in place that cover the cost of durable medical equipment and technology platforms, including broadband, used in connection with home monitoring.

v. A detailed summary of the applicant's current and planned health equity initiatives and activities for the Medicaid and CHIP populations generally, and specifically for those who are pregnant, birthing, or postpartum.

1) Include, if available, information on State Health Improvement Plans, and Community Health Needs Assessments or the equivalent in the chosen region. What is the plan or timeline, if any, for updating such plans or assessments?

2) Include a description of how the applicant has or plans to include the community in TMaH Model project design or implementation.

3) Include an overview of current language access assistance program(s). What is the plan or timeline, if any, for reviewing and/or updating such program(s)?

4) Describe existing activities aimed at reducing health disparities and identifying and addressing health-related social needs, including any state investments or policies that support collection of demographic and health-related social needs data, if any. Describe how receipt of TMaH Model funding or TA would enable enhancement of existing activities or addition of new activities.

6. **Optional Model Elements: Model Pillars (Optional Elements):** The applicant should provide detailed information about the status of the following optional TMaH Model elements in which it desires TA to implement. These are not required for participation, but the applicant may elect to receive support to implement these elements. **With the exception of extension of Medicaid coverage to 12 months postpartum, no optional elements may be added during TMaH Model Pre-Implementation or Implementation Periods.**

   In addition, please provide brief relevant background, context and program goals for selecting each element and how it may improve maternal and child health outcomes.

   a. Medicaid coverage of additional types of midwives
   b. Growth of the perinatal community health worker (CHW) workforce
   c. Creation of regional partnerships in rural areas
   d. Extension of Medicaid eligibility to 12 months postpartum
   e. Promotion of shared decision-making
   f. Expansion of group perinatal care
   g. Increased use of home visits, mobile clinics and telehealth
   h. Expansion of oral health care

7. **Sustainability Plan (required):** Describe how improvements in maternal health outcomes and reductions in disparities will be sustained beyond the model performance period after the Cooperative Agreement ends (see Section B Federal Award Information). Specifically, applicants should address how they will sustain funding and activities under the model.

8. **Stakeholder Recruitment Plans (required)**
   a. Payor Recruitment Plan – If the applicant is a managed care state, all Medicaid contracted payors within the model test area must participate. The applicant should summarize communications with MCPs to-date regarding participation, including how agreements with MCPs will be formalized (i.e., managed care contract, state directed payment for value-based payment models, etc.). The applicant should provide a timeline for finalizing formal agreements with payors.

The applicant should also describe what activities the MCPs have committed to undertake to recruit providers.

b. Provider Recruitment Plan – The applicant should state whether provider participation will be voluntary or mandatory in the test region. The applicant should summarize communications and outreach with providers to-date, if any, regarding their interest in and capacity to participate in the model and indicate the number and type of providers expected to serve beneficiaries under the model. The applicant should describe how additional provider partners will be recruited to the TMaH model and specify how each provider type would support the model's aims and objectives.

c. Community Based Organization (CBO) Recruitment Plan – The applicant should describe the nature and type of services CBOs would be expected to provide under the model. If known at the time of application, the applicant should list the CBOs interested in participating in the TMaH Model. The applicant should describe how it intends to recruit or obtain support from such relevant CBOs and specify how each CBO type would support the model's aims and objectives.

9. **Tribal Engagement (Program Priority - Optional) –** CMS may consider and give preference to applicants for partnering with at least one federally recognized Tribe to implement TMaH Model. Please describe any partnerships with a Tribe and the role of the Tribe. Please also provide a Tribal letter of support as an appendix.

10. **Safety Net Provider, Birth Center and Community-Based Organization Partnership (Program Priority - Optional)** CMS may consider and give preference to applicants that include (please list) safety net providers (see Appendix VII Glossary), including FQHCs, as well as birth centers, and CBOs, as TMaH Model partners. Please also provide letters of support as an appendix.

11. **Health Care Disparity (Program Priority - Optional) –**Please identify disparities in outcomes and indicate how participation in the model can help to reduce those health disparities. Applicants implementing the TMaH Model statewide must identify disparities in outcomes with respect to national averages. Applicants choosing to implement the model in a sub-state region must identify disparities in outcomes with respect to state averages.

D.3.2 BUDGET NARRATIVE (MAXIMUM 10 PAGES)

Applicants must supplement Form SF-424A with a Budget Narrative. The Budget Narrative includes a yearly breakdown of costs, for each line item outlined in the SF-424A, according to a 12-month period. Include a clear description of the proposed costs for each activity within the line item. See Table 9 below for examples of Cooperative Agreement funding uses.

The budget narrative must clearly define the proportion of the requested funding designated for each activity and justifies the applicant's readiness to receive funding. The budget must separate out funding administered directly by the applicant as the lead agency from funding sub-awarded

to other partners. Voluntary committed cost sharing or matching is not expected unless specifically stated otherwise in Section C.2 Cost Sharing or Matching.

Detailed justifications must be provided for each activity/cost proposed to be funded under this award along with full computations for budget estimates.

Also clearly link each activity to the goals/milestones of this NOFO and be consistent with model requirements. Indirect costs must be reasonable and are only reimbursable in accordance with HHS grants policy.

TABLE 9 EXAMPLES OF COOPERATIVE AGREEMENT FUNDING USE

Category	Eligible Activity
Recruitment and Partnerships	• Engage MCPs on the TMaH Model • Recruit TMaH Model providers • Convene PQCs, CBOs and other partners
Model Development	• Participate in discussions and activities related to advancing model elements • Complete draft SPA/waiver documents, as needed, and apply for federal waivers to implement TMaH Model elements as necessary and appropriate • Participate in discussions and provide feedback to CMS on development of the payment model • Design and implement any necessary claims processing procedures to support the value-based payment approach • Collect cost and quality data for monitoring and evaluation purposes and to meet model requirements • Complete quarterly reporting requirements
Health IT, Data, and Infrastructure	• Data sharing between payers, providers and CBOs, as appropriate and needed to support model operations • Data warehousing, extraction and management to support model operations • Data linkage and analytic activities to support model operations
Personnel	• Salaries for key personnel to support model implementation
Partner Providers	• In Model Year 3, Recipients will provide Partner Providers with a portion of Cooperative Agreement funding to complete required activities (see Section A.4.3.1 Provider Infrastructure Payments – Model Year 3)

For additional information and instructions for completing the SF-424A and Budget Narrative, please refer to Appendix I. Guidance for Preparing a Budget Request and Narrative.

D.3.3 APPENDICES

- Resumes and/or curriculum vitae (**required** for identified managers, Project Director, and all other Key Personnel identified at the time of application)
- Job Descriptions for key model personnel **(required -** may be provided in the project narrative or this appendix)
- Organization Chart **(required –** may be provided in the project narrative or this appendix)

- Letters of Support (Optional - from the applicant's governor or state legislators, hospitals, safety net providers, primary care providers, birth centers, federally recognized Tribes operating in the state, and/or community-based organizations or other)

D.3.4 Business assessment of applicant organization (maximum 12 pages)

CMS evaluates the risk posed by an applicant before they receive an award. This analysis of risk includes items such as financial stability, quality of management systems, internal controls and the ability to meet the management standards prescribed in 45 CFR Part 75.

An applicant must review, answer, and submit the business assessment questions outlined in Appendix III. Business Assessment of Applicant Organization.

D.3.5 Program Duplication Assessment (maximum 10 pages)

An applicant must submit a Program Duplication Assessment.

We will consider an applicant's understanding of program duplication risks as well as the thoroughness of its plan to avoid program duplication during our review of the application, including the applicant's proposed Budget.

The U.S. Government Accountability Office (GAO) defines program duplication as two or more agencies or programs engaged in the same activities or providing the same services to the same beneficiaries (2017 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits).

Responses to the questionnaire must provide CMS with sufficient information to prevent program and funding duplication related to the TMaH Model, including whether:

- Other programs funded by Medicaid, Title V agencies, or other federal, state or local programs will provide direct care coordination or case management services to the Model population; and
- Some or the entire model focus population, including Partner Providers, may also participate in a separate program, model, demonstration, or value-based payment model that would be similar to the TMaH Model delivery and payment model.

If a Recipient engages in program duplication, the Recipient must report the duplication to CMS within 30 days of discovery and must eliminate the program duplication. CMS provides this duplication background and the assessment to assist applicants in understanding program duplication risks. **Failure to complete the program duplication assessment will disqualify the applicant.** Evidence that the applicant is at serious risk of program duplication may result in disqualification.

Confirm Responsibility to Avoid Program Duplication

Applicant must submit a document which addresses the following:

1. Confirms that it will ensure award funds are not used to duplicate or supplant current federal, state, or local funding, or be used for the non-federal share of Medicaid payments:

   a. (sample question to consider): Is this expense paid for by another federal, state or local program (i.e., Medicaid, Medicare, Title V block grant funds, the local health department, or another innovation model)?
   b. (Sample question to consider): Is the activity a service already provided directly to an attributed beneficiary (e.g., under current Medicaid benefits)?
2. Please provide an explanation for how your Project Narrative accounts for any existing programs or resources that can be leveraged for the TMaH Model.
3. Please summarize your standard operating procedures and best practices for avoiding program duplication between the TMaH Model and any related federal, state and/or local initiatives. If available, please attach as an appendix to the application your standard operating procedure for preventing program duplication.
4. State if you expect to be involved in any value-based payment and/or delivery reform programs or demonstrations during the model implementation phase that are related to any TMaH Model element or that could impact the TMaH Model (calendar years 2025-2034).
5. Please provide a list and description of all value-based payment and/or delivery reform programs or demonstrations that you are currently involved in or plan to be involved in during the model that are related to any TMaH Model element or that could impact the TMaH Model (calendar years 2025-2034). For each program identified, please provide the following information:
   a. Name of the program
   b. Description of the program objectives and allowed expenses
   c. Payer(s) of the program services
   d. Amount of funding on an annual basis
   e. Expected start and end dates of the program (if applicable)
   f. Authority for the value-based payment model (if applicable)
   g. Whether beneficiaries who you propose to include in the TMaH Model population are eligible for services under the program
   h. What percentage of proposed TMaH Model enrollees would participate in both programs (if applicable)
   i. An explanation for the difference in the delivery and payment methodology between TMaH Model and the separate program or initiative, describing how payment under the TMaH Model and separate program or initiative would not result in duplicative services or funding.

Hypothetical scenarios with program duplication implications are included below to provide further clarity. These hypothetical scenarios are examples only. They are not an exhaustive description of all potential areas of program duplication.

Scenario 1: Staff Overlap and Program Duplication

The applicant intends to use Medicaid administrative funding *and* TMaH Model Cooperative Agreement funding to pay for the salary of a SMA staff person assigned to implement the new payment and service delivery models for TMaH Model. The staff person has other duties unrelated to TMaH Model. In this example, the Recipient must ensure the staff person properly accounts for his or her time and effort for separate tasks: implementation (model activity) and other duties as assigned (non-model activity). The Recipient must take care to avoid using TMaH Model Cooperative Agreement funding for non-model duties. The Recipient may *not* use TMaH Model Cooperative Agreement funds to cover the portion of a staff person's time spent fulfilling other duties as an employee of a SMA nor may the Recipient receive Medicaid reimbursement for the portion of time the staff member is working on model activities and is being reimbursed through Cooperative Agreement funds.

Scenario 2: Health Information Technology Enhancements

The applicant proposes to use TMaH Model Cooperative Agreement funding to enhance health information technology capacity to support delivery of home monitoring for diabetes and hypertension services to Medicaid enrollees. No other federal, state, or local agency or program funds these enhancements. The Recipient may use TMaH Model Cooperative Agreement funds to finance the infrastructure and policy development necessary to enable delivery of home monitoring services to the model population. The Recipient may not, however, use TMaH Model funds to cover the cost of home monitoring services.

Scenario 3: Patient Safety Improvements

A state submitting an application for the TMaH Model already partners with the state's PQC to help advance identified AIM patient safety bundles, including the safe reduction of primary cesarean birth, and proposes to expand this bundle to additional hospitals in the implementation region. The state must identify their ongoing collaboration with the PQC as an area of potential program duplication, because it will be able to leverage existing resources and expertise to extend the safe reduction of primary cesarean birth AIM patient safety bundle to additional hospitals in the implementation region. The state should account for these efficiencies in its budget request.

Consistent with the federal government's aim to avoid program duplication, we also prohibit the use of TMaH Model Cooperative Agreement funding to supplant funding for services or administrative expenses already provided by federal, state, or local agencies, programs, or other CMS models. Applicants are encouraged to propose the use of TMaH Model Cooperative Agreement funding to extend and strengthen the impact of past and current programs and activities, but Recipients must not use TMaH Model Cooperative Agreement funding to supplant or duplicate past, current, or projected future funding.

If the applicant is unclear about whether it would be permissible to use TMaH Model Cooperative Agreement funding for a specific activity, consider, at a minimum:

1. Is this expense fully paid for by another federal, state, or local program or grant (e.g., SAMHSA, HRSA, NIH, or another CMS model)?
2. Is this service already provided through a separate program, model, demonstration, or alternative payment model to a member of the TMaH Model's focus population of pregnant Medicaid and CHIP beneficiaries?

State or CHIP Agency/ Medicaid MCP:
If you answer yes to either of these questions, then you would not be allowed to use Cooperative Agreement funding to pay for this expense.

D.4 Unique Entity Identifier and System for Award Management (SAM)

Unless the applicant is an individual or Federal awarding agency that is excepted from those requirements under 2 CFR 25.110(b) or (c), or has an exception approved by the Federal awarding agency under 2 CFR 25.110(d)), each applicant is required to:

i. register in SAM.gov before submitting its application;

ii. provide a valid unique entity identifier in its application; and

iii. continue to maintain an active SAM registration with current information at all times during which it has an active Federal award or an application or plan under consideration by a Federal awarding agency.

The Federal awarding agency may not make a Federal award to an applicant until the applicant has complied with all applicable unique entity identifier and SAM requirements. If an applicant has not fully complied with the requirements by the time the Federal awarding agency is ready to make a Federal award, the Federal awarding agency may determine that the applicant is not qualified to receive a Federal award and use that determination as a basis for making a Federal award to another applicant.

D.5 Submission Dates and Times

All applications must be submitted electronically and be received through Grants.gov by the date and time below. Applications received after September 20, 2024, 11:59 PM, Eastern Time, may not be reviewed or considered for award.

Due Date for Applications
11:59 PM Eastern Time (Baltimore, MD)
September 20, 2024

D.6 Intergovernmental Review

Program is not subject to Executive Order 12372, "Intergovernmental Review of Federal Programs" (45 CFR 100). Please check box "C" on item 19 of the SF 424 (Application for Federal Assistance) as Executive Order 12372 does not apply to these Cooperative Agreements.

D.7 Cost Restrictions

Direct Costs

Funding under this NOFO can only be used for supportive functions necessary to build capacity and implement the TMaH payment model consistent with the applicant's approved budget and project plan. Cooperative Agreement funding cannot be used to duplicate or supplant other funding sources, including state Medicaid and CHIP coverage of care delivery services.

Indirect Costs

See Section F.2 Administrative and National Policy Requirements of this NOFO for more information on indirect costs.

The following activities/costs are not allowable unless an exception is specifically authorized by statute or stated otherwise in this NOFO:

- Model Year 4 upside-only performance payments to be paid by Recipient using the appropriate Medicaid authority and following CMS review processes. **Cooperative Agreement funding cannot be used for these payments.**
- Pre-award costs.
- Matching requirements to 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 (e.g., vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
- 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, etc.
- Matching requirements to satisfy local entities.
- Construction.
- Capital expenditures for improvements to land, buildings, or equipment which materially increase their value or useful life as a direct cost, except with the prior written approval of the Federal awarding agency.
- The cost of independent research and development, including their proportionate share of indirect costs (unallowable in accordance with 45 CFR 75.476).
- 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 in accordance with 45 CFR 75.450.
- Certain telecommunications and video surveillance equipment. See 2 CFR 200.216 to make sure this does not apply to any proposed equipment in your application.
- Meals unless in limited circumstances such as:
    - Subjects and patients under study;
    - Where specifically approved as part of the project or program activity (not grantee 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.

- To pay providers for services covered under Medicaid and/or CHIP, including services already covered under such programs or any newly covered services under this model.
- Costs of any Medicaid-covered service at any time during the Model, nor may they be used to supplant or duplicate existing resources that cover the costs of Medicaid-covered services or administrative expenses.
- Other services that are provided after, or because of, the TMaH Model. For example, transportation, travel, or construction expenses.

D.8 MANDATORY DISCLOSURE

Submission is required for all applicants, in writing, to the awarding agency and to the HHS Office of Inspector General (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:

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

AND

U.S. Department of Health and Human Services
Office of Inspector General
ATTN: Mandatory Grant Disclosures, Intake Coordinator
330 Independence Avenue, SW, Cohen Building
Room 5527
Washington, DC 20201

URL: https://oig.hhs.gov/fraud/report-fraud/index.asp

(Include "Mandatory Grant Disclosures" in subject line)

Fax: (202) 205-0604 (Include "Mandatory Grant Disclosures" in subject line) or

Email: MandatoryGranteeDisclosures@oig.hhs.gov

Materials should be scanned and emailed to the Grants Management Specialist assigned to this NOFO.

D.9 HHS FORM 690

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

Subrecipients that receive funding from Recipients (including contractors under grants) rather than directly from CMS, also are required to file an HHS 690. The applicant/recipient is

responsible for determining whether those organizations have the required Assurance on file and, if not, ensuring that it is filed with OCR.

E. Application Review Information

E.1 Criteria

Merit reviewers use the NOFO to evaluate each application. You should pay particular attention to Sections A.4 Program Requirements, D. Application and Submission Information, and E.1 Criteria.

The merit review panelists will assess and score applicants' responses with the criteria below, using a scale of 100 total base points.

- Incomplete, unclear, and confusing proposals will receive point reductions.
- Project Narratives with significant content deficiencies may receive a score of zero.
- Proposals that merely restate the content of the NOFO, without responding to the Program Requirements and Application Review Criteria, will receive a score of zero.
- Each part of the Project Narrative is weighted as indicated below.
- The scoring criteria breakdown is reflective of the total possible number of points available, but each item is scored on a range starting from zero. Points are awarded based on the quality of the applicant's response.
- You must document all source material. If any text, language, or materials are from another source, you must be clear if it is a quote and cite it. Also cite any sources if you use numbers, ideas, or other material that are not your own. If you do not follow this requirement, the reviewers will reduce their scores accordingly. They may choose to award no points at all.

Below are the review criteria for the information requested in D.3.1. Project Narrative and D.3.2 Budget Narrative. All elements of the Project Narrative and Budget Narrative are used to assess an applicant's ability to design and implement an intervention that aims to improve maternal health outcomes for Medicaid and CHIP beneficiaries residing in the proposed implementation region and produce cost savings to Medicaid.

Although not scored, the Program Duplication Assessment questions are required.

TABLE 10 APPLICATION CRITERIA

Section	Topics	Points	Scoring Criteria (Section D.3 Model Requirements)
Project Narrative (80 Points)			
1.	Maternal Health Policy Priorities	5	Per Section D.3.1(1) of this NOFO: Clearly articulate how participation in the TMaH Model and achievement of model elements (see

			Table 2 of NOFO) will advance and align with the state's maternal health policy priorities.
2.	Organization, Administration, and Capacity	7	Per Section D.3.1(2) of this NOFO: (5 Pts) **Description of the entity** that will perform the Cooperative Agreement activities under this funding opportunity, including: • Name of the Authorized Organizational Representative • Identification of individual(s) who will have management authority over the model (with resume or CV included in the Project Narrative or Appendix) • Identification of individual who will serve as the Project Director (primary liaison to CMS for the TMaH Model) and a resume or CV included in the Project Narrative or as an Appendix • Additional staff capacity (e.g., job descriptions including key personnel positions that may currently be vacant) • An organizational chart (included in Project Narrative or s an appendix) which clearly identifies the reporting relationships of key personnel assigned to oversee this Cooperative agreement • Description of the anticipated role of any subrecipients, contractors or partners that may be engaged to help implement the model (2 Pts) **Description of prior experience** through participation in CMS models and partnerships with federal Medicaid maternal health programs, or other state-led maternal health initiatives as well as prior efforts and known challenges to improving maternal care across different programmatic areas as detailed in D.3.1.(2).
3.	Payment Environment	5	Per Section D.3.1(3) of this NOFO: • Describe any statewide and maternal health-related value-based payment efforts that include Medicaid and/or CHIP

			beneficiaries • Please describe your state's commitment to implementing the TMaH payment model in the selected region, including (if relevant) how existing payment efforts will be phased out or incorporated into the TMaH payment model • Please describe all enabling factors and/or potential barriers to implementing or aligning with the TMaH payment approaches • Please indicate whether the TMaH Model will be implemented in a fee-for-service program, managed care program or both • Please provide existing language related to maternal health policies and priorities in procurement materials and contracts with each MCP in the proposed test area and, if applicable, in the sub-state comparison area
4.	Regional Plan	15	Per Section D.3.1(4) of this NOFO: (2.5 Pts) **Describe and justify the state or sub-state test and comparison regions,** including summary of health care delivery system in the region and, if proposing sub-state region, rationale for proposed sub-state region, as further detailed D.3.1.(4)(a) and D.3.1.(4)(c). (2.5 Pts) Provide evidence that **the number of Medicaid and CHIP beneficiaries** in the proposed model region will be no fewer than 1,000 per year, as further detailed in D.3.1.(4)(a). (2.5 Pts) Propose both a **test and comparison region per requirements** in Section F.6.1.2 Evaluation as noted D.3.1.(4)(b). (2.5 Pts) Provide a **list of counties or ZIP codes** where the model will be implemented, if the TMaH Model will be limited to a sub-state region as noted D.3.1.(4)(d). (2.5 Pts) Provide information on the hospitals, birth centers, HRSA-supported health centers

			(e.g., FQHCs), and other providers in the proposed model region as further detailed in D.3.1.(4)(e)(ii). (2.5 Pts) Provide information on the **health outcomes for Medicaid and CHIP beneficiaries**, if possible, in the proposed model region as further detailed in D.3.1.(4)(f).
5.	Model Pillars	30	Describe the current status of each required element, per D.3.1(5) of this NOFO, relative to the Pre-Implementation Period milestones in Table 3. For each element, describe the specific activities the Recipient will undertake to achieve the associated milestone. **a. (10 pts) Pillar 1- Access, Infrastructure and Workforce** i. Increase Access to Midwifery Workforce ii. Increase Access to Birth Centers iii. Cover Doula Services iv. Improve Data Infrastructure v. Develop Payment Model **b. (10 pts) Pillar 2 – Quality Improvement and Patient Safety** i. Support Implementation of AIM Patient Safety Bundles ii. Support Birthing-Friendly Hospital Designation **c. (10 pts) Pillar 3 – Whole-Person Care Delivery** i. Increase risk assessments, screenings, referrals and follow-up for perinatal depression, anxiety tobacco use, substance use disorder and HRSN ii. Increase home monitoring of Diabetes and Hypertension iii. Develop Health Equity Plan
6.	Sustainability Plan	9	Per D.3.1(7), Describe how improvements in maternal health outcomes and reductions in disparities will be sustained after the model performance period and Cooperative Agreement period of performance ends. Address how you will sustain funding and activities under the model.

7.	Stakeholder Recruitment Plans	9	Describe in detail how payors, providers and CBOs will be recruited to the TMaH Model, including agreement type and optional letters of support, if applicable, per Section D.3.1(8) in this NOFO.
Budget Narrative (20 points)			
8.	Budget Narrative	20	(10 Pts) Detailed budget, adhering to the format outline in Appendix I, Guidance for Preparing a Budget Request and Narrative, for the period of performance, per Section D.3.2 in this NOFO (10 Pts) Reasonableness of requested funding according to tasks proposed: ▪ (4 of 10 Pts) Funds requested are reasonable based on the total available funding and each activity is linked to the goals of this NOFO and consistent with the TMaH Model requirements. ▪ (3 of 10 Pts) Funds requested are reasonable to support personnel costs. If using a subrecipient to carry out the Required Core Functions or Optional Functions, then the applicant has described how the subrecipient will operate functions of the intervention. ▪ (3 of 10 Pts) Funds requested are reasonable based on proposed project goals.
Total Base Points			**100**

E.2 Merit Review and Selection Process

CMS will consider the geographic diversity, scale, program priorities (see Section D.3 Program Requirements and Expectation (9-11)), and quality of all applications when making final award determinations, as well as participation in other CMS models (specifically the States Advancing All-Payer Health Equity Approaches and Development, and Innovation in Behavioral Health models). While the selection of optional elements will not be scored, CMS will consider the applicant's overall needs, plan and approach for implementing TMaH.

The application itself is not a legally binding agreement and does not require any applicant or CMS to enter into a Cooperative Agreement. CMS will select Recipients at CMS's sole discretion unless statutorily prohibited. Such selection will not be subject to administrative or judicial review, per Section 1115A(d)(2)(B) of the Act.

Please refer to Appendix V. Merit Review and Selection Process for more information on the review and selection process.

E.3 Federal Awardee Performance Integrity Information System (FAPIIS)

In accordance with 45 CFR Part 75:

> i. CMS, prior to making a Federal award with a total amount of Federal share greater than the simplified acquisition threshold,[xii] is required to review and consider any information about the applicant that is in the designated integrity and performance system accessible through SAM (currently FAPIIS) (see 41 U.S.C. 2313).
>
> ii. An applicant, at its option, may review information in the designated integrity and performance systems accessible through SAM and comment on any information about itself that the HHS awarding agency previously entered and is currently in the designated integrity and performance system accessible through SAM.
>
> iii. CMS will consider any comments by the applicant, in addition to the other information in the designated integrity and performance system, in making a judgment about the applicant's integrity, business ethics, and record of performance under Federal awards when completing the review of risk posed by applicant as described in §75.205.

F. Federal Award Administration Information

F.1 Federal Award Notices

If successful, applicants will receive a Notice of Award (NoA) signed and dated by the CMS Grants Management Officer. The NoA is the legal document authorizing the Cooperative Agreement funding award and issued to the applicant as listed on the SF-424. The NoA is available to the applicant organization through the online grants management system used by CMS and recipient organizations, GrantSolutions. Any communication between CMS and applicant prior to issuance of the NoA is not an authorization to begin performance of a project.

If unsuccessful, CMS notifies the applicant electronically to the email address as listed on its SF-424, within 30 days of the award date of the program.

F.2 Administrative and National Policy Requirements

A. National/Public Policy Requirements

By signing the application, the authorized organizational official certifies that the organization will comply with applicable public policies. Each Recipient is responsible for establishing and

[xii] *Simplified acquisition threshold* means the dollar amount below which a non-Federal entity may purchase property or services using small purchase methods. Non-Federal entities adopt small purchase procedures to expedite the purchase of items costing less than the simplified acquisition threshold. The simplified acquisition threshold is set by the Federal Acquisition Regulation at 48 CFR Subpart 2.1 (Definitions) and in accordance with 41 U.S.C. 1908.

maintaining the necessary processes to monitor its compliance and that of its employees and, as appropriate, subrecipients and contractors under the award with these requirements. Recipients should consult the applicable Appropriations Law, Exhibit 3 of the HHS Grants Policy Statement, titled Public Policy Requirements, located in Section II, pages 3-6, as well as the Terms and Conditions for information on potentially applicable public policy requirements.

Recipients should review and comply with the reporting and review activities regarding accessibility requests outlined in Appendix IV, Accessibility Requirements.

B. Administrative Requirements

- All equipment, staff, and other budgeted resources and expenses must be used exclusively for the projects identified in the applicant's original application or agreed upon subsequently with CMS and may not be used for any prohibited uses.
- Consumers and other stakeholders must have meaningful input into the planning, implementation, and evaluation of the project.
- This award is subject to 45 CFR Part 75, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS awards, which implements 2 CFR Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards ("Uniform Guidance") effective December 26, 2014. See below for more information.

Uniform Administrative Requirements, Cost Principles, and Audit Requirements

Applicant and Recipients should take note of the following information found in 45 CFR Part 75:

Uniform Administrative Requirements

In accordance with 45 CFR §75.112, all award Recipients receiving federal funding from CMS must establish and comply with the **conflict-of-interest policy requirements** outlined by CMS (available for applicant upon request).

In accordance with 45 CFR §75.113, **Mandatory Disclosures**, the non-Federal entity or applicant for a Federal award must disclose, in a timely manner, in writing to the HHS awarding agency or pass-through entity all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Non-Federal entities that have received a Federal award including the term and condition outlined in Appendix XII to 45 CFR Part 75 are required to report certain civil, criminal, or administrative proceedings to SAM. Failure to make the required disclosures can result in the imposition of any of the remedies described in §75.371, including suspension or debarment. (See also 2 CFR Parts 180 and 376, and 31 U.S.C. 3321). For specific information on reporting such disclosures to CMS and HHS please see Section F.3 Terms and Conditions.

Cost Principles

CMS grant and Cooperative Agreement funding awards provide for reimbursement of actual, allowable costs incurred and are subject to the Federal cost principles. The cost principles establish standards for the allowability of costs, provide detailed guidance on the cost accounting treatment of costs as direct or indirect, and set forth allowability and allocability principles for selected items of cost. Applicability of a set of cost principles depends on the type of

organization. Recipients must comply with the cost principles set forth in HHS regulations at 45 CFR Part 75, Subpart E with the following exceptions: (1) hospitals must follow Appendix IX to part 75; and (2) commercial (for-profit) organizations are subject to the cost principles located at 48 CFR subpart 31.2. As provided in the cost principles in 48 CFR subpart 31.2, allowable travel costs may not exceed those established by the Federal Travel Regulation (FTR).

There is no universal rule for classifying certain costs as either direct or indirect (also known as Facilities & Administration (F&A) costs) under every accounting system. A cost may be direct with respect to some specific service or function, but indirect with respect to the Federal award or other final cost objective. Therefore, it is essential that each item of cost incurred for the same purpose is treated consistently in like circumstances either as a direct or F&A cost to avoid double-charging of Federal awards. Guidelines for determining direct and F&A costs charged to Federal awards are provided in 45 CFR §§75.412 to 75.419. Requirements for development and submission of indirect (F&A) cost rate proposals and cost allocation plans are contained in Appendices III-VII, and Appendix IX to Part 75.

Indirect Costs

CMS will reimburse indirect costs to Recipients under an award if (1) allowable under the governing statute, regulations, or HHS grants policy; (2) the Recipient requests indirect costs; and (3) the Recipient has a federally approved indirect cost rate agreement covering the grant supported activities and period of performance, or the non-federal entity has never received an indirect cost rate, except for those non-Federal entities described in Appendix VII(D)(1)(b) to 45 CFR part 75, and elects to charge a de minimis rate of 10 percent of Modified Total Direct Costs (MTDC).

If the applicant entity has a current negotiated indirect cost rate agreement (NICRA) and is requesting indirect costs, a copy of the current NICRA must be submitted with the application.

Commercial (For-Profit) Organizations: Indirect Costs are allowable under awards to for-profit organizations. The for-profit Recipient must have a federally approved indirect cost rate agreement covering the grant supported activities and period of performance. Indirect cost rates for for-profit entities are negotiated by DFAS in the Office of Acquisition Management and Policy, National Institutes of Health (if the preponderance of their federal awards are from HHS), or other Federal agency with cognizance for indirect cost rate negotiation. If there is no federally approved indirect cost rate for the specific period of performance and the for-profit Recipient has never received an indirect cost rate, then the non-federal entity may elect to charge a de minimis rate of 10 percent of MTDC.

Cost Allocation

In accordance with 45 CFR §75.416 and Appendix V to Part 75 – State/Local Government-wide Central Service Cost Allocation Plans, each state/local government will submit a plan to the HHS Cost Allocation Services for each year in which it claims central service costs under Federal awards. Guidelines and illustrations of central service cost allocation plans are provided in a brochure published by the HHS entitled “A Guide for State, Local and Indian Tribal Governments: Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government.” A copy of this brochure may be

obtained from the HHS Cost Allocation Services. A current, approved cost allocation plan must be provided to CMS if central service costs are claimed.

Public Assistance Cost Allocation Plans

Appendix VI to Part 75 – Public Assistance Cost Allocation Plans, provides that state public assistance agencies will develop, document and implement, and the Federal Government will review, negotiate, and approve, public assistance cost allocation plans in accordance with Subpart E of 45 CFR part 95. The plan will include all programs administered by the state public assistance agency. Where a letter of approval or disapproval is transmitted to a state public assistance agency in accordance with Subpart E, the letter will apply to all Federal agencies and programs. This Appendix (except for the requirement for certification) summarizes the provisions of Subpart E of 45 CFR part 95.

Audit Requirements

The audit requirements in 45 CFR Part 75, Subpart F, apply to each award Recipient fiscal year that begins on or after December 26, 2014. A non-Federal entity that expends $750,000 or more during the non-Federal entity's fiscal year in Federal awards must have a single or program-specific audit conducted for that year in accordance with the provisions of Subpart F, Audit Requirements.

Commercial Organizations (including for-profit hospitals) have two options regarding audits, as outlined in 45 CFR §75.501 (see also 45 CFR §75.216).

F.3 Terms and Conditions

All HHS awards must follow the requirements in 45 CFR part 75. This part establishes Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards to Recipients.

HHS Grants Policy Statement

All HHS awards must follow the policies in the HHS Grants Policy Statement (GPS). These policies are Terms and Conditions. The awarding agency lists any exceptions to the GPS in the Notice of Award.

Other Award Terms and Conditions

Standard Terms and Conditions

See the CMS Standard Terms and Conditions.

Non-Discrimination Legal Requirements for Recipients of Federal Financial Assistance

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

Material Noncompliance

CMS may terminate any award for material noncompliance. 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.

F.4 COOPERATIVE AGREEMENT TERMS AND CONDITIONS OF AWARD

This NOFO issues financial assistance through a Cooperative Agreement. Cooperative Agreements are used when CMS anticipates substantial CMS programmatic involvement with each Recipient during the performance of the activities. Under each Cooperative Agreement, CMS' purpose is to support and stimulate the Recipient's activities by involvement in, and otherwise working jointly with, the award Recipient in a partnership role. To facilitate appropriate involvement during the period of this Cooperative Agreement, CMS and the Recipient may be in contact at least once a month, and more frequently when appropriate.

There are specific roles for both the Recipient and CMS.

The Recipient must:

- Comply with the Terms and Conditions.
- Collaborate with CMS staff to implement and monitor the project.
- Submit quality measures as required by CMS.
- Submit all required performance assessments, evaluations, and financial reports as stated in the Terms and Conditions.
- Attend and take part in bi-weekly calls with the CMS Project Officer (PO) on progress and challenges. The meetings will include Recipient key personnel and the PO.
- Cooperate with CMS efforts to conduct independent, federally funded evaluations of TMaH Model, which may include completion of surveys and participation in interviews, site visits, and other activities that CMS determines necessary to conduct comprehensive evaluations. Evaluation results will be used to meet CMS' statutory requirement to analyze the quality of care furnished under the model, including measurement of patient-level outcomes and patient centeredness as well as changes in federal spending on Medicaid and CHIP beneficiaries by reason of the model. Failure to cooperate with evaluation efforts may result in termination from the model.
- Participate in targeted learning activities throughout the course of the TMaH Model, including the period after selection but prior to performance start date; responding to surveys or other mechanisms to assist CMS in identifying Recipient learning needs; and other items listed below in Section F.6.1.2 Programmatic Reporting.
- Cooperate with CMS-organized program audits and initial assessments of Recipient interventions, data collection, data reporting, and other model terms. Initial assessments, which occur for the first 36 months of the period of performance (Pre-Implementation Period), aim to assess whether Recipients have the operational structures and processes in place to support successful implementation and maintain compliance with certain

requirements of the TMaH Model. Conducting initial assessments during the early stages of model implementation allows for an open dialogue between CMS and Recipients as well as an opportunity for direct and timely feedback. Performance audits, starting in month 36 of the period of performance and continuing every two years through the end of the Implementation Period, occur after basic education and provision of assistance, and serve as a compliance-based assessment of Recipients' adherence to model policies.

CMS will:

- Have overall programmatic responsibility for monitoring the project's conduct and progress, including site visits.
- Collaborate with the Recipient and provide substantial project planning and implementation input.
- Develop and provide substantial technical implementation guidance on the payment model to be in place in Model Year 5.
- Provide substantial input in evaluation activities.
- Make recommendations on continuing the project.
- Review and approve communications and marketing materials and website content before launch and updates.
- Review and approve all key personnel.
- Maintain regular communication with the Recipient through at least monthly conference calls and providing TA and consultation.
- Review and provide feedback on all required performance assessment reports.
- Review and approve all required submitted data.
- Provide a structured approach to sharing, integrating, and actively applying improvement concepts, tactics, and lessons learned.

Substantial involvement pertains to programmatic involvement, **not** administrative oversight.

F.5 Health Information Technology (IT) Interoperability Language

Successful applicants under this NOFO agree that:

TABLE 11 INTEROPERABILITY AGREEMENTS

Where award funding involves:	Recipients and subrecipients are required to:

Implementing, acquiring, or upgrading health IT for activities by any funded entity	Use health IT that meets standards and implementation specifications adopted in 45 CFR part 170, Subpart B, if such standards and implementation specifications can support the activity.
Implementing, acquiring, or upgrading health IT for activities by eligible clinicians in ambulatory settings, or hospitals, eligible under Sections 4101, 4102, and 4201 of the HITECH Act	Use health IT certified under the ONC Health IT Certification Program, if certified technology can support the activity. Use multi-factor authentication and have basic cybersecurity incident response plans in place as recommended by the HHS Health Industry Cybersecurity Practices document.

If standards and implementation specifications adopted in 45 CFR part 170, Subpart B cannot support the activity, Recipients, and subrecipients are encouraged to utilize health IT that meets non-proprietary standards and implementation specifications developed by consensus-based standards development organizations. This may include standards identified in the ONC Interoperability Standards Advisory.

F.6 Reporting

F.6.1 Monitoring

CMS will monitor the performance of each Recipient pursuant to the Terms and Conditions of Award. Federal reporting requirements include:

- Programmatic Reporting
  - Progress Reports
  - Evaluation
- Federal Financial Report (FFR)
- Federal Funding Accountability and Transparency Act (FFATA)
- Responsibility and Qualification Reports
- Payment Management System (PMS)
- Audit Reporting (Federal Audit Clearing House)
- Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

F.6.1.2 Programmatic Reporting

Progress Reports

Each Recipient must comply fully with CMS and any CMS contractor's efforts to monitor and evaluate the TMaH Model. CMS will monitor programmatic progress through data collection and reporting to the CMS program team and the Office of Acquisition and Grants Management (OAGM). CMS' goal is to monitor and measure TMaH Model activities to optimize its usefulness for the CMS and Recipients. Recipients will closely track TMaH Model progress through CMS Project Officers, and through the support activities provided by CMS implementation contractors. In connection with monitoring, CMS will provide feedback to Recipients on Model implementation efforts to facilitate compliance with the Terms and Conditions.

CMS will monitor the performance of each award Recipient pursuant to the milestones in Table 3 and the Terms and Conditions. No later than Model Year 3, CMS will develop and share a list of milestones for Model Years 4-10, which CMS will develop after consultation with Recipients. The Model Year 4-10 milestones are expected to include benchmarks associated with: implementing the Model Year 4 and Model Year 5 payment approach (see section A.4.3 Medicaid Payment Model for additional details); continuing model elements, such as efforts in Model Years 1-3 to broaden and increase access to doulas and midwives; and continuing partnerships with PQCs to advance AIM patient safety protocols.

Beginning in the first quarter of Model Year 1, each Recipient will be required to participate in TMaH Model monitoring activities that include but are not limited to:

- Submission of quarterly progress reports
- Engage with appropriate state agencies and other partners as necessary to develop strategies and draft agreements to complete required data linkage and sharing
- Regular communications with a CMS Project Officer
- Regular learning system event attendance and participation
- Full participation in TA, per the approved TA plan

Evaluation

CMS will conduct a formal and concurrent evaluation of each Recipient's performance to assess model impact. The primary goal of the evaluation will be to assess the Pre-Implementation Period and Implementation Period as a whole and to determine whether targeted TA, payment reforms, expanded workforce, and implementation of evidence-based approaches improves experience and outcomes for pregnant and postpartum Medicaid members and their infants, decreases disparities among subpopulations, and optimizes spending. The evaluation will triangulate sources (e.g. comparing claims, EHR records where possible and birth certificate data) to ensure reliability of findings. CMS will investigate the effects of the model on state-level changes, regional changes and outcomes, and patient-level outcomes.

- **State level analysis** will include assessment of policy changes, implementation processes and state population-level changes in service uptake related to TMaH Model initiatives.

- **Regional analysis** will assess effects of model TA relative to a comparison area, population-level changes in service use, and population-level outcomes. The regional analysis will also investigate model implementation and the experiences of providers, program staff, and other stakeholders. If a state plans to offer intensive TA and expansion of all elements of TMaH Model statewide, one or more other states will be chosen for the regional comparison.

Patient-level analysis will assess whether TMaH Model interventions reduced rates and/or disparities in rates of low-risk cesarean sections, severe maternal morbidity, preterm births, and low-birth-weight infants, among other outcomes. Additionally, the evaluation will examine enrolled patients' experience of care. If a state plans to develop partnerships and offer intensive TA and expansion of all elements of TMaH Model statewide, the application should propose at least three other states for potential patient-level comparison. See below in this Section, Intervention Area, "Regional implementation with in-state comparison group," and "Full state implementation with out-of-state comparison group," to review provision of comparison groups for regional and statewide implementation. This evaluation is expected to cover the entirety of the model's performance period, from the initiation of the Pre-Implementation Period through the end of program operations. Recipients and their care delivery partners are solely responsible for any Institutional Review Board (IRB) procedures and approvals and any other permissions required by their institutions. CMS acknowledges that individuals cannot be compelled to participate in the evaluation.

CMS will evaluate each Recipient using the most rigorous evaluation design feasible, applying appropriate quantitative and qualitative mixed methods to examine program outcomes and the implementation processes that lead to successes or challenges. CMS will require Recipients to provide CMS and the evaluation contractor data that includes, but is not limited to:

- **Claims and encounter data.** The evaluation requires that Recipients provide timely and accurate Medicaid claims to the Transformed Medicaid Statistical Information System (T-MSIS). Prior to model start, each state applicant must be current on their submissions.
- **Medicaid and CHIP identifiers.** CMS must have access to claims and encounter data with identifiers sufficient to longitudinally track all Medicaid and CHIP beneficiaries in the intervention and comparison regions (areas not served by the model), including both pregnant individuals and infants.
- **Medicaid dyad linkage.** States must link birthing parent Medicaid records to infant Medicaid records and be able to submit these individually identifiable linked records to CMS, from the baseline period (no earlier than January 1, 2023) through the end of the model operations. All TMaH Model Recipients should plan to provide these data for all Medicaid-covered births in the state.
- **Vital records.** States are required to provide the evaluation with vital records (birth, death and fetal death certificates) for the entire state from the baseline period (no earlier than January 1, 2023) through the end of the model operations.

- Each recipient will have to begin the formal process of entering into a Memorandum of Understanding (MOU) among itself, the state department owning vital records (such as a state department of health), and CMS.
- If state policies cannot allow transmissions of vital records data to CMS, applicants should propose alternative means of providing individual-level identifiable data encompassing exact birthweight, estimated gestational age in weeks plus days, elements for determining NTSV cesarean rates, fetal death for which the state would require a fetal death certificate, maternal death from pregnancy onset through the postpartum year, and infant death (birth through the first year).

- **Linked Medicaid Dyads and Vital Records.** States are required to link the Medicaid dyads to the appropriate vital record, from the baseline period (no earlier than January 1, 2023), and then annually, through the end of the model operations for the entire state. TA will be provided if needed to establish these linkages.
- **Electronic Health Record Data.** The evaluation may need practices or health systems to report data elements from EHRs that are not available from or reliable in other sources (e.g. results of health screenings) for all model enrolled beneficiaries, and when possible, for comparison regions. TA will be provided if needed to aid in such reporting.
- **Patient Level Screenings and Measures not available in other sources.** Screening and measures will include health related social needs screenings (HRSN), and may include results of behavioral health screenings, home monitoring data, a patient-reported experience measure (PREM), and other screenings and measures as needed for all enrolled patients, and when possible, for comparison regions.
- **Recipient and site-level health, utilization and referral data that is not captured in sources listed above.** This may include any information related to care in the prenatal and postpartum period for the enrolled pregnant person and their infants (up to 1 year post birth-given continuous federal Medicaid coverage). Required data may include, but are not limited to, referrals, patient follow-up on recommended services, interactions with related agencies such as social services, or other data deemed necessary.
- **Program documentation.** Documents may include applications for State Plan Amendments (SPAs) or waivers, TA and training materials, recruitment and educational materials, and other documents developed or used by Recipients for TMaH Model implementation.
- **Qualitative and additional survey data.** In budget **year one**, beginning the second quarter, and every quarter thereafter for the duration of the model performance period, Recipients and their program partners will assist the CMS model evaluation contractor with the acquisition of qualitative data. Qualitative data will include patient and staff experience, implementation processes, data collection and linkage, value-based payment development and implementation, and other emergent topics. Individual Medicaid patients enrolled in the model are not mandated to opt into participation in any specific qualitative data gathering activity. However, Recipients are required to facilitate patient participation in qualitative data

collection activities. Data collection activities that may require Recipient cooperation/participation include but are not limited to:

- arranging and granting interviews;
- assisting in recruiting for focus groups and individual interviews with model-associated staff and patients;
- allowing observations of any model-funded activities and care delivery settings;
- providing documents such as patient education and staff training materials;
- facilitating surveys of staff and/or patients; and
- any other necessary activities.

Value-based payment related information may include interviews with MCO and state personnel associated with implementation, as well as care delivery staff experiencing value-based payment implementation.

The evaluation assesses administrative data (e.g. Medicaid claims, vital records, linkages) on an annual basis. Evaluation site visits are no more frequent than annually. Other data (e.g. EHR, screenings, site level) may need to be provided more frequently in accordance with overall program needs such as monitoring.

Intervention Area

States may operate regionally or statewide. If a state chooses statewide implementation, they should plan to offer TA, expansion of all TMaH Model services, and the value-based payment model across their entire state and should note that all data needed to match comparison populations may not be available from other states.

- **Regional implementation with in-state comparison group.**
  States may choose a region that shows overall poor birth outcomes or high levels of disparities in outcomes among subpopulations. The region can comprise counties or ZIP codes and should consider overlapping MCO coverage in the region (if relevant), mirroring the MCO's catchment area to the extent possible. The region does not need to be contiguous as long as an appropriate comparison region can be identified (also does not have to be contiguous) and the state has the resources to implement the entire model simultaneously across the entire chosen region. States choosing regional implementation should propose a comparison region in their application that is similar in demographic composition, resource availability, and population size and density and where they expect to have little or no service overlap. Having a within-state comparison group allows the evaluation to control for the individual state's laws, policies and contexts over the course of the model for both the regional analysis and the patient-level impacts analysis. See exhibits below for examples of comparison areas in a separate CMS model. Exhibit 1 shows the intervention and comparison groups for Connecticut's Integrated Care for Kids program, Embrace New Haven. The intervention focuses on an urban area comprised of ZIP Codes in New Haven and the comparison area is comprised of ZIP Codes in Bridgeport. Exhibit 2 shows intervention and

comparison groups for New Jersey's Integrated Care for Kids program. New Jersey's intervention covers two counties with two similar counties as comparators.

FIGURE 3 MAP OF EMBRACE NEW HAVEN'S INCK MODEL AND COMPARISON REGIONS

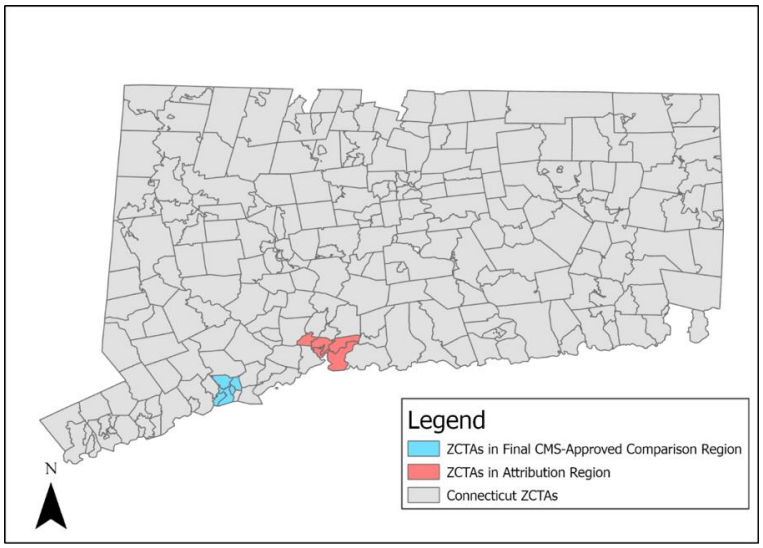
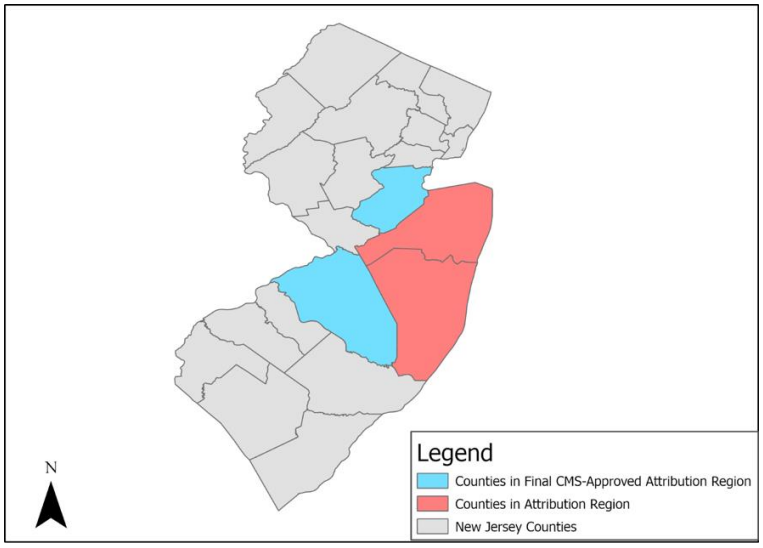


FIGURE 4 MAP OF NJ INCK ATTRIBUTION AND COMPARISON REGIONS



- **Full state implementation with out-of-state comparison group.**

  In their application, states choosing to implement across their entire state should explain how they will implement all elements of the model across the entire state in concert. States choosing statewide implementation should propose at least three other states that they believe are comparable in demographic composition, resource availability, population size and density, birth outcomes and disparities, and Medicaid policy.

F.6.1.3 Financial Reports

CMS Recipients must submit Federal Financial Reports (FFRs) via the Payment Management System (PMS).

Semi-Annual, Annual, and Final Expenditure Reporting

Recipients are required to record their expenses in real-time as well as submit semi-annual or annual expenditure FFRs.

You must report at least annually via the Payment Management System. Frequency of required expenditure reporting, whether semi-annually or annually, is stipulated in the Model Terms and Conditions. Instructions on how to complete the FFR can be found (after logging on) here.

F.6.1.4 Federal Funding Accountability and Transparency Act (FFATA) Reporting Requirements

Recipients are required to report certain information about themselves and their first-tier sub-recipients for awards. A specific term is included on your NoA. If your organization is a Recipient of grants or Cooperative Agreements, you must report on subawards of $30,000 or greater. There are additional reporting requirements if:

- 80% or more of your prior year annual gross revenues are from federal awards;
- $25 million or more in annual gross revenues are from federal awards; or
- The public does not have access to compensation information filed under Securities and Exchange Commission (SEC) and IRS requirements

Additional Guidance on FFATA

- Prime recipients report their own executive compensation if they meet all the criteria, as part of their profile at System for Award Management (SAM)
- Prime recipients report subaward information at the FFATA Subaward Reporting System (FSRS)
- 2 Code of Federal Regulations (CFR) 25

F.6.1.5. Responsibility and Qualification Reporting

Recipients that have active federal contract, grant, or Cooperative Agreement funding awards with a cumulative value greater than $10,000,000 at any time during the period of performance are **required** to disclose semi-annual information about criminal, civil, and administrative proceedings that reached final disposition within the most recent five-year period and that were connected with the award or performance of an award. Recipients must also make semi-annual disclosures regarding such proceedings and/or affirm that there is no new information to provide. This information will be made publicly available in **Responsibility and Qualification** records (formerly Federal Awardee Performance and Integrity Information System) on SAM.gov.

Additional Guidance

- Responsibility/Qualification Information
- Federal Awarding Agency Review of Risk Posed by Applicants, 2 CFR 200.205

F.6.1.6 Audit Report Requirements

Recipients must comply with audit requirements outlined in HHS regulation 45 CFR Part 75 (implementing 2 CFR Part 200). See Subpart F – Audit Requirements.

F.6.1.7 Payment Management System Reporting Requirements

Once CMS issues an award, 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.

The PMS funds request process enables Recipients to request funds using a Personal Computer with an Internet connection. The funds are delivered to the Recipient via Electronic Funds Transfer (EFT). If you are a new Recipient, please go to PMS Access Procedures to find information to register in PMS. If you need further help with that process, please contact the One-DHHS Help Desk via email at pmssupport@psc.gov or call (877) 614-5533 for assistance.

F.6.1.8 Government-wide Suspension and Debarment Reporting Requirements

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification.

a. You certify on behalf of the applicant organization, by submission of your proposal, that neither you nor your principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.

b. Failure to make required disclosures can result in any of the remedies described in 45 CFR § 75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. § 3354).

c. If you are unable to attest to the statements in this certification, you must include an explanation and insert in “Other Relevant Documents”.

G. CMS Contacts

Applicants should refer to the sources listed below for application questions including administrative, budgetary, or program requirements. Please reference "NOFO Inquiry" in the email subject line.

G.1 Programmatic Questions

For Programmatic questions about this funding opportunity, please contact:

tmahmodel@cms.hhs.gov

G.2 Administrative/Budget Questions

For administrative or budget questions about this funding opportunity, please contact:

tmahmodel@cms.hhs.gov.

H. Other Information

Publication of this NOFO does not oblige CMS to award any specific project or to obligate any available funds. CMS may cancel or withdraw this NOFO at any time.

Award decisions are discretionary and are not subject to appeal to any CMS or HHS official or board.

General information about the Model is here.

APPENDIX I. GUIDANCE FOR PREPARING A BUDGET REQUEST AND NARRATIVE

All applications must include a detailed budget and narrative that explains the federal and the non-federal expenditures broken out by the object class cost categories listed on SF-424A − Section B (Budget Category) for non-construction awards.

- You must request funding only for activities that will support this specific Notice of Funding Opportunity.
- The budget and narrative must be consistent with and support the Project Narrative. The proposed costs must be reasonable, allowable, allocable, and necessary for the supported activity.
- Both the Standard Form SF-424A and the Budget Narrative must include a yearly breakdown of costs for the entire period of performance.
- Refer to the program specific Funding Restrictions and Limitations and Standard Funding Restrictions, as well as to 45 CFR Part 75 (for applicable administrative requirements and cost principles).

Please review the directions below to ensure both documents are accurately completed and consistent with application requirements.

Cost Sharing

Voluntary committed cost sharing or matching is not expected unless specifically stated otherwise in Section C.2 Cost Sharing or Matching of the NOFO. Inclusion of voluntary committed cost sharing requires CMS to monitor the Recipient's compliance with non-federal cost sharing. Monitoring includes CMS reviewing the non-federal expenditures on the FFR, SF-425.

Standard Form SF-424A

All applicants must submit an SF-424A. **Since the total Period of Performance is 10 budget years (10 budget periods), then the Applicant must submit two, additional SF-424A Forms (for an overall total of three (3) SF-424A Forms).**

- **(Form 1) SF-424A Form – Costs for Years 1-4**
- **(Form 2) SF-424A Form – Costs for Years 5-8**
- **(Form 3) SF-424A Form – Costs for Years 9-10**

Blank SF-424A forms (Budget Information for Non-Construction Programs) can be found at Grants.gov. **The total aggregate federal costs for all three SF-424A forms reflecting budget years 1-10 (i.e., combining the total costs from column 5 of each SF-424A form) should be consistent with the total Federal costs requested on the SF-424, Application for Federal Assistance (field 18a of SF-424).**

Review the general instructions provided for form SF-424A as well as the instructions outlined below.

- **Note:** The directions in the Notice of Funding Opportunity (NOFO) may differ from those provided by Grants.gov. Please follow the instructions included in this NOFO when completing the SF-424A.
- **Note:** The total requested on the SF-424 (Application for Federal Assistance) reflects the overall total requested on the SF-424A (Budget Information – Non-Construction) for the entire period of performance.

Section A – Budget Summary

- Grant Program Function or Activity (column a)
  - Enter "Name of Notice of Funding Opportunity" in row 1.
- New or Revised Budget, Federal (column e)
  - Enter the Total Federal Budget Requested for the project period in rows 1 and 5.
- New or Revised Budget, Non-Federal (column f)
  - Enter Total Amount of any Non-Federal Funds Contributed (if applicable) in rows 1 and 5.
- New or Revised Budget, Total (column g)
  - Enter Total Budget Proposed in rows 1 and 5, reflecting the sum of the amount for the Federal and Non-Federal Totals.

Section B – Budget Categories

- Enter the total costs requested for each Object Class Category (Section B, number 6) for each year of the period of performance.

- **First SF-424A Form**

  - Column (1) = Enter Year 1 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges are reflected in row j. The total for direct and indirect charges for all year 1 line items is entered in column 1, row k (sum of row i and j).
  - Column (2) = Enter Year 2 estimated costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges are reflected in row j. The total for direct and indirect charges for all year 2 line items is entered in column 2, row k (sum of row i and j).
  - Column (3) = Enter Year 3 estimated costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges are reflected in row j. The total for direct and indirect charges for all year 3 line items are entered in column 3, row k (sum of row i and j).
  - Column (4) = Enter Year 4 estimated costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges are reflected in row j. The total for direct and indirect charges for all year 4 line items are entered in column 4, row k (sum of row i and j).
  - Column (5) = Enter total costs for years 1-4 for each line item (rows a-h), direct total costs (row i), and indirect costs (row j). The total costs for all line items are entered in row k (sum of row i and j). The total in column 5, row k should match

the total provided in Section A – Budget Summary, New or Revised Budget, column g, row 5.

- **Second SF-424A Form**
  - Column (1) = Enter Year 5 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges are reflected in row j. The total for direct and indirect charges for all year 5 line items is entered in column 1, row k (sum of row i and j).
  - Column (2) = Enter Year 6 estimated costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges are reflected in row j. The total for direct and indirect charges for all year 6 line items is entered in column 2, row k (sum of row i and j).
  - Column (3) = Enter Year 7 estimated costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges are reflected in row j. The total for direct and indirect charges for all year 7 line items are entered in column 3, row k (sum of row i and j).
  - Column (4) = Enter Year 8 estimated costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges are reflected in row j. The total for direct and indirect charges for all year 8 items are entered in column 4, row k (sum of row i and j).
  - Column (5) = Enter total costs for years 5-8 for each line item (rows a-h), direct total costs (row i), and indirect costs (row j). The total costs for all line items are entered in row k (sum of row i and j). The total in column 5, row k should match the total provided in Section A – Budget Summary, New or Revised Budget, column g, row 5.
- **Third SF-424A Form**
  - Column (1) = Enter Year 9 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges are reflected in row j. The total for direct and indirect charges for all year 9 line items is entered in column 1, row k (sum of row i and j).
  - Column (2) = Enter Year 10 estimated costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges are reflected in row j. The total for direct and indirect charges for all year 10 line items is entered in column 2, row k (sum of row i and j).
  - Column (3) = N/A ($0)
  - Column (4) = N/A ($0)
  - Column (5) = Enter total costs for years 9-10 for each line item (rows a-h), direct total costs (row i), and indirect costs (row j). The total costs for all line items are entered in row k (sum of row i and j). The total in column 5, row k should match the total provided in Section A – Budget Summary, New or Revised Budget, column g, row 5.

Budget Narrative – Sample Narrative and Instructions

You must complete a Budget Narrative and upload it to the Budget Narrative Attachment Form in the application kit. Only request funding for activities not already funded/supported by other funding sources. In the budget request, applicant distinguishes between activities funded under this application and activities funded with other sources. Other funding sources include other HHS grant programs, and other federal funding sources as applicable. Insufficient budget detail and justification may negatively impact the review of the application.

A sample Budget Narrative is included below.

A. (Personnel) Salaries and Wages

For each requested position, provide the following information:

- title of position
- name of staff member occupying the position, if available
- annual salary
- percentage of time budgeted for this program (FTE or level of effort)
- total months of salary budgeted
- total salary requested
- justification and description of each role and the scope of responsibility for each position, relating it to the accomplishment of program objectives. These individuals must be employees of the applicant organization.

Note: The Consolidated Appropriations Act restricts the amount of direct salary to Executive Level II of the Federal Executive Pay Scale. This salary cap applies to direct salaries and to those salaries covered under indirect costs, also known as facilities and administrative (F & A).

Sample Budget

TABLE 12 SAMPLE BUDGET PERSONNEL PART 1

Personnel Total	*$_____*
Grant	*$_____*
*Recipient Share**	*$_____*

*Cost sharing only.

TABLE 13 SAMPLE BUDGET PERSONNEL PART 2

Position Title	**Name (if known)**	**Annual**	**Time**	**Months**	**Amount Requested**
Project Director	Susan Taylor	$45,000	100%	12 months	$45,000
Finance Administrator	John Johnson	$28,500	50%	12 months	$14,250
Outreach Supervisor	Vacant	$27,000	100%	12 months	$27,000
Total:					$86,250

Sample Justification

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

Job Description: Project Director - (Name)

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

B. Fringe Benefits

Fringe benefits are usually applicable to direct salaries and wages. Provide information on the rate of fringe benefits used and the basis for their calculation (reference NICRA if applicable). If a fringe benefit rate is not used, itemize how the fringe benefit amount is computed. This information must be provided for each position (unless the rates for all positions are identical).

Sample Budget

TABLE 14 SAMPLE BUDGET FRINGE BENEFITS PART 1

Fringe Total $_____
Grant $_____
Recipient Share $_____*

*Cost sharing only.

TABLE 15 SAMPLE BUDGET FRINGE BENEFITS PART 2

Fringe Benefit	**Rate**	**Salary Requested**	**Amount Requested**
FICA	7.65%	$45,000	$3443
Worker's Compensation	2.5%	$14,250	$356
Insurance	Flat rate - $2,000 (100% FTE for 12 months)	$2,000	$2,000
Retirement	5%	$27,000	$1,350
Total			$7,149

C. Travel

Dollars requested in the travel category are for **applicant staff travel only**. Travel for consultants is in the consultant category. Allowable travel for other participants, advisory

committees, review panel, etc. is itemized in the same way specified below and placed in the **"Other"** category. Travel incurred through a contract is in the contractual category.

Provide a narrative describing the travel staff members will perform. This narrative includes a justification of why this travel is necessary and how it will enable the applicant to complete program requirements included in the Notice of Funding Opportunity. List where travel will be undertaken, number of trips planned, who will be making the trip, and approximate dates. If mileage is to be paid, provide the number of miles and the cost per mile. The mileage rate cannot exceed the rate set by the General Services Administration (GSA). If travel is by air, provide the estimated cost of airfare. The lowest available commercial airfares for coach or equivalent accommodations is used. If per diem/lodging is to be paid, indicate the number of days and amount of daily per diem as well as the number of nights and estimated cost of lodging. Costs for per diem/lodging cannot exceed the rates set by GSA. Include the cost of ground transportation when applicable. Please refer to the GSA website .***Sample Budget***

TABLE 16 SAMPLE BUDGET TRAVEL PART 1

Travel Total	*$_____*
Grant	*$_____*
*Recipient Share**	*$_____*

*Cost sharing only.

TABLE 17 SAMPLE BUDGET TRAVEL PART 2

Purpose of Travel	**Location**	**Item**	**Rate**	**Cost**
Site Visits	Neighboring areas of XXX	Mileage	$0. 655x 49 miles (use mileage rate in effect at time of mileage incurrence) x 25 trips	$802
Training (ABC)	Chicago, IL	Airfare	$200/flight x 2 persons	$400
		Luggage Fees	$50/flight x 2 persons	$100
		Hotel	$140/night x 2 persons x 3 nights	$840
		Per Diem (meals)	$49/day x 2 persons x 4 days	$392
		Transportation (to and from airport)	$50/shuttle x 2 persons x 2 shuttles	$200
		Transportation (to and from hotel)	$25/shuttle x 2 persons x 2 shuttles	$100
				$2,834

Sample Justification

The Project Coordinator and the Outreach Supervisor will travel to (location) to attend a

conference on the following topic XXXX held once a year in Chicago, IL. Attending this conference is directly linked to project goals/objectives and is a necessity because XXXX. The information and tools we will gather from attending this conference will help us to accomplish project objectives by XXXX. A sample itinerary is provided upon request. The Project Coordinator will also make an estimated 25 trips to birth center sites to monitor program implementation (# of birth centers, # of trips per site). We are still identifying all birth center sites, and have identified an average mileage total for each site. This travel is necessary to ensure birth center sites are consistently and systematically collecting birth center data and submitting by deadlines provided. On-site monitoring will enable us to address concerns. This travel also furthers our efforts to accomplish specific project goals for the following reasons _____.

D. Equipment

Equipment is tangible nonexpendable personal property, including exempt property, charged directly to the award having a useful life of more than one year and an acquisition cost of $5,000 or more per unit. However, consistent with Recipient policy, lower limits may be established.

Note: Technology items such as computers that do not meet the $5,000 per unit threshold or an alternative lower limit set by Recipient policy that may therefore be classified as **supplies**, must still be individually tagged and recorded in an equipment/technology database. This database should include any information necessary to properly identify and locate the item, for example; serial # and physical location of equipment (e.g. laptops, tablets, etc.). Provide justification for the use of each equipment item and relate it to specific program objectives. List maintenance or rental fees for equipment in the "Other" category. Ensure that all IT equipment is uniquely identified. Show the unit cost of each item, number needed, and total amount.

Sample Budget

TABLE 18 SAMPLE BUDGET EQUIPMENT PART 1

Equipment Total	*$_____*
Grant	*$_____*
*Recipient Share**	*$_____*

*Cost sharing only.

TABLE 19 SAMPLE BUDGET EQUIPMENT PART 2

Item(s)	**Rate**	**Cost**
All-in-one Printer, Copier, and Scanner (large scale)	1 @ $5,800	$5,800
X-Ray Machine	1 @ $8,000	$8,000
Total:		$13,800

Sample Justification

Provide complete justification for all requested equipment, including a description of how the program utilizes the equipment. For equipment and tools shared amongst programs, please cost allocate as appropriate. Applicant should provide a list of hardware, software and IT equipment

that will be required to complete this effort. Additionally, they should provide a list of non-IT equipment that will be required to complete this effort.

E. Supplies

Supplies includes all tangible personal property with an acquisition cost of less than $5,000 per unit or an alternative lower limit set by Recipient policy. Individually list each item requested. Show the unit cost of each item, number needed, and total amount. Provide justification for each item and relate it to specific program objectives. Classify technology items such as computers that do not meet the $5,000 per unit threshold or an alternative lower limit set by Recipient policy as **supplies** and individually tag and record in an equipment/technology database. If appropriate, General Office Supplies may be shown by an estimated amount per month times the number of months in the budget category.

Sample Budget

TABLE 20 SAMPLE BUDGET SUPPLIES PART 1

Supplies Total	*$_____*
Grant	*$_____*
*Recipient Share**	*$_____*

*Cost sharing only.

TABLE 21 SAMPLE BUDGET SUPPLIES PART 2

Item(s)	**Rate**	**Cost**
Laptop Computer	2 @ $1,000	$2,000
Printer	1 @ $200	$200
General office supplies	12 months x $24/mo x 10 staff	$2,880
Educational pamphlets	3,000 copies @ $1 each	$3,000
Educational videos	10 copies @ $150 each	$1,500
Total:		$9,580

Sample Justification

General office supplies will be used by staff members to carry out daily activities of the program. The project coordinator will be a new position and will require a laptop computer and printer to complete required activities under this Notice of Funding Opportunity. The price of the laptop computer and printer is consistent with those purchased for other employees of the organization and is based upon a recently acquired invoice (which can be provided upon request). The pricing of the selected computer is necessary because it includes the following tools XXXX (e.g. firewall, etc.). The education pamphlets and videos will be purchased from XXX and used to illustrate and promote safe and healthy activities. Usage of these pamphlets and videos will enable us to address components one and two of our draft proposal. Word Processing Software will be used to document program activities, process progress reports, etc.

F. Consultant/Subrecipient/Contractual Costs

A complete description and cost breakdown, as outlined below, is provided for each consultant, subrecipient or contract.

REQUIRED REPORTING INFORMATION FOR CONSULTANT HIRING

This category is appropriate when hiring an individual who gives professional advice or provides services (e.g. training, expert consultant, etc.) for a fee and who is not an employee of the Recipient organization. Submit the following required information for consultants:

1. Name of Consultant: Identify the name of the consultant and describe the person's qualifications.
2. Organizational Affiliation: Identify the organizational affiliation of the consultant, if applicable.
3. Nature of Services to be Rendered: Describe in outcome terms the consultation to be provided including the specific tasks to be completed and specific deliverables.
4. Relevance of Service to the Project: Describe how the consultant services relate to the accomplishment of specific program objectives.
5. Number of Days of Consultation: Specify the total number of days of consultation.
6. Expected Rate of Compensation: Specify the rate of compensation for the consultant (e.g., rate per hour, rate per day). Include a budget showing other costs such as travel, per diem, and supplies.
7. Justification of expected compensation rates: Provide a justification for the rate, including examples of typical market rates for this service in your area.
8. Method of Accountability: Describe how the applicant monitors progress and performance of the consultant. Identify who is responsible for supervising the consultant agreement.

REQUIRED REPORTING INFORMATION FOR SUBRECIPIENT APPROVAL

The costs of project activities to be undertaken by a subrecipient is included in this category. Please use formats from "Sample Budget" and "Sample Justification" above. For more information on subrecipient and contractual relationships, please refer to HHS regulation 45 CFR 75.351 *Subrecipient and Contractor Determinations* and 75.352 *Requirements for pass-through entities*.

In Model Year 3, Recipients are required to disperse a portion of Cooperative Agreement funding to partner providers for activities related to "Provider Infrastructure Payments" as described and per the requirements specified in Section A.4.3.1.

REQUIRED REPORTING INFORMATION FOR CONTRACT APPROVAL

All Recipients must submit to CMS the following required information for establishing a contract to perform project activities.

1. Name of Contractor: Who is the contractor? Identify the name of the proposed contractor and indicate whether the contract is with an institution or organization.

2. Method of Selection: How was the contractor selected? State whether the contract is sole source or competitive bid. If an organization is the sole source for the contract, include an explanation as to why this institution is the only one able to perform contract services.
3. Period of Performance: How long is the contract period? Specify the beginning and ending dates of the contract.
4. Scope of Work: What will the contractor do? Describe in outcome terms, the specific services/tasks performed by the contractor as related to the accomplishment of program objectives. Clearly define the deliverables.
5. Method of Accountability: Describe the monitoring plan of the progress and performance of the contractor during and on close of the contract period. Identify who will be responsible for supervising the contract.
6. Itemized Budget and Justification: Provide an itemized budget with appropriate justification. If applicable, include any indirect cost paid under the contract and the indirect cost rate used.

G. Construction (not applicable)

H. Other

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

Sample Budget

TABLE 22 SAMPLE BUDGET CONSTRUCTION PART 1

Other Total	*$_____*
Grant	*$_____*
*Recipient Share**	*$_____*

*Cost sharing only.

TABLE 23 SAMPLE BUDGET CONSTRUCTION PART 2

Item(s)	**Rate**	**Cost**
Telephone	$45 per month x 3 employees x 12 months	$1,620
Postage	$250 per quarter x 4 quarters	$1,000
Printing	$0.50 x 3,000 copies	$1,500
Equipment Rental specify item	$1,000 per day for 3 days	$3,000
Internet Provider Service	$20 per month x 3 employees x 12 months	$720
Word Processing Software (specify type)	1 @ $400	$400
Total:		$8,240

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

additional justification. For printing costs, identify the types and number of copies of documents to be printed (e.g., procedure manuals, annual reports, materials for media campaign).]

Sample Justification
We are requesting costs to accommodate telephone and internet costs for the 3 new hires that will be working on this project in the new space designated. We are also requesting printing and postage costs to support producing fliers to disseminate in the community and brochures to educate participants enrolled in the program. The word processing software will be used to help us track data and compile reports. To track and compile the data, we will need to rent _____. Without this equipment, we will not be able to produce this information in an accurate and timely manner.

I. Total Direct Costs

$_____

Show total direct costs by listing totals of each category.

J. Indirect Costs

$_____

To claim indirect costs, the applicant organization must have a current approved negotiated indirect cost rate agreement (NICRA) established with the Cognizant Federal agency unless the organization has never established one (see 45 CFR §75.414 for more information). If a rate has been issued, a copy of the most recent indirect cost rate agreement must be provided with the application.

Sample Budget

The rate is ___% and is computed on the following direct cost base of $_____.

Personnel $_____
Fringe $_____
Travel $_____
Supplies $_____
Other $_____
Total $ x ____% = Total Indirect Costs

If the applicant organization has never received an indirect cost rate, except for those non-Federal entities described in Appendix VII(D)(1)(b) to 45 CFR part 75, the applicant may elect to charge a de minimis rate of 10 percent of modified total direct costs (MTDC). If the applicant has never received an indirect cost rate and wants to exceed the de minimis rate, then costs normally identified as indirect costs (overhead costs) can be budgeted and identified as direct

costs. These costs should be outlined in the “other” costs category and fully described and itemized as other direct costs.

APPENDIX II. APPLICATION AND SUBMISSION INFORMATION

Please CTRL/Click to access links or paste to your browser. Please note these are the most up-to-date directions and available at the time of this NOFO's publication. Applicants are advised to check the websites for any changes. Also, phone numbers are provided if additional assistance is needed as several websites have made recent changes to links and directions.

This NOFO contains all the instructions to enable a potential applicant to apply. The application is written primarily as a narrative with the addition of standard forms required by the Federal government for all grants and Cooperative Agreements.

EIN, UEI, LOGIN.GOV, AND SAM REQUIREMENTS (ALL APPLICATIONS)

Employer Identification Number

You must have an Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN), to apply. **You should begin the process of obtaining an EIN/TIN as soon as possible to ensure this information is received in advance of application deadlines. The process to obtain an EIN typically takes up to 5 weeks.**

Unique Entity Identifier (UEI)

You must have a UEI number to apply.

You must obtain a Unique Entity Identifier (UEI) number as soon as possible to ensure all registration steps are completed in time.

See the following link for additional information on obtaining a UEI:

- GAO

Login.gov

You must sign in to Grants.gov with Login.gov credentials. See how to link these accounts.

System for Award Management (SAM)

You must register in the System for Award Management (SAM) database before you submit an application to Grants.gov. Applicants can access SAM and complete the online registration. UEI and EIN/TIN numbers are required to complete the registration process. To register one or more domestic entities and appoint an entity administrator, you must send a notarized letter to SAM.

You should begin the SAM registration process as soon as possible to ensure that it does not impair your ability to meet required submission deadlines. The process to register in SAM typically takes up to 2 weeks following receipt of the notarized letter (additional 5 weeks if an EIN must be established first).

After you register with SAM, you must update the information there every 12 months for your account to remain active. Grants.gov rejects electronic submissions from applicants with expired registrations. If your SAM account expires, the renewal process requires the same validation as required for a new account.

You must also successfully register with SAM prior to registering in the Federal Funding Accountability and Transparency Act Subaward Reporting System (FSRS) as a prime Recipient user. Please also refer to F5.c (Federal Funding Accountability and Transparency Act Reporting Requirements) of this Funding Opportunity for more information. Primary Recipients must maintain a current registration with the SAM database, and **may make subawards only to entities that have UEI numbers.**

Organizations must report executive compensation as part of the registration profile at SAM by the end of the month following the month in which this award is made, and annually thereafter (based on the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109-282), as amended by Section 6202 of Public Law 110-252 and implemented by 2 CFR Part 170).

How to Apply for Grants

Grants.gov is an online portal for submitting federal award applications. It requires a one-time registration to submit applications. All competitive Notice of Funding Opportunities must be submitted electronically through Grants.gov.

For assistance with this process use this contact or 1-800-518-4726. Below is an overview of the instructions from the Grants.gov website. Applicants can access the site directly for more detailed information.

How to Register to Apply through Grants.gov

- *Obtain A UEI number.*
- *Complete SAM registration*
- *Create a Login.gov Account (Users must sign in to Grants*.gov *with Login.gov credentials)*
- ***Register*** *to obtain a Grants.gov username and password.*
  - Click the Register link and complete the on-screen instructions.
  - The person submitting your application must be registered with Grants.gov as the Authorized Organizational Representative (AOR) for the specific UEI number cited on the SF-424 (first page). See the Applicant Training page for details.
- ***To link your Grants*.gov account to a Login.gov account.**
  - See detailed instructions.
- ***Add a Profile to the Account***:
  - The profile corresponds to a single applicant organization the user represents (i.e., an applicant) or an individual applicant. If you work for or consult with multiple organizations and have a profile for each, you may log in to one Grants.gov account to access all your grant applications. To add an organizational profile, enter the UEI (Unique Entity Identifier) for the organization in the field while adding a profile. For more detailed instructions about creating a profile.

- ***EBiz POC Authorized Profile Roles***:

- EBiz POCs will no longer use their UEI or DUNS Number during login. EBiz POCs will use an applicant account associated with their email address and UEI (Unique Entity Identifier) by using an existing applicant account or registering a new one.
- EBiz POCs will login using multi-factor authentication through Login.gov. The Expanded AOR (Authorized Organizational Representative) role will be automatically assigned to the EBiz POC. Users with the Expanded AOR can control organization preferences, user access, and apply for grants with the same account. To be recognized as EBiz POC in Grants.gov, users will need to use an applicant account with an email address that matches the SAM.gov account email address for their organization.
    - Click here for more details.

- ***Track Your Application Status***:

- ***Electronic Signature***:
    - The name of the organization applicant with the AOR role that submitted the application is inserted into the signature line of the application, serving as the electronic signature. The EBiz POC **must** authorize people who are able to make legally binding commitments on behalf of the organization as a user with the AOR role; **this step is often missed, and it is crucial for valid and timely submissions.**

Grants.gov Workspace:

Workspace is the standard way for organizations to apply for federal grants in Grants.gov. Workspace allows a grant team to simultaneously access and edit different forms within an application.

Create a Workspace**.**

Mandatory Fields in Forms: In the forms, you will note fields marked with an asterisk and a different background color. These fields are mandatory fields that must be completed to successfully submit your application.

Complete SF-424 Fields First: The forms are designed to fill in common required fields across other forms, such as the applicant name, address, and UEI Number. Once it is completed, the information will transfer to the other forms.

Submit a Workspace: An application may be submitted through workspace by clicking the Sign and Submit button on the Manage Workspace page, under the Forms tab. **Grants.gov recommends submitting your application package at least 24-48 hours prior to the close date to provide you with time to correct any potential technical issues that may disrupt the application submission.**

Track a Workspace Submission: After successfully submitting a workspace application, a Grants.gov Tracking Number (GRANTXXXXXXXX) is automatically assigned to the application. The number will be listed on the Confirmation page that is generated after submission. Using the tracking number, access the Track My Application page under the Applicants tab or the Details tab in the submitted workspace.

If you are experiencing difficulties with your submission, it is best to call the Grants.gov Support Center and get a ticket number. The Support Center ticket number will assist CMS with tracking your issue and understanding background information on the issue.

Timely Receipt Requirements and Proof of Timely Submission

All grant and cooperative agreement applications must be submitted electronically and **received** through Grants.gov by **11:59 p.m. Eastern Standard or Daylight Time** (Baltimore, MD) by the applicable deadline date. Please refer to the Executive Summary of this NOFO for submission deadline date.

Proof of timely submission is automatically recorded and an electronic date/time stamp is generated within the system when the application is successfully received by Grants.gov. The AOR who submitted the application will receive an acknowledgement of receipt and a tracking number (GRANTXXXXXXXX) with the successful transmission of their application. The AOR will also receive the official date/time stamp and Grants.gov Tracking number in an email serving as proof of their timely submission.

Please note, you may incur a time delay before you receive acknowledgement that the application has been accepted by the Grants.gov system. Applicants should not wait until the application deadline to apply. Notification by Grants.gov that the application is incomplete may not be received until close to or after the application deadline. Consequently, you may not be able to correct errors and resubmit the application. Applications submitted after the deadline, because of errors on the part of the applicant, will not be reviewed.

Once CMS successfully downloads the application from Grants.gov, the AOR will receive an electronic acknowledgment of receipt of the application. Proof of timely submission will be the official date and time that Grants.gov receives your application. Applications received after the established due date for the program will be considered late and may not be considered for funding by CMS.

Applicants using slow internet, such as dial-up connections, should be aware that transmission can take some time before your application is received. The Support Center reports that some applicants end the transmission because they think that nothing is occurring during the transmission process. Please be patient and give the system time to process the application.

Grants.gov complies with Section 508 of the Rehabilitation Act of 1973. If an individual uses assistive technology and is unable to access any material on the site, including forms

contained within an application package, the individual can e-mail the contact center for help, or call 1-800-518-4726.

APPENDIX III. BUSINESS ASSESSMENT OF APPLICANT ORGANIZATION

You must complete the business assessment questions outlined below. There are eleven (11) topic areas labeled A-K, with a varying number of questions within each topic area. **You MUST provide a brief substantive answer to each question (and supporting documentation as applicable).** If the answer to any question is non-applicable, please provide an explanation. If CMS cannot complete its review without contacting the applicant for additional clarification, the applicant risks selection for award.

A. General Information

1. Provide organization:
    a. Legal name:
    b. EIN (include PMS prefix and suffix, if applicable-ex. **1**-12356789-**A1)**:
    c. Organizational Type:
2. What percentage of the organization's capital is from Federal funding? (percentage = total Federal funding received in previous fiscal year / organization's total gross revenue in previous fiscal year).
3. Does/did the organization receive additional oversight (ex: Correction Action Plan, Federal Awardee Performance and Integrity Information System (FAPIIS) finding, reimbursement payments for enforcement actions) from a Federal agency within the past 3 years due to past performance or other programmatic or financial concerns with the organization)?
    a. If yes, please provide the following information: Name of the Federal agency; reason for the additional oversight as explained by the Federal agency
    b. If resolved, please indicate how the issue was resolved with the agency.
4. Does the organization currently manage grants with other U.S. Department of Health and Human Services components or other Federal agencies?
5. Explain your organization's process to ensure annual renewal in System for Award Management (to include FAPIIS).
6. Explain your organization's process to comply with (a) 45 CFR 75.113 Mandatory Disclosures and (b) your organization's process to comply with FFATA requirements.
7. Do you have conflict of interest policies? Does your organization or any of its employees have any personal or organizational conflicts of interest related to the possible receipt of these CMS award funds? If yes, please explain and provide a mitigation plan.
8. Does your organization currently, or in the past, had delinquent Federal debt in the last 3 years? If yes, please explain.
9. Have you filed bankruptcy or entered into proceedings for bankruptcy, whether voluntarily or involuntarily?
10. Has the organization obtained fidelity bond insurance coverage for responsible officials and employees of the organization in amounts required by statute or organization policy? What is that amount?
11. Do you have (and briefly describe) policies and procedures in place to meet the

requirements below? If not, explain your plan and estimated timeline for establishing these policies and procedures if selected for award.

a. make determinations between subrecipients versus contracts in accordance with 45 CFR 75.351?
b. notify entities at the time of the award/agreement if they are a subrecipient in compliance with 45 CFR 75.352?
c. manage, assess risk, review audits, and monitor the subrecipients as necessary to ensure that subawards are used for authorized purposes in compliance with laws, regulations, and Terms and Conditions and that established subaward performance goals are achieved (45 CFR § 75.351–75.353)?

B. Accounting System

1. Does the organization have updated (last two years) written accounting policies and procedures to manage federal awards in accordance with 45 CFR Part 75?
    a. If no, please provide a brief explanation of why not.
    b. Describe the management of federal funds and how funds are separated (not co-mingling) from other organizational funds.
2. Briefly describe budgetary controls in effect to preclude incurring obligations more than:
    a. Total funds available for an award.
    b. Total funds available for a budget cost category.
3. Has any government agency rendered an official written opinion within the last 3 years concerning the adequacy of the organization's accounting system for the collection, identification, and allocation of costs under Federal awards?
    a. If yes, please provide the name and address of the Agency that performed the review.
    b. Provide a summary of the opinion.
    c. How did your organization resolve any concerns?
4. How does the accounting system provide for recording the non-Federal share and in-kind contributions (if applicable for a grant program)?
5. Does the organization's accounting system provide identification for award funding by federal agency, pass-through entity, Assistance Listing (CFDA), award number and period of funding? If yes, how does your organization identify awards? If not, please explain why not.

C. Budgetary Controls

1. What are the organization's controls utilized to ensure that the Authorized Organizational Representative (AOR), as identified on the SF-424, approves all budget changes for the federal award?
2. Describe the organization's procedures for minimizing the time between transfer of funds from the U.S. Treasury (e.g. Payment Management System) and disbursement for grant activities (See 45 CFR §75.305, "Payment.").

D. Personnel

1. Does the organization have a current organizational chart or similar document establishing clear lines of responsibility and authority?
    a. If yes, please provide a copy.
    b. If no, how are lines of responsibility and authority determined?
2. Does the organization have updated (last two years) written Personnel and/or Human Resource policies and procedures? If no, provide a brief explanation.
3. Does the organization pay compensation to Board Members?
4. Are staff responsible for fiscal and administrative oversight of HHS awards (Grants Manager, CEO, Financial Officer) familiar with federal rules and regulations applicable to grants and Cooperative Agreements (e.g. 45 CFR Part 75)?
5. Please describe how the payroll distribution system accounts for, tracks, and verifies the total effort (100%) to determine employee compensation.

E. Payroll

1. In preparation of payroll is there a segregation of duties for the staff who prepare the payroll and those that sign the checks, have custody of cash funds and maintain accounting records? Please describe.

F. Consultants (See Appendix I to this NOFO for relevant information)

1. Are there written policies or consistently followed procedures regarding the use of consultants which detail the following (include explanation for each question below)?
    a. Briefly describe the organization's method or policy for ensuring consultant costs and fees are allowable, allocable, necessary and reasonable.
    b. Briefly describe the organization's method or policy to ensure prospective consultants prohibited from receiving Federal funds are not selected.

G. Property Management

1. Briefly describe the system for property management (tangible or intangible) utilized for maintaining property records consistent with 45 CFR 75.320(d). Refer to (45 CFR 75.2) for definitions of property to include personal property, equipment, and supplies.
2. Does the organization have adequate insurance to protect the Federal interest in equipment and real property (see 45 CFR §75.317, "Insurance coverage.")? How does the organization calculate the amount of insurance?

H. Procurement

Describe the organization's procurement procedures (in accordance with 45 CFR §75.326--§75.335, "Procurement procedures")? If there are no procurement procedures, briefly describe how your organization handles purchasing activities. A. Include individuals responsible and their roles. B. Describe the competitive bid process for procurement purchases of equipment, rentals, or service agreements that are over certain dollar amounts.

I. Travel

1. Describe the organizations written travel policy. Ensure, at minimum, that:
    a. Travel charges are reimbursed based on actual costs incurred or by use of per diem and/or mileage rates (see 45 CFR §75.474, "Travel costs.").
    b. Receipts for lodging and meals are required when reimbursement is based on actual cost incurred.
    c. Subsistence and lodging rates are equal to or less than current Federal per diem and mileage rates.
    d. Commercial transportation costs incurred at coach fares unless adequately justified. Lodging costs do not exceed GSA rate unless adequately justified (e.g. conference hotel).
    e. Travel expense reports show purpose and date of trip.
    f. Travel costs are approved by organizational official(s) and funding agency prior to travel.

J. Internal Controls

1. Provide a brief description of the applicant's internal controls that will provide reasonable assurance that the organization will manage award funds properly. (see 45 CFR §75.303, "Internal controls.")
2. What is your organization's policy on separation of duties as well as responsibility for receipt, payment, and recording of cash transactions?
3. Does the organization have internal audit or legal staff? If not, how do you ensure compliance with the award? Please describe.
4. If the organization has a petty cash fund, how is it monitored?
5. Who in the organization reconciles bank accounts? Is this person familiar with the organization's financial activities? Does your organization authorize this person to sign checks or handle cash?
6. Are all employees who handle funds required to be bonded against loss by reason of fraud or dishonesty?

K. Audit

1. What is your organization's fiscal year?
2. Did the organization expend $750,000 or more in Federal awards from all sources during its most recent fiscal year?
3. Has your organization submitted:
    (a) an audit report to the ***Federal Audit Clearing House (FAC)*** in accordance with the Single Audit Act in the last 3 years? (see 45 CFR §75.501, "Audit requirements" and 45 CFR §75.216 "Special Provisions for Awards to Commercial Organization as Recipient.") **or**
    (b) an independent, external audit? If no, briefly explain. If yes, address the following:
        i. The date of the most recently submitted audit report.
        ii. The auditor's opinion on the financial statement.

iii. If applicable, indicate if your organization has findings in the following areas: 1) *internal controls, 2) questioned or unallowable costs, 3) procurement/suspension and debarment, 4) cash management of award funds, and 5) subrecipient monitoring.*

iv. Include (if applicable):

1. A description of each finding classified as Material Weakness.
2. A description of each finding classified as Significant Deficiency.

4. Does the organization have corrective actions in the past 2 years for the findings identified above (3(iii))? If yes, describe the status (closed or open) and progress made on those corrective actions.

APPENDIX IV. ACCESSIBILITY REQUIREMENTS

CMS and its Recipients are responsible for complying with federal laws regarding accessibility as noted in the Award Administration Information/Administration and National Policy Requirements Section.

The Recipient may receive a request from a beneficiary or member of the public for information in accessible formats. All successful applicants under this Notice of Funding Opportunity must comply with the following reporting and review activities regarding accessibility requests:

Accessibility Requirements:

1. Public Notification: If you have a public facing website, you shall post a message no later than **30** business days after award that notifies your customers of their right to receive an accessible format. See sample language. Your notice shall be crafted applicable to your program.
2. Processing Requests Made by Individuals with Disabilities:
    a. Documents:
        i. When receiving a request for information in an alternate format (e.g., Braille, Large print, etc.) from a beneficiary or member of the public, you must:
            1. Consider/evaluate the request according to civil rights laws.
            2. Acknowledge receipt of the request and explain your process within **2** business days.
            3. Establish a mechanism to provide the request.
        ii. If you are unable to fulfill an accessible format request, CMS may work with you to provide the accessible format as funding and resources allow. You shall refer the request to CMS within **3** business days if unable to provide the request. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:
            1. The e-mail title shall read "Grantee (Organization) Alternate Format Document Request."
            2. The body of the e–mail shall include:
                a. Requester's name, phone number, e-mail, and mailing address.
                b. The type of accessible format requested, e.g., audio recording on compact disc (CD), written document in Braille, written document in large print, document in a format that is read by qualified readers, etc.
                c. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
                d. The document that needs to be put into an accessible format shall be attached to the e-mail.
                e. CMS may respond to the request and provide the information directly to the requester.

iii. The Recipient shall maintain record of all alternate format requests received including the requestor's name, contact information, date of request, document requested, format requested, date of acknowledgment, date request provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

b. Services

i. When receiving request for auxiliary aids and services (e.g., sign language interpreter) from a beneficiary or member of the public, you must:

1. Consider/evaluate the request according to civil rights laws.
2. Acknowledge receipt of the request and explain your process within **2** business days.
3. Establish a mechanism to provide the request.

ii. If you are unable to fulfill an accessible service request, CMS may work with you to provide the accessible service as funding and resources allow. You shall refer the request to CMS within **3** business days if unable to provide the service. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:

1. The e-mail title shall read "Grantee (Organization) Accessible Service Request."
2. The body of the e–mail shall include:
   a. Requester's name, phone number, e-mail, and mailing address.
   b. The type of service requested (e.g., sign language interpreter and the type of sign language needed).
   c. The date, time, address and duration of the needed service.
   d. A description of the venue for which the service is needed (e.g., public education seminar, one-on-one interview, etc.)
   e. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
   f. Any applicable documents shall be attached to the e-mail. CMS will respond to the request and respond directly to the requester.

iii. The Recipient shall maintain record of all accessible service requests received including the requestor's name, contact information, date of request, service requested, date of acknowledgment, date service provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

3. Processing Requests Made by Individuals with Limited English Proficiency (LEP):

a. Documents:

i. When receiving a request for information in a language other than English from a beneficiary or member of the public, you must:

1. Consider/evaluate the request according to civil rights laws.
2. Acknowledge receipt of the request and explain your process within **2** business days.
3. Establish a mechanism to provide the request as applicable.

ii. If you are unable to fulfill an alternate language format request, CMS may work with you to provide the alternate language format as funding and resources allow. You shall refer the request to CMS within **3** business days if unable to provide the request. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:

1. The e-mail title shall read "Grantee (Organization) Alternate Language Document Request."
2. The body of the e–mail shall include:
   a. Requester's name, phone number, e-mail, and mailing address.
   b. The language requested.
   c. Contact information for the person submitting the e-mail – Organization (Recipient), name, phone number and e-mail.
   d. The document that needs to be translated shall be attached to the e-mail.
   e. CMS may respond to the request and provide the information directly to the requester.

iii. The Recipient shall maintain record of all alternate language requests received including the requestor's name, contact information, date of request, document requested, language requested, date of acknowledgment, date request provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

b. Services

i. When receiving request for an alternate language service (e.g., oral language interpreter) from a beneficiary or member of the public, you must:

1. Consider/evaluate the request according to civil rights laws.
2. Acknowledge receipt of the request and explain your process within **2** business days.
3. Establish a mechanism to provide the request as applicable.

ii. If you are unable to fulfill an alternate language service request, CMS may work with you to provide the alternate language service as funding and resources allow. You shall refer the request to CMS within **3** business days if unable to provide the service. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:

1. The e-mail title shall read "Grantee (Organization) Accessible Service Request."
2. The body of the e–mail shall include:
   a. Requester's name, phone number, e-mail, and mailing address.
   b. The language requested.
   c. The date, time, address and duration of the needed service.
   d. A description of the venue for which the service is needed (e.g., public education seminar, one-on-one interview, etc.)
   e. Contact information for the person submitting the e-mail –

Organization (Recipient), name, phone number and e-mail.
f. Any applicable documents shall be attached to the e-mail.
g. CMS will respond to the request and respond directly to the requester.

iii. The Recipient shall maintain record of all alternate language service requests received including the requestor's name, contact information, date of request, language requested, service requested, date of acknowledgment, date service provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

Please contact the CMS Office of Equal Opportunity and Civil Rights for more information about accessibility reporting obligations at AltFormatRequest@cms.hhs.gov.

APPENDIX V. MERIT REVIEW AND SELECTION PROCESS

The review and selection process will include the following:

I. Applications will be screened to determine eligibility for further review using the criteria detailed in Sections C. Eligibility Information, and D. Application and Submission Information (with cross-reference to Appendix II), of this NOFO. Applications that are received late or fail to meet the eligibility requirements as detailed in this NOFO or do not include the required forms will not be reviewed. However, the CMS/OAGM/GMO, in his or her sole discretion, may continue the review process for an ineligible application if it is in the best interest of the government to meet the objectives of the program.

II. Applications will be evaluated by a merit review committee. Merit Reviewers use the criteria described in Section E1. Criteria of the NOFO, to evaluate each application. The merit review committee may include Federal and/or non-Federal reviewers.

III. The results of the merit review of the applications are key in decision making, but not the only factor. Final award decisions will be made by a CMS approving official. In making these decisions, the CMS approving official will take into consideration:

   a. evaluation of the merit review panel;
   b. the readiness of the applicant to conduct the work required;
   c. the scope of overall projected impact on the aims;
   d. reviews for programmatic and grants management compliance;
   e. the reasonableness of the estimated cost to the government and anticipated results;
   f. the geographic diversity of all applications;
   g. the diversity of the project types; and
   h. the likelihood that the proposed project will result in the benefits expected.

IV. As noted in 45 CFR Part 75.205, CMS will do a review of risks posed by applicants prior to award.

V. CMS reserves the right to conduct pre-award negotiations with potential Recipients.

APPENDIX VI. APPLICATION CHECK-OFF LIST

Use this checklist to make sure you have everything you need to submit a compliant application.

Required Contents

A complete application consists of the materials organized in the sequence below. Please ensure that the project and budget narratives are page-numbered, and the below forms are completed with an electronic signature and enclosed as part of the application. **Everything listed below must be submitted through Grants.gov. Placeholders are designated in the application kit available on grants.gov. Documents without specific placeholders in the application kit available on Grants.gov should be uploaded under "Other Attachments Form."**

- ☐ SF-424: Application for Federal Assistance
- ☐ SF-424A: Budget Information for Non-construction Programs
- ☐ SF-LLL: Disclosure of Lobbying Activities
- ☐ Project/Performance Site Location Form(s)
- ☐ Applicant's Application Cover Letter (**excluded from page limitations**)
- ☐ Project Abstract
- ☐ Project Narrative
- ☐ Business Assessment of Applicant Organization
- ☐ Budget Narrative
- ☐ Program Duplication Assessment
- ☐ Cost Allocation Plan (CAP)/Indirect Cost Rates (excluded from page limitations)
- ☐ Appendices

CMS will not review or consider applications that do not meet the application due date. Technical and other issues can occur. We recommend that you submit your application at least three to five days before the due date.

Grants.gov can take up to 48 hours to notify you of a successful submission.

APPENDIX VII. GLOSSARY

TABLE 24 GLOSSARY

Term	Definition
Alliance For Innovation on Maternal Health (AIM) Patient Safety Bundles	AIM patient safety bundles are a structured set of protocols for improving the processes of care and patient outcome to address the leading cause of preventable maternal morbidity and mortality in the Unites States. The AIM framework centers on five Rs: Readiness, Recognition, Response, Reporting and Systems Learning, and Respectful, Equitable, & Supportive Care. For more information on these bundles see the AIM website.
"Birthing-Friendly" Hospital Designation	A publicly reported, public-facing hospital designation representing the quality and safety of maternity care. CMS will award this designation to hospitals that report "Yes" to both questions in the Maternal Morbidity Structural Measure, indicating that the hospital participated in a national or statewide quality collaborative and implemented all recommended interventions.
Beneficiary	A person who has health care coverage through Medicaid or CHIP.
Medicaid Benefits ***Mandatory Medicaid Benefits*** ***Optional Medicaid Benefits***	States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services within broad federal regulations. Federal law requires states to provide certain mandatory benefits and allows states the choice of covering other optional benefits. All regulatory citations may be found here. Mandatory Medicaid benefits include services such as inpatient and outpatient hospital services, physician services, laboratory and x-ray services, and home health services, among others. Optional benefits include services such as prescription drugs, case management, physical therapy, and occupational therapy.
Birth Center	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 that are included in the plan.
Community-Based Organization (CBO)	Community-Based Organization (CBO) means a public or private organization that is representative of a community or a significant segment of a community. Such entities are generally organized to provide services or to advocate for community improvement.
Doula Services	Doula Services are provided by a nonclinical trained professional who can provide emotional, physical, and informational support during pregnancy, delivery, and after childbirth. Doulas and other care team members (e.g. perinatal CHW) may provide some or all of the services below. The below 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 and cultural 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 health-related social needs **Labor and Delivery Services** • Providing physical comfort measures, information, and emotional support • Advocating for beneficiary needs • Being an active member of the birth team **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 health-related social needs Many doulas focus on a specific reproductive moment, e.g., birth doulas and postpartum doulas.
Food Desert	An area that has limited access to affordable and nutritious food.
Group Perinatal Care	Group perinatal care engages groups of pregnant or postpartum people to provide clinical care, social support and in-depth education during facilitated sessions. Group perinatal care can also be tailored to meet certain population needs, such as sessions focused on smoking cessation, depression and anxiety among other topics, and may be delivered via telehealth or hybrid modalities.
Health Equity	The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes.
Health Equity Plan (HEP)	A document that assesses and outlines a plan to address health equity needs in an organization or region. The HEP shall include: ○ Features, obstacles, and demographics of the test region population ○ Health disparities to be addressed ○ Updates to the plan submitted on an annual basis ○ Strategies to overcome obstacles to equitable care

	○ How will leaders in the Recipient and other relevant organizations be held accountable for equitable outcomes? ○ A plan to meet requirements in transportation and translation A process for measuring and tracking stratified outcomes in the organization or region of interest for conditions with identified disparities.
Health Related Social Need (HRSN)	Individual-level, adverse social conditions that negatively affect a person's health or health care.
Home Monitoring	A form of telehealth that allows providers to monitor and manage their patients' acute and chronic conditions. Home monitoring may use medically designated handheld or wearable devices to collect health data remotely or may use smartphones with applications that leverage wireless technologies to track patients while they are away from the clinical setting.
Implementation Period	A seven-year period of active model testing during which providers will participate in a payment model that will include cost and quality performance incentives, preceded by a three-year Pre-Implementation Period.
In lieu of Service or Setting (ILOS)	An MCO, PIHP, or PAHP may cover, for enrollees, services or settings that are in lieu of services or settings covered under the State plan as follows: 1. The State determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the State plan; 2. The enrollee is not required by the MCO, PIHP, or PAHP to use the alternative service or setting; 3. The approved in lieu of services are authorized and identified in the MCO, PIHP, or PAHP contract, and will be offered to enrollees at the option of the MCO, PIHP, or PAHP; and 4. The utilization and actual cost of in lieu of services is considered in developing the component of the capitation rates that represents the covered State plan services, unless a statute or regulation explicitly requires otherwise.
Medicaid Managed Care	The delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care plans (MCPs) that have a risk contract with the State as defined in 42 CFR 438.2. Plans typically accept a set per-member-per-month (capitation) payment for a defined set of services and contract with providers responsible for providing these services.
Medicaid Managed Care Organization (MCO)	An entity that has, or is seeking to qualify for, a comprehensive risk contract as defined in 42 CFR 438.2., and that is: 1. A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of title 42; or 2. Any public or private entity that meets the advance directives requirements of subpart I of part 489 of title 42 and is determined by the Secretary to also meet the following conditions:

	i. Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity. ii. Meets the solvency standards of 42 CFR § 438.116.
Midwife	A health care professional who assists the patient during the prenatal, birth, and postpartum periods with a focus on a holistic, whole-person care delivery approach to the birthing process. A midwife can practice in multiple settings, including a hospital, birth center, a clinic, or the patient's home. All midwives are trained in the midwifery-led model of care.
Certified Nurse Midwife (CNM)	CNMs are registered nurses who pursue graduate education and certification. They have prescriptive authority in all 50 states, the District of Columbia and the U.S. territories. Nurse-midwives are defined at 42 CFR § 440.165.
Certified Midwife (CM)	CMs are non-nurses with a bachelor's degree that have a background in a science or health-related field. They must have a graduate degree for entry into practice. CMs have prescriptive authority in select states.
Certified Professional Midwife (CPM)	CPMs must have a high school degree or equivalent and can enter the profession through vocational routes, including apprenticeship programs or educational programs accredited by the Midwifery Education Accreditation Council. CPMs generally do not maintain prescriptive authority but are authorized to administer certain medications in certain states. Non-nurse licensed midwives are placed under the other licensed practitioner (440.60) benefit. This benefit is used only when the professional is licensed. Certified only midwives can also be covered under other benefits depending on whether they are supervised or not.
Midwifery Model of Care	The Midwifery model of care provides health care that incorporates appropriate consultation, collaborative management, and/or referral, as indicated by the health status of the patient. Abbreviated from Core Competencies for Basic Midwifery Practice (2020). - Advocacy of non-intervention in physiologic processes in the absence of complications - Incorporation of evidence-based care into clinical practice - Promotion of whole-person care, which respects, and is inclusive of, diverse histories, backgrounds, and identities - Using an understanding of social determinants of health to provide high-quality care to all persons including those from underserved communities - Advocating for informed choice, shared decision making, and the right to self-determination - Integration of cultural safety into all care encounters - Incorporation of evidence-based integrative therapies - Skillful communication, guidance, and counseling

	- Ability to collaborate with and refer to other members of the interprofessional health care team - Ability to provide safe and effective care across settings including home, birth center, hospital, or any other maternity care service
Non-Emergency Medical Transportation (NEMT)	Transportation to and from scheduled medical appointments or any in-person, non-emergency medical event.
Partner Providers	Maternal health providers and practices providing maternity care services to Medicaid and CHIP beneficiaries in the TMaH Model. These providers include but are not limited to obstetrician-gynecologists, midwives, physicians, fetal medicine specialists, nurses, and other clinical and support staff, such as doulas, lactation consultants, and perinatal community health workers.
Partner Care Delivery Locations	Locations where maternity care services are provided to Medicaid and CHIP beneficiaries. These include but are not limited to hospitals, birth centers, obstetrician-gynecology practices, rural health clinics, FQHCs, Tribal sites and other points of care.
Partner Organizations	Non-clinical organizations that will partner with Recipient and/or Partner Providers and Partner Care Delivery Locations to implement the TMaH Model, including 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 (CHW)	A frontline perinatal health worker is a trusted member of and/or has a close understanding of the birthing community. The relationship enables the perinatal CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. Builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.
Perinatal Quality Collaborative	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	Three-year period beginning at date of Award with a focus in the first two years on TA and in the third on operational readiness, followed immediately by Implementation Period.
Provider Infrastructure Payments	Provider Infrastructure Payments will be made no later than the first quarter of Model Year 3 to support care delivery transformation. The Provider Infrastructure Payments may only be used by providers for the activities described in Section A.4.3.1 of this document and must be detailed in the Recipient's Project Narrative, subject to CMS approval. Provider

	Infrastructure Payments may be dispersed to Partner Providers and Partner Care Delivery Locations via managed-care plans, foundations, or another entity at the discretion of the Recipient. Additional detail on the necessary information in agreements between Recipients and Partner Providers and Partner Care Delivery Locations is included in the aforementioned section of this document.
Risk-Appropriate Care	Clinical approach that highlights the importance of assigning patients to maternity care provider types based on their prenatal risk assessment. This clinical approach also includes ensuring adequately staffed and equipped facilities; regionalized care with defined relationships between different level facilities; initial and continuous risk assessment; and considers the potential benefit of caring for patients with a high risk of maternal morbidity in centers with higher-level, acuity-focused resources and specialty and subspecialty personnel. Lower-acuity birthing settings are often the preferred and appropriate option for most pregnant people, particularly in rural areas where travel distance to a high-volume or high-acuity hospital can be a barrier to care. The goal of creating systems for risk-appropriate care is to support the safe care for all pregnant people in all facilities.
Safety Net Providers	Safety net providers for the purposes of this model include: 1. FQHCs that are paid under the FQHC prospective payment system or bill at the Tribal/Indian Health Service All Inclusive Rate (AIR) 2. Rural health clinics 3. American Indian and Alaska Native (AI/AN) Indian Healthcare service sites: a. Indian Health Services sites operated by Indian Health Services (IHS) b. Tribal and Tribal Organizations Health Service sites c. Urban Indian Organizations (UIOs) sites 4. Safety net hospitals a. Hospitals receiving DSH payments or meeting federal DSH criteria b. Critical Access Hospitals c. Rural Emergency Hospitals
Severe Maternal Morbidity (SMM)	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 (ICD) 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	Hospital In-Patient Quality Reporting measure of SMM, comprising 21 ICD-10 diagnosis and procedure codes [from the?] CDC definition of Severe Maternal Morbidity. More information can be found here.
Shared Decision Making	A process in which both the patient and provider contribute to the medical decision-making process and agree on treatment decisions.

Social Determinants of Health (SDOH)	The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
Social Risk Factors	The wide array of non-clinical drivers of health known to negatively impact patient outcomes, including factors such as socioeconomic status, housing availability, and nutrition (among others), often unequally affecting historically marginalized communities on the basis of race and ethnicity, rurality, sexual orientation and gender identity, religion, and disability.
State Doula Support Council (SDSC)	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 trained, practicing, and enrolled as Medicaid providers. SDSCs will only provide advice and guidance to local and state officials and key audiences, including the Recipient, on policies related to advancing Doula Services reimbursement and coverage, expanding recruitment and training opportunities, and developing resources to aid nonclinical trained professionals performing Doula Services in enrolling as state Medicaid providers. The Councils may comprise, at the state's discretion, nonclinical trained professionals performing Doula Services, representatives from doula organizations, a representative from the SMA, and other participants. Care should be taken to ensure that SDSC membership is representative of the population served by the Model as deemed appropriate by the State, including Tribal communities where applicable. Decisions regarding the number of members, meeting schedule and frequency, member stipends or other details are at the discretion of the Recipient. The Council shall not advise the federal government, including CMS or CMS contractors, on any matter.
State Plan	An agreement between a state and CMS describing how that state administers its Medicaid and CHIP programs.
State Plan Amendment (SPA)	When a state is planning to make a change to its Medicaid and CHIP program policies or operational approach, states send SPAs to the Center for Medicaid and CHIP Services (CMCS) for review and approval. States also submit SPAs to make corrections or update their Medicaid or CHIP State Plan with new information.
Value-Based Care	A comprehensive and longitudinal method of providing care, prioritizing quality and outcomes over quantity of services provided.
Value-Based Payment	System of financial incentives that promote value-based care by holding providers accountable for improving patient outcomes while also giving them greater flexibility to deliver the right care at the right time.
Whole-Person Care	Helping and empowering individuals, families, communities, and populations to improve their health in multiple interconnected biological, behavioral, social, and environmental areas. Instead of treating only a specific disease, whole person health focuses on restoring health, promoting resilience, and preventing diseases across a lifespan.

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