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16

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF LONG TERM SUPPORTS AND SERVICES

Lori A. Weaver
Commissioner

Melissa A. Hardy

Director

105 PLEASANT STREET, CONCORD, NH 03301
603-271-5034 1-800-852-3345 Ext. 15034
Fax: 603-271-5166 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

October 25, 2024

The Honorable Ken Weyler, Chairman
Fiscal Committee of the General Court and

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

1. Pursuant to the provisions of RSA 14:30-a, VI, authorize the Department of Health and Human Services, Division of Long Term Supports and Services to accept and expend funds from the Centers for Medicare & Medicaid Services, entitled Money Follows the Person Rebalancing Demonstration, in the amount of $1,680,986 effective upon Fiscal Committee and Governor and Executive Council approvals through June 30, 2025. Funding source: 100% Federal Funds.

2. Contingent upon approval of Requested Action #1 and pursuant to the provisions of RSA 124:15, authorize the Department of Health and Human Services, Division of Long Term Supports and Services, to establish three (3) full-time temporary positions; two (2) 11-9150 Social and Community Service Managers-4, pay schedule SOC11, pay band 5, position numbers 9T3367 (Housing Continuum Administrator) and 9T3368 (Quality Assurance Coordinator), and one (1) 21-1090 Miscellaneous Community and Social Service Specialists-7, pay schedule SOC21, pay band 7, position number 9T3369 (Person-Centered Planning Liaison), effective upon Fiscal Committee and Governor and Executive Council approvals through June 30, 2025. Funding source: 100% Federal Funds.

05-095-048-481010-89200000 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS; HHS: DLTSS-ELDERLY&ADULT SVCS; GRANTS FOR SOCIAL SVC PROG; MONEY FOLLOWS THE PERSON

Class	Description	Current Adjusted Authorized	Requested Action	Revised Adjusted Authorized
000 – 400146 - 16	Federal Funds	$1,854,883	$1,680,986	$3,535,869
	General Funds	$0	$0	$0
Total Revenue		**$1,854,883**	**$1,680,986**	**$3,535,869**
020 - 500200	Current Expenses	$4,701	$18,496	$23,197
037 - 500173	Technology-Hardware	$0	$11,700	$11,700

038 - 500175	Technology-Software	$400	$0	$400
039 - 500188	Telecommunications	$8,631	$0	$8,631
041 - 500801	Audit Fund Set Aside	$1,922	$3,530	$5,452
042 - 500620	Additional Fringe Benefits	$18,409	$102,896	$121,305
059 - 500117	Temp Full Time	$267,011	$704,246	$971,257
060 - 500601	Benefits	$132,222	$317,213	$449,435
070 - 500704	In-State Travel Reimburse	$7,168	$2,010	$9,178
074 - 500589	Grants For Pub Asst And Rel	$1,398,734	$391,116	$1,789,850
080 - 500710	Out Of State Travel Reimb	$15,685	$26,039	$41,724
102 - 500731	Contracts For Program Servi	$0	$103,740	$103,740
Total Expenses		**$1,854,883**	**$1,680,986**	**$3,535,869**

EXPLANATION

This request is being made to accept and expend additional awarded grant funds to administer the Money Follows the Person (MFP) Rebalancing Demonstration Program. The Department of Health and Human Services (Department), Bureau of Adult and Aging Services (BAAS) submitted a proposal to receive funding under a new opportunity titled MFP Demonstration Expansion. On August 16, 2022, BAAS was notified funding would be available to New Hampshire for a planning phase with a start date of September 1, 2022. The Fiscal Committee approved the acceptance of the funds with item FIS 23-309 on October 19, 2023. BAAS has begun the Planning Phase during which BAAS worked closely with the MFP Stakeholder Consultative Group designing and developing an MFP Demonstration that supports and strengthens the home and community-based services (HCBS) system of care for New Hampshire's older adults and adults with chronic illnesses. BAAS and its stakeholders identified capacity building initiatives during the Planning Phase and developed an implementation plan for those initiatives. Funding was made available for planning and capacity building for up to $5 million through the project period that ends September 30, 2028. The authority for the MFP Demonstration is section 6071 of the Deficit Reduction Act of 2005.

Over the past two decades, the Department leveraged multiple federal funding opportunities to advance long term supports and services (LTSS) system strengthening, including earlier rounds of MFP funding to establish the NH Community Passport Program (CPP) in 2007. CPP helped 308 individuals transition from nursing homes to community settings between 2007-2016. Today, the Choices for Independence (CFI) waiver program, which helps older adults and adults with chronic illnesses continue living independently, continues CPP's focus providing necessary supports and services for people to age in place. During the planning phase, the Department has used MFP funds to engage technical experts and build its capability to assess HCBS system capacity, nursing facility bed needs and capacity, and determine what additional providers or services are needed, particularly for self-directed services and equitable care. This process included identifying racial, ethnic, and other differences and developing partnerships and strategies to address them. BAAS contracted with The Center on Aging and Community Living (CACL) at the University of New Hampshire (UNH) for technical support with data and evaluation throughout the grant.

The Project Director has convened an MFP Consultative Group of internal and external stakeholders to support the planning and implementation of the MFP Demonstration. The Department has contracted with

CACL to support the system assessment and gap analysis of HCBS and facilitate a process to develop an MFP Operational Protocol (OP). The MFP OP is a clear plan for using funds to advance state strengthening HCBS, including direct service workforce challenges, i.e., workforce capacity, recruitment, retention, and training needs. The MFP OP also outlines a strategy to identify and enroll participants, including partnering with and training transition coordination and housing support providers and includes implementing the National Core Indicators – Aging and Disability experience survey to subjectively assess how well services are supporting the participant and also support compliance with quality measures required by the Centers for Medicaid and Medicare Services (CMS). The MFP OP outlines how BAAS will collaborate with providers and ensure services are delivered in a person-centered, coordinated fashion and will leverage cross-agency collaboration with state and local housing agencies, community-based organizations, social service agencies, aging/disability networks, and HCBS beneficiaries. The MFP OP has been submitted and is currently being reviewed by CMS. To support the MFP OP, in August 2024, BAAS submitted and approved for a supplemental budget request supporting administrative capacity for operational efforts. BAAS will establish 3 full time temporary positions to support the demonstration efforts and implement contract procurements and contract amendments for MFP operations after the MFP OP is approved by CMS.

The funds are to be budgeted as follows:

Class 020, Current Expense, are for supplies and postage.

Class 037, Technology Hardware, are for the purchase of computer equipment associated with the positions.

Class 041, Audit Fund Set Aside, for financial and compliance audits.

Class 042, Additional Fringe Benefits, for payments to retirees' health insurance.

Class 059, Temp Full Time, are needed to pay for two (3) full-time temporary positions titled Person-Centered Planning Liaison, Quality Coordinator, and Housing Continuum Administrator.

Class 060, Benefits, are needed to pay benefits costs associated with the full-time temporary staffing.

Class 070, In State Travel Reimbursement, are for local travel to convene MFP Consultative Group comprised of key stakeholders from within DHHS and those external to the state agency.

Class 74, Grants for Pub Asst and Rel, are to contract with vendors to hire PC-IC Coordinators and Housing Navigators, as well as implement the Certified Older Adult Peer Specialist (COAPS) program model to support older adults.

Class 080, Out of State Travel Reimbursement, are for out of state travel for staff to attend the national HCBS Conference. The purpose of the HCBS Conference is to share practices and policies that improve state systems delivering LTSS for all ages and abilities.

Class 102, Contracts for Program Services, for payment of qualified and demonstration HCBS and Supplemental costs.

The following information is provided in accordance with the comptroller's instructional memorandum dated September 21, 1981.

1) List of personnel involved: Three (3) full-time temporary positions titled; Person-Centered Planning Liaison, Quality Assurance Coordinator, and Housing Continuum Administrator.

2) Nature, Need, and Duration: BAAS will hire three full-time temporary positions; a Quality Assurance Coordinator, a Person-Centered Planning Liaison and a Housing Continuum Administrator. The Quality Assurance Administrator will be responsible for planning, developing and implementing long term quality assurance and quality improvement policies, operational strategies and interpreting data to draw conclusions that impact programs, funding and service delivery. The Person-Centered Planning Liaison will be responsible for developing, implementing and overseeing comprehensive person-centered planning practices throughout programs and services administered by BAAS. The Person-Centered Planning liaison will also collaborate with internal and external stakeholders to create a system that will ensure person-centered planning and thinking principles are incorporated throughout the system of care for healthy aging. The Housing Continuum Administrator will be responsible for developing, coordinating and implementing an integrated housing and residential support continuum of care across programs operated within the Department, as well as those operated by external community-based organizations by collaborating with state and local housing agencies and organizations to identify or develop options to expand Medicaid recipients' access to affordable accessible housing. The proposed grant funding for these positions ends on September 30, 2028.

3) Relationship to existing agency programs: Over the past two decades, the Department has leveraged multiple federal funding opportunities to advance long term supports and services system reform, including earlier rounds of MFP funding.

4) Has a similar program been requested of the legislature and denied? No.

5) Why wasn't funding included in the agency's budget request? These funds were unanticipated at the time the budget was created.

6) Can portions of the grant funds be utilized? Grant funds are being utilized for these positions.

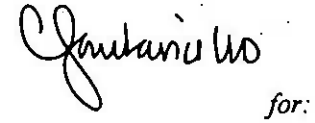
7) Estimate the funds required to continue this position: Funds for these positions are estimated at $1,469,513 for the entire 5-year grant period, which will be fully grant funded for the duration.

Area served: Statewide.

Source of Funds: 100% Federal from the Centers for Medicare & Medicaid Services, Money Follows the Person Rebalancing Demonstration.

In the event that federal funds become no longer available, general funds will not be requested to support the program expenditures.

Respectfully Submitted,



for:

Lori A. Weaver
Commissioner

Division of Long Term Supports and Services
Money Follows the Person

Fiscal Situation: Account 05-95-48-481010-89200000

Agency Income:	
Grant Award 1LICMS331877 (Multi-Year)	$5,000,000.00
Grant Award 1LICMS331877 (Supplemental)	$1,505,388.00
Total Funds Available	**$6,505,388.00**
SFY 23 Expenses	($141,802.24)
SFY 24 Expenses	($763,376.66)
Prior Fiscal Year Expenses	**($905,178.90)**
SFY 2025 Adjusted Authorized Appropriations	($1,854,882.96)
SFY 2026 Multi Year Allocation	($776,446.00)
Service Dollars Appropriated in Service Class Lines	(519,660.00)
Allocated Indirect Costs	(768,233.90)
Total Appropriations	**($3,919,222.86)**
Net Grant Funds Remaining	$1,680,986.24
This Request	**$1,680,986.00**

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Notice of Award

Award# 1LICMS331877-01-02
FAIN# 1LICMS331877
Federal Award Date: 09/12/2024

Recipient Information

1. Recipient Name
NEW HAMPSHIRE DEPARTMENT OF HEALTH & HUMAN SERVICES
129 Pleasant St
New Hampshire Dept of Health and Human Services
Concord, NH 03301-3852
[NO DATA]

2. Congressional District of Recipient
02

3. Payment System Identifier (ID)
1026000618B5

4. Employer Identification Number (EIN)
026000618

5. Data Universal Numbering System (DUNS)
011040545

6. Recipient's Unique Entity Identifier (UEI)
LA2HR1U97VC6

7. Project Director or Principal Investigator
Ms. Lisa Dunham
Administrator IV, MPF Project Director
lisa.m.dunham@dhhs.nh.gov
6032719786

8. Authorized Official
Ms. Wendi Aultman
Wendi.Aultman@dhhs.nh.gov
603-271-9068

Federal Agency Information
Office of Acquisitions and Grants Management

9. Awarding Agency Contact Information
Ms. Courtney Whitten
Grants Management Specialist
courtney.whitten@cms.hhs.gov
410-786-0362

10. Program Official Contact Information
Mr. Jeffrey Clopein
Project Officer
jeffrey.clopein@cms.hhs.gov
410-786-7252

Federal Award Information

11. Award Number
1LICMS331877-01-02

12. Unique Federal Award Identification Number (FAIN)
1LICMS331877

13. Statutory Authority
Section 6071 of the DRA of 2005

14. Federal Award Project Title
Welcome Home: Expanding Home and Community Based Care for Older Adults in New Hampshire

15. Assistance Listing Number
93.791

16. Assistance Listing Program Title
Money Follows the Person Rebalancing Demonstration

17. Award Action Type
MFP Directed Supplement

18. Is the Award R&D?
No

Summary Federal Award Financial Information

19. Budget Period Start Date 09/01/2022 **- End Date** 09/30/2028		
20. Total Amount of Federal Funds Obligated by this Action		$1,590,388.00
20a. Direct Cost Amount		$1,505,388.00
20b. Indirect Cost Amount		$85,000.00
21. Authorized Carryover		$0.00
22. Offset		$0.00
23. Total Amount of Federal Funds Obligated this budget period		$5,000,000.00
24. Total Approved Cost Sharing or Matching, where applicable		$0.00
25. Total Federal and Non-Federal Approved this Budget Period		$6,590,388.00
26. Period of Performance Start Date 09/01/2022 **- End Date** 09/30/2028		
27. Total Amount of the Federal Award including Approved Cost Sharing or Matching this Period of Performance		$6,590,388.00

28. Authorized Treatment of Program Income
ADDITIONAL COSTS

29. Grants Management Officer - Signature
Mrs. Monica Anderson
Grants Management Officer

30. Remarks

See Remarks (continuation)

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Notice of Award

Award# 1LICMS331877-01-02
FAIN# 1LICMS331877
Federal Award Date: 09/12/2024

Recipient Information

Recipient Name
NEW HAMPSHIRE DEPARTMENT OF HEALTH & HUMAN SERVICES
129 Pleasant St
New Hampshire Dept of Health and Human Services
Concord, NH 03301-3852
[NO DATA]

Congressional District of Recipient
02

Payment Account Number and Type
1026000618B5

Employer Identification Number (EIN) Data
026000618

Universal Numbering System (DUNS)
011040545

Recipient's Unique Entity Identifier (UEI)
LA2HR1U97VC6

31. Assistance Type
Cooperative Agreement

32. Type of Award
Other

33. Approved Budget
(Excludes Direct Assistance)

I. Financial Assistance from the Federal Awarding Agency Only
II. Total project costs including grant funds and all other financial participation

a. Salaries and Wages	$1,177,226.00
b. Fringe Benefits	$628,397.00
c. Total Personnel Costs	$1,805,623.00
d. Equipment	$0.00
e. Supplies	$38,740.00
f. Travel	$68,450.00
g. Construction	$0.00
h. Other	$654,002.00
i. Contractual	$3,423,408.00
j. TOTAL DIRECT COSTS	$5,990,223.00
k. INDIRECT COSTS	$600,165.00
l. TOTAL APPROVED BUDGET	$6,590,388.00
m. Federal Share	$6,590,388.00
n. Non-Federal Share	$0.00

34. Accounting Classification Codes

FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	OBJECT CLASS	CFDA NO.	AMT ACTION FINANCIAL ASSISTANCE	APPROPRIATION
4-5991913	MFP331877A	1LI	412K	93.791	$1,590,388.00	75-2425-0516

Remarks (Continuation)

This Notice of Award approves application dated 08/13/2024 for MFP Directed Supplemental funding for calendar year 2024. The 2024 MFP approved budget is $1,590,388.00 with an unobligated balance as of 12/31/2023 of $0.00. The total financial assistance for this action and to be funded for 2024 is $1,590,388.00.

This Notice of Award approves key staff changes per your letter dated 08/13/2024 to include Wendi Aultman as Authorized Organizational Representative and Lisa Dunham as Project Director.

AWARD ATTACHMENTS

NEW HAMPSHIRE DEPARTMENT OF HEALTH & HUMAN SERVICES 1LICMS331877-01-02

1. NH Recipient Terms and Conditions
2. MFP Program Terms and Conditions
3. CMS Standard Terms and Conditions

Money Follows the People (MFP) Rebalancing Demonstration Project

Recipient Specific Terms and Conditions

Recipient:
New Hampshire Department of Health & Human Services

FY24

1. **General**. In addition to all CMS Standard Terms and Conditions and Program Terms and Conditions, Recipient is subject to the following Recipient-specific Terms and Conditions. The Centers for Medicare and Medicaid Services (CMS) may add or otherwise amend these Recipient Specific Terms and Conditions as necessary at any point during the MFP Demonstration performance and project period.

2. **Purpose:** The purpose of this document ("Recipient Specific Terms and Conditions") is to request a revised and detailed documentation that addresses the deficiencies of the 2024 MFP Directed Supplemental request.

3. **Term**. The recipient shall submit the required documentation **within 90 days from the date of the notice of award (NoA)** and schedule a meeting with the CMS Grants Management Officer and CMS Project Officer. In addition, the recipient must report on the progress of these recipient-specific terms and conditions during monthly meetings with the Project Officer and Grants Management Specialist until all terms are met. Additional meetings may be scheduled to resolve these matters timely, if and when necessary. Funding for any positions not filled within the 90 days will be restricted immediately. A budget amendment will be required for funds availability after that date.

    a. **Personnel Cost Category:** There are **vacant positions** identified within the budget that must be filled within 90 days. If additional time is required to hire any vacant positions, a funding restriction may be applied to the award. Any restrictions will be discussed with the recipient prior to implementation.
        i. **MFP Quality Coordinator**
        ii. **MFP Person Centered Systems Liaison**
        iii. **MFP Housing Continuum Administrator**

If there are any questions or concerns, please contact the Grants Management Specialist and Project Officer assigned to this award. Thank you.

Money Follows the Person (MFP) Demonstration
Program Terms and Conditions

I. Preface

The following are the Program Terms and Conditions ("PTCs") for the Money Follows the Person (MFP) demonstration ("demonstration"), to enable the "Recipient" as identified on line 1 of the Notice of Award (NoA) to operate the demonstration.

The requirements contained in the Notice of Funding Opportunity (NOFO), FON# CMS-1LI-22-001, is incorporated by reference as Program Terms and Conditions attached to this NoA. In the event of any inconsistency between the provisions of these Program Terms and Conditions and the provisions of the NOFO, the provisions of these Program Terms and Conditions must prevail.

These PTCs are in effect from January 1, 2022 through the project period end date identified on line 19 of the Recipient's NoA. The demonstration period for the Recipient is the date of the period of performance issued in the Recipient's NoA.

The PTCs have been arranged into the following subject areas:

I. Preface
II. Program Authority and Objectives
III. General Program Requirements
IV. General Participant Eligibility Requirements
V. MFP Qualified Home and Community-Based Services
VI. Allowable and Required Services and Activities
VII. Quality Assurance and Quality Improvement
VIII. Operational Protocol
IX. General Reporting Requirements

Additional attachment(s) have been included to provide supplementary information and guidance for specific PTCs:

Attachment A Description of MFP Qualified Home and Community-Based Services (HCBS)

II. Program Authority and Objectives

The authority for the MFP demonstration is section 6071 of the Deficit Reduction Act of 2005 (DRA). Section 6071 of the DRA has been amended by: section 2403 of Patient Protection and Affordable Care Act; section 2 of the Medicaid Extenders Act of 2019; section 5 of the Medicaid Services Investment and Accountability Act of 2019; section 4 of the Sustaining Excellence in Medicaid Act of 2019; section 205 of the Further Consolidated Appropriations Act, 2020 (CAA); section 3811 of the Coronavirus Aid, Relief, and Economic Security Act, 2020; section 2301 of the Continuing Appropriations Act, 2021 and Other Extensions Act; section 1107 of the Further Continuing Appropriations Act, 2021, and Other Extensions Act; and section 204 of the Consolidated Appropriations Act, 2021 (CAA).

As stated in section 6071(a) of the DRA, the program purposes and objectives of MFP are:

(1) Increase the use of HCBS, rather than institutional long-term services and supports (LTSS), in the Medicaid program;
(2) Eliminate barriers or mechanisms, whether in state law, the state Medicaid plan, the state budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary LTSS in the settings of their choice;
(3) Increase the ability of state Medicaid programs to assure continued provision of HCBS to eligible individuals who choose to transition from an institution to a community setting; and
(4) Ensure that procedures are in place (at least comparable to those required under the qualified HCBS program) to provide quality assurance for eligible individuals receiving Medicaid HCBS and to provide for continuous quality improvement in such services.

III. General Program Requirements

1. Adequacy of Infrastructure. The Recipient will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including outreach and enrollment; maintaining eligibility systems; timely access to HCBS waiver programs and state plan HCBS; effective transition coordination; and reporting on financial, quality measures, and other demonstration components. The state must assure access to an approved Medicaid HCBS program for MFP participants during the 365-day enrollment period or 366-day enrollment period in a leap year, if applicable.

2. Communication. The Recipient must have and maintain an account with GrantSolutions (GS) in order to communicate, receive, and obtain documentation from CMS. If the designated Recipient Authorized Organizational Representative (AOR) and the principal investigator/program director (PI/PD) do not already have accounts in GS, the Recipient must require the individual to contact GS immediately upon receipt of award to complete a user account form. Any change in personnel with access to GS must also be communicated to CMS and GS staff so that the key responsible individuals are current and correct within the GS system.

3. Program Guidance. The Recipient must operate their MFP program in accordance with MFP program guidance, which includes but is not limited to, MFP instructions, MFP frequently asked questions and answers, or other guidance posted on the CMS Medicaid.gov MFP webpage to support the efficient administrative and operational components of the demonstration and award.

4. Operational Protocol. The Recipient must develop and amend as necessary an Operational Protocol (OP) that details how the state will adhere to statutory and program requirements as specified in section VIII of these PTCs.

5. Public Development Process. Similar to the requirement in section 6071(c)(1) of the DRA for MFP applications, the Recipient must provide assurance that it has engaged, and will continue to engage, in a public development/stakeholder engagement process. Recipients are expected to engage a broad community of stakeholders, including but not limited to, Medicaid agency leadership, participants in HCBS programs, residents in

long-term care facilities, family members and other caregivers, HCBS providers, the aging and disability network, health plans, housing providers, and the direct care workforce, to inform the state's approach to the design of the MFP demonstration, delivery of services and activities, and the ways in which the state can leverage the MFP demonstration to expand and enhance the HCBS system. The public development/stakeholder engagement process must be documented in the OP.

6. CMS Program Monitoring. CMS will assign a specific Project Officer to the Recipient to discuss ongoing demonstration operations, including but not limited to actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on program performance, transition benchmark achievements, supplemental budgetary spending, and progress on HCBS capacity building and rebalancing initiatives. This program monitoring may be conducted by phone, document review, on-site visit, or other appropriate means, such as by reviewing program progress reports. CMS will provide updates on any programmatic aspect of the demonstration, as well as federal policies and issues that may affect the demonstration. The Recipient and CMS will meet at a minimum once a month via a call, except in cases when a legal holiday or an unexpected state or federal business disruption may occur. CMS and the Recipient will jointly develop the agenda for the calls. This monitoring will serve to assess compliance with program requirements.

7. State Monitoring. The Recipient must conduct monitoring and oversight of the MFP demonstration operational activities, including, but not limited to:

a. The Recipient must monitor the services delivered under the demonstration using appropriate quantitative and qualitative measures.
b. The Recipient must monitor the quality and cost-effectiveness of program operations and the delivery of services.
c. The Recipient must implement processes for identifying issues, communicating issues to the appropriate entities, and taking corrective action.

8. Person-Centered Planning. The Recipient must use person-centered planning processes to identify MFP participants' LTSS needs, and the resources available to meet those needs, and to provide access to additional service and support options as needed. The Recipient assures that it will use person centered planning tools in compliance with the characteristics set forth in 42 C.F.R. § 441.301(c)(1)-(3).

9. MFP Service Area(s) and Target Populations. Consistent with the requirements in section 6071(c)(4) and section 6071(c)(5) of the DRA for MFP applications, the Recipient is required to specify the MFP participant target population(s) they plan to recruit and enroll in the demonstration program and to specify the geographic service area(s) of the demonstration. Individuals targeted for program participation must meet the eligibility criteria set forth in section 6071(b)(2) of the DRA, and as described in section IV of these PTCs. Additionally, the Recipient is required to specify the projected numbers of eligible individuals in each target group for each year of the demonstration program. The Recipient must also describe the target population(s). The Recipient must include all of the information stated in this paragraph in its OP.

10. Corrective Action Plan. If the Recipient does not comply with the Program Terms and Conditions of the demonstration, CMS may issue a Corrective Action Plan (CAP).

The CAP will identify the compliance concerns and summarize actions to date; detail possible enforcement actions; recommend steps, solutions, and deadlines for addressing the concern; and require the Recipient to submit a written plan to address the compliance concerns in response to the CAP. Failure to comply with these requirements may be a basis for applying a CAP in addition to the consequences defined in Standard Terms and Conditions (STC) 4 and STC 26.

IV. General Participant Eligibility Requirements

11. Individual Eligibility. An individual must meet certain MFP eligibility requirements to qualify for participation in the MFP demonstration. An individual must reside in an MFP-qualified inpatient facility as described in PTC 13 and must meet the definition of "eligible individual" in section 6071(b)(2) of the DRA.

12. Income Eligibility. Section 6071(d)(3) of the DRA expressly authorizes the waiver of the income and resource eligibility rules at section 1902(a)(10)(C)(i)(III) of the Social Security Act in order to permit a Recipient to apply institutional eligibility rules to individuals transitioning to community-based care.

13. Inpatient Facility. As defined by section 6071(b)(3) of the DRA, the term "inpatient facility" means "a hospital, nursing facility, or intermediate care facility for individuals with [intellectual or developmental disabilities]. Such term includes an institution for mental diseases, but only, with respect to a State, to the extent medical assistance is available under the State Medicaid plan for services provided by such institution."

14. Institution for Mental Diseases (IMD) Exclusion. The term "institution for mental diseases" means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. The paragraph following section 1905(a)(31)(B) of the Social Security Act generally prohibits states from receiving "any [Medicaid] payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an [IMD]." Medicaid beneficiaries ages 21 through 64 residing in an IMD who are receiving services that are covered under a Substance Use Disorder or Serious Mental Illness section 1115 demonstration and who meet the MFP individual eligibility criteria may transition from an IMD to the community under the demonstration.

15. Qualified Residence. As defined by section 6071(b)(6) of the DRA the term "qualified residence" means, "with respect to an eligible individual":

- a home owned or leased by the individual or the individual's family member;
- an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and
- a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.

V. MFP Qualified Home and Community-Based Services (HCBS).

16. Qualified HCBS. Section 6071(b)(5) of the DRA defines "qualified HCB program" as follows: "The term 'qualified HCB program' means a program providing home and community-based long-term care services operating under Medicaid, whether or not operating under waiver authority."

The qualified HCBS program[1] is the Medicaid service package(s) that the Recipient will make available to a demonstration participant when they move to a community-based residence. This program can be comprised of any Medicaid home and community-based state plan and waiver program services. Awardees are permitted to claim an MFP-enhanced match rate as described in PTC 22 for the first 365-day post-transition period or 366-day enrollment period in a leap year, if applicable for qualified HCBS for demonstration participants who transition from an institutional LTSS setting into the community. A list of MFP-qualified HCBS is included as Attachment A.

17. MFP Demonstration Services. MFP demonstration services are qualified HCBS that could be provided, but are not currently provided, under the Recipient's Medicaid program. See Attachment A for a list of qualified HCBS. MFP demonstration services may be helpful to recipients in states that do not have comprehensive transition services included in HCBS waiver programs or in the State Plan.

The Recipient is expected to test and offer MFP Demonstration Services specific to the state's demonstration for MFP participants. These MFP Demonstration Services must be identified through a person-centered planning process. Demonstration Services are reimbursed at an MFP-enhanced match rate. MFP Demonstration Services are not required to continue after the conclusion of the MFP demonstration program or for the participant, at the end of the 365-day enrollment period (or 366-day enrollment period, in the case of a leap year). The Recipient must submit demonstration service descriptions in the OP. Recipients must submit an amendment to the OP when adding or removing MFP Demonstration Services.

18. Self-Directed Supports. The Recipient must provide resources to support participants or the participant's authorized representative (e.g., a surrogate, parent, or legal guardian) in directing their own care when that care is provided by an individual provider. If the Recipient elects to provide self-directed services (as defined in section 6071(b)(8) of the DRA) under the MFP demonstration, the Recipient must provide assurances that the services meet the requirements set forth in section 6071(c)(12) of the DRA in its OP.

19. Continuity of Qualified HCBS. In accordance with section 6071(c)(2) of the DRA, the MFP demonstration must operate in conjunction with a qualified HCBS program to assure continuity of services for eligible individuals. The demonstration operates in conjunction with a qualified HCBS program that is in operation in the state for such

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[1] For the purposes of these PTCs, CMS will use the term "HCBS program" when referencing section 6071 of the DRA definition of an "HCB program".

individuals in a manner that assures continuity of Medicaid coverage for such individuals so long as such individuals continue to be eligible for medical assistance and meet the program requirements for the receipt of HCBS.

20. Home and Community-Based Setting Requirements. The Recipient must ensure that home and community-based settings have all the qualities required by 42 C.F.R. § 441.301(c)(4)(i), and other such qualities that the Secretary determines to be appropriate based on the needs of the individual as indicated in their person-centered plan. In a provider owned or controlled setting, the additional qualities required by 42 C.F.R. § 441.301(c)(4)(vi) must be met. Specific to this demonstration, section 6071(b)(6)(C) of the DRA ("a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside") applies.

21. Informed Choice. Consistent with section 6071(c)(6) of the DRA, CMS will require that individuals identified as potential demonstration participants have been provided with individual choice regarding participation in the demonstration. Specific requirements must be addressed in the OP, for assurances and proposed processes that ensure:

- each eligible individual or the individual's authorized representative will be provided the opportunity to make an informed choice regarding whether to participate in the MFP demonstration; and
- each eligible individual or the individual's authorized representative will have input into, and approve the selection of the qualified residence in which the individual will reside and the setting in which the individual will receive HCBS.

22. MFP-Enhanced FMAP. Qualified HCBS and demonstration services (see PTC 16 and 17) receive MFP-enhanced reimbursement. The "MFP-enhanced FMAP" for a state, for a fiscal year (as defined in section 6071(e)(5) of the DRA), is equal to the published FMAP for the state, increased by a number of percentage points equal to 50 percent of the number of percentage points by which the FMAP for the state is less than 100 percent; but, in no case shall the MFP-enhanced FMAP for a state exceed 90 percent.

The MFP-enhanced FMAP rate may be applied to qualified HCBS and MFP demonstration services under a fee-for-service or managed care delivery system. A state may not claim the MFP-enhanced FMAP for any expenditures other than those listed in Attachment A.

The Recipient must develop and administer appropriate billing methodologies and controls for qualified HCBS and demonstration services eligible for the MFP-enhanced FMAP. The Recipient will not submit claims for demonstration expenditures through the Medicaid Budget and Expenditure System (MBES); however, the Recipient is expected to include aggregate expenditures in the MBES under the CMS 64.9i and 10i and 10Pi (as needed) forms. The Recipient must continue to submit non-demonstration expenditures for MFP participants on the regular CMS 64 form.

VI. Allowable and Required Services and Activities

23. Transition Coordination Services. Consistent with section 6071(c)(6) of the DRA, the Recipient must provide comprehensive person-centered transition coordination services that includes the provision of housing-related supports to assist an MFP participant to locate and secure MFP-qualified accessible, affordable community-based housing. Recipients have flexibility in defining the specific set of services that satisfy the following components:

- Person-centered service planning;
- Comprehensive transition services;
- Care coordination; and
- Promotion of community-integration.

The Recipient must include state-selected performance measures in the Work Plan subject to CMS review and approval to monitor and report on the performance of transition coordination services and housing-related supports, identify opportunities for service improvement, and provide a measure of progress toward achieving program goals around the provision of these services. The Recipient will report on the performance measures in the Work Plan as described in PTC 49. The Recipient agrees to participate in a CMS-sponsored housing-related services and supports learning collaborative at date(s) specified by CMS. The MFP project director and MFP programs employing MFP housing specialist(s) and/or housing coordinator(s) are expected to participate.

24. Supplemental Services. Supplemental services are short-term services to support an MFP participant's transition that are otherwise not allowable under the Medicaid program. Supplemental services are not expected to continue after the demonstration period or MFP participants' 365-day enrollment period(s) or 366-day enrollment period in a leap year, if applicable, following an inpatient facility stay of over 60 continuous days. Federal funding is available to cover 100 percent of supplemental services. The Recipient must submit supplemental service descriptions in the OP. Recipients must submit an amendment to the OP when adding or removing supplemental services. Certain supplemental services have additional requirements that the Recipient must adhere to when implementing the service. These requirements will be issued in MFP policy guidance documents. The Recipient must describe how the requirements are to be met in the OP.

25. Administrative Activities—Program Operations. The Recipient shall use demonstration administrative funding to cover expenses required to execute the planning and operation of the program. This includes making investments in technology, tools, stakeholder engagement, marketing, and human resources that will allow the state program to build capacity to serve MFP target populations and pursue program goals in accordance with state priorities and the objectives of the MFP demonstration. MFP funding is available to cover up to 100 percent of the cost of administrative activities directly attributable to the operation of the state's MFP demonstration. Examples of reimbursable activities include MFP travel expenses, training, outreach and marketing, IT

infrastructure to accommodate MFP financial and evaluation reporting requirements, and key personnel.[2]

26. Administrative Activities—Required Personnel. The Recipient must fund two full-time equivalent (FTE) positions to operate and administer the program: (1) MFP project director; and (2) MFP data and quality analyst. MFP grant funding is available to cover up to 100 percent of the cost of these two FTE personnel positions.

a. MFP Project Director: The Recipient shall ensure the continuous employment of a dedicated full-time equivalent MFP project director through the end of the Recipient's period of performance. CMS expects the Recipient to hire an MFP project director with sufficient Medicaid and long-term services and supports experience to develop, monitor, and operationalize the administrative and financial obligations of the demonstration as well as having the necessary skills to implement MFP and HCBS infrastructure activities and state system relationship building. A full-time equivalent MFP project director may include one of the following position types:

- A full-time (1.0 full-time equivalent (FTE)) state employee;
- A full-time (1.0 FTE) contracted personnel position with an employee/employer relationship with the state grant administering department; or
- A full-time (1.0 FTE) university position within a university organization that is recognized as a state entity with a memorandum of agreement with the Recipient or state administering department.

The Recipient must submit a prior approval request, specifically a principal investigator/program director (PI/PD) amendment in GrantSolutions to include the MFP project director resume or Curriculum Vitae. The resume must include a description of relevant work experience demonstrating program management experience pertaining to Medicaid LTSS; a description of budget, finance, communication, and technology skills; and a description of leadership and partnership building experience.

Should the named MFP project director discontinue full-time employment, the Recipient must submit an interim plan prior to the position vacancy to CMS on how the Recipient will assure the continuation of demonstration administration and operations while the state pursues, within a reasonable time-frame, the hiring of a new MFP project director. The Recipient must submit a prior approval for any new MFP project director applicant subject to the same terms as described above. This would include an interim or temporary PI/PD.

b. MFP Data and Quality Analyst: The Recipient shall ensure the continuous employment of a dedicated full-time equivalent MFP data and quality analyst through the end of the period of performance. CMS expects the Recipient to hire an MFP data and quality analyst with sufficient data quality skills to perform data quality measurement and metric generation, data aggregation into quality performance indicators, and data interpretation,

[2]Key personnel (wt): individuals, in addition to the principal investigator/program director (PI/PD) and the authorized organizational representative (AOR), identified by the OPDIV in the Notice of Award (NoA) that are considered critical to the project, i.e., their removal or absence from the project would have a significant impact on the approved project. The AOR who has the delegated authority to execute decisions on behalf of the recipient and the PI/PD are always considered both a "key person" and a "principal", as defined below. Other key personnel generally are not considered "principals" for purposes of suspension and debarment.

as well as the ability to develop various data reporting structures and formats. A full-time equivalent MFP data and quality analyst may include one of the following position types:

- A full-time (1.0 FTE) state employee;
- A full-time (1.0 FTE) contracted personnel position with an employee/employer relationship with the state grant administering department; or
- A full-time (1.0 FTE) university position within a university organization that is recognized as a state entity with a memorandum of agreement with the state grant administering department.

27. Administrative Activities—Additional Uses of Funds to Expand and Enhance the State's HCBS System. The Recipient may use award funding for administrative activities to expand and enhance the state's HCBS system under the Medicaid program. The Recipient must describe administrative activities to expand and enhance the state's HCBS system in the OP and must follow applicable reporting requirements as described in PTC 41. MFP funding is available to cover up to 100 percent of the cost of administrative activities to implement the state's MFP project and to expand and enhance the state's HCBS system.

28. National Evaluation. The Recipient must cooperate with CMS and the CMS-directed national program evaluation's contractor tasked with the evaluation of the MFP demonstration. As required under section 6071(g)(2) of the DRA, the Secretary must submit a final report to the President and Congress not later than September 30, 2026, and section 6071(i)(1) of the DRA requires the Secretary to submit a Best Practices Report not later than September 30, 2022, providing the findings and conclusions on the conduct and effectiveness of the MFP demonstration and best practices from MFP state demonstration projects. The Recipient will be required to provide information and data to inform the CMS Evaluation Reports in a form and manner and by a deadline specified by CMS.

29. Cooperation with the Contractor for Quality Assurance and Improvement, and Technical Assistance and Oversight. The Recipient must fully cooperate with the CMS-designated contractor to support quality assurance and improvement, oversight, and technical assistance activities. The Recipient must participate in certain technical assistance activities and venues as directed by CMS throughout the Recipient's period of program performance.

30. Annual MFP Intensive Meeting. The Recipient agrees to attend an annual meeting of MFP demonstration projects for the duration of the Recipient's period of program performance. The location, date, and time of the meeting is to be determined. Grant award funds may be used to cover expenses associated with attending an annual meeting of MFP demonstration projects. The MFP project director and the MFP data and quality analyst are expected to attend.

VII. Quality Assurance and Quality Improvement

31. Quality Management Strategy and Plan. In accordance with section 6071(c)(11)(A) of the DRA, Recipients are required to develop and implement a

comprehensive and integrated quality management strategy and plan, subject to CMS review and prior approval. The plan will focus on quality assurance and quality improvement for HCBS under the state Medicaid program, including a plan to assure the health and welfare of individuals participating in the MFP demonstration. Such a strategy enhances the state's capacity to assure that the LTSS system operates as designed and that the critical processes of discovery, remediation, and systems improvement occur in a structured and routine manner.

The plan must include targeted system performance requirements to which the critical processes apply, aligning with assurances defined within the section 1915(c) HCBS waiver program, including that 1) the state conducts level of care need determinations consistent with the need for institutionalization; 2) plans of care are responsive to participants' needs; 3) qualified providers serve participants; 4) health and welfare of participants is protected; (5) State Medicaid Agency retains administrative authority over the program; and (6) the state provides financial accountability of the program.

32. 24-Hour Back-Up System. The quality management plan must include a 24-hour back-up system for critical services. The plan should address, at a minimum, the back-up systems related to (1) critical services, (2) transportation, (3) direct care workers, (4) repair and replacement for durable medical equipment (DME) and other equipment (including provision of loaning equipment while repairs are being made), and (5) access to medical care (including how participants are assisted with initial appointments, how to make appointments, and how to resolve appointment or care issues). The Recipient must describe how the requirement will be met in the OP.

33. Continuous Quality Improvement. To ensure that procedures are in place and comparable to those required under Medicaid's qualified HCBS program, the Recipient will be required to implement a CMS-defined set of nationally standardized HCBS quality measures to provide quality assurance for eligible individuals receiving Medicaid HCBS and to provide for continuous quality improvement in such services. See PTC 43 for reporting requirements on the HCBS quality measures.

34. Continuous Quality Improvement Technical Assistance. In accordance with section 6071(f) of the DRA, technical assistance will be available under MFP to support the Recipient in developing a comprehensive quality management strategy to include use of data collection tools and resources, reporting, data quality monitoring, and program evaluation methods. The MFP Quality and Data Analyst must participate in quality improvement technical assistance activities.

VIII. Operational Protocol

35. Operational Protocol Components. The Operational Protocol (OP) is the operational guide that outlines the Recipient's demonstration and addresses how the Recipient will meet the objectives of the MFP program. The Recipient must leverage input from stakeholders, including HCBS participants and providers, to design the program and operational elements of the MFP demonstration and prepare the OP. The OP shall describe the operational approach and project implementation plan, including program benchmarks and program content where applicable, for the following program components:

- Target population and service area
- Reporting
- Project Administration
- Recruitment and Enrollment
- Outreach/Marketing/Education
- Stakeholder Engagement
- Benefits and Services
- Transition and Housing Services
- Self-Direction and Informal Caregiving
- Quality Measurement, Assurance, and Monitoring
- Continuity of Care Post-Transition
- Equity
- Public Health Emergencies
- Tribal Initiative (if applicable)

CMS reserves the right to amend or add new OP elements during the demonstration period. The Recipient must submit the OP to CMS for review and approval. Only after CMS approval of the OP may the Recipient enroll participants in MFP and request reimbursement for MFP-funded services and claim the MFP-enhanced FMAP. The MFP-enhanced match will be available prospectively upon the date of CMS's approval of the OP, not retrospectively.

36. Operational Protocol – Amendment Process. The Recipient must amend its MFP OP in response to changes in federal or state law, regulation, or policy impacting MFP eligibility, enrollment, or program operations and when responding to new needs that affect MFP operations, inclusive of changes to any of the required MFP OP elements. Recipient requests to amend the OP must be submitted to CMS for approval no later than 30 days prior to the planned date of implementation of the change and may not be implemented until approved. OP amendment requests must include the following:

(a) An explanation of the stakeholder process used by the Recipient consistent with the Recipient requirements described in the OP to reach a decision regarding the requested amendment;

(b) A detailed description of the amendment, including impact on MFP program participants which isolates, by MFP program target populations, the impact, and includes Medicaid beneficiaries eligible for LTSS;

(c) An implementation date for the amendment provisions;

(d) A data analysis which identifies the impact of the proposed amendment on the current CY budget and for the demonstration period of performance. If applicable, a revised budget must be submitted through the GrantSolutions Grants Management Module; and

(e) A description of how the MFP program sustainability plan will be modified to incorporate the amendment provisions.

IX. General Reporting Requirements.

37. Reporting. Consistent with section 6071(c)(13) of the DRA, the Recipient must collect, and report to CMS and/or its contractors data related to MFP Demonstration Project progress and goal achievement. The Recipient is required to report projected and actual financial information on demonstration expenditures. Additionally, the Recipient must comply with reporting requirements for grant accountability as stated in the Standard Terms and Conditions of Award.

38. Qualified HCBS Expenditures Reporting Requirements. The Recipient must report on qualified HCBS expenditures in the MFP demonstration financial reporting forms A, B, C, and D ("ABCD") as further described in PTC 48. The Recipient must report quarterly on MFP qualified HCBS expenditures for state plan services and HCBS waiver programs for each calendar year.

39. Demonstration Services Reporting Requirements. The Recipient must report on each discrete demonstration service in the MFP demonstration financial reporting forms ABCD and in the Semi-Annual Progress report as specified in PTC 42. The Recipient must report demonstration expenditures on a calendar year quarterly basis in the financial reporting forms ABCD and on a calendar year semi-annual basis in the semi-annual report. Additionally, the Recipient shall participate in discussions with CMS and MFP evaluators on implementation of the demonstration service(s), including progress toward the goals, and key challenges, achievements and lessons learned.

40. Supplemental Services Reporting Requirements. The Recipient must report on each discrete supplemental service in the MFP demonstration financial reporting forms ABCD and in the Semi-Annual Progress report as described in PTC 42. The Recipient must report supplemental expenditures on a calendar year quarterly basis in the financial reporting forms ABCD and on a calendar year semi-annual basis in the Semi-Annual Progress report. CMS reserves the right to require additional reporting on supplemental services as part of a supplemental services housing plan.

41. Administrative Activities Reporting Requirements. The Recipient must report on expenditures for administrative activities in the MFP demonstration financial reporting forms ABCD, in the Semi-Annual Progress report as further described in PTC 42, and in the Work Plan as described in PTC 49. The Recipient must report on expenditures for each discrete administrative activity.

42. Semi-Annual Progress Report. The Semi-Annual Progress report is to present the Recipient's analysis and the status of the various operational areas in reaching the objectives of the demonstration. Through the Semi-Annual Progress reports, the Recipient will further enumerate how it has, or intends to, meet or align with the Recipient's MFP operational procedures and processes; transition benchmarks; program goals for expanding and enhancing HCBS; and sustainability plans. The Recipient must submit the Semi-Annual Progress report in the form and manner specified by CMS, no later than 60 calendar days following the end of each second and fourth calendar year quarter. The Recipient must submit the progress report through the final reporting period of the Recipient's program period of performance, even if the Recipient has not operated for a complete reporting period.

43. HCBS Quality Measures. The Recipient must report on the HCBS Quality Measure Set, as described in State Medicaid Director Letter # 22-003, to provide quality assurance for eligible individuals receiving Medicaid HCBS and to provide for continuous quality improvement in such services, as discussed in PTC 33. The HCBS Quality Measure Set is a set of nationally standardized quality measures for Medicaid-funded HCBS that is intended to promote more common and consistent use within and across states of such nationally standardized quality measures in HCBS programs, create opportunities for CMS and states to have comparative quality data on HCBS programs, and drive improvement in quality of care and outcomes for people receiving HCBS. See https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf for more information.

The Recipient must also report annually on a minimum of three MFP performance indicators that are connected to the achievement of the objectives identified in section 6071(a) of the DRA and to satisfy the objective in section 6071(d)(4)(A)(i) in a form and manner specified by CMS. These measures will inform progress on MFP demonstration project outcomes and HCBS system reform efforts and must be approved by CMS.

44. Transformed Medicaid Statistical Information System (T-MSIS) Reporting. The Recipient must submit production data monthly to T-MSIS that is specific to MFP enrollees as specified by CMS. The Recipient must coordinate with the state staff responsible for the state's T-MSIS files to remedy issues related to data accuracy and completeness, data submission timeliness, and other issues identified in the state's monthly production data submissions related to MFP enrollees.

45. Critical Incident Reporting. The Recipient must have a system as well as policies and procedures in place through which providers must identify, report, and investigate critical incidents that occur within the delivery of services under this demonstration. The Recipient must ensure that provider contracts reflect these requirements. The Recipient must also have a system as well as policies and procedures in place through which to detect, report, investigate, and remediate abuse, neglect, and exploitation. The Recipient must educate providers and participants about this system. The Recipient must require providers to take specific action steps in the event of known or suspected abuse, neglect, or exploitation. The Recipient is required to report on critical incidents related to MFP participants in each Semi-Annual Progress Report.

46. Maintenance of Effort. In accordance with section 6071(c)(9) of the DRA, the Recipient must provide information and assurances that total expenditures under the state Medicaid program for HCBS will not be less for any fiscal year during the MFP demonstration project period for any succeeding fiscal year before the first year of the MFP demonstration project. Maintenance of effort (MOE) will be monitored by comparing spending in the baseline year (federal fiscal year prior to the Program Implementation Phase and HCBS Transitions Phase) to each subsequent year of MFP demonstration project operation. The spending will be in aggregate and will include spending on all state plan HCBS and HCBS waiver programs (see Attachment A for descriptions of HCBS covered under this demonstration project). During the Program

Implementation and HCBS Transitions Phase, the Recipient will report these expenditures for all populations. In other words, the HCBS expenditures will not be limited to demonstration service areas or to demonstration populations. These expenditures will be reported annually to CMS on a CMS-provided MOE template form.

47. MFP Capacity Building Supplemental Funding Opportunity. Recipients in receipt of an HCBS Capacity Building supplemental funding award must report on the activities and milestones funded through this opportunity in the Semi-Annual Progress report and Work Plan and must report on expenditures on a quarterly basis in the financial reporting forms ABCD. The Recipient must report, as part of the annual supplemental budget process, on the projected and actual expenditures related to the MFP Capacity Building supplemental award.

48. General Financial Reporting Requirements. The Recipient will comply with all general financial reporting requirements as stated in the "FINANCIAL REPORTING" section of the Standard Program Terms and Conditions of Award. In addition to the Federal Financial Report (SF-425) (see a.), the Recipient will be required to submit the following programmatic financial reports:

a. Federal Financial Report (SF-425) – Semi-annual submission. This report describes the extent to which the MFP demonstration project contributes to accomplishing MFP objectives.

b. CMS 64.9i, 9Pi and 64.10i, 10Pi – Quarterly submission. These forms allow the state and CMS to track expenditures associated with the demonstration participants.

c. MFP Financial Reporting Forms (ABCD) – Quarterly submission. The MFP financial reporting forms are modified from the CMS Form-64. The forms provide a mechanism for tracking expenditures under the demonstration.

d. Maintenance of Effort (MOE) Form – Annual submission. This form captures all HCBS expenditures by comparing spending in the baseline year (federal fiscal year prior to the Program Implementation Phase and HCBS Transitions Phase) to each subsequent year of MFP demonstration project operation. The spending will be in aggregate and will include spending on all state plan HCBS and HCBS waiver programs (see Attachment A for descriptions of HCBS covered under this demonstration project). During the Program Implementation and HCBS Transitions Phase, the Recipient will report these expenditures for all populations. In other words, the HCBS expenditures will not be limited to demonstration service areas or to demonstration populations.

e. MFP Worksheet for Proposed Budget (WFPB) – Annual submission. This form provides CMS with a standardized report of each Recipient's high-level budget information, as well as projected transition benchmark information. The WFPB is included as a section in the annual budget workbook submission required in the annual supplemental funding request.

49. Work Plan on State Initiatives to Expand and Enhance HCBS. CMS expects the Recipient to use grant funds for the purposes of providing new or expanded HCBS and for initiatives to strengthen HCBS system infrastructure. The Recipient must submit a

standardized (CMS-provided template) Work Plan as required by section 6071(c)(7)(B)(iii) of the DRA to document progress on the use of initiatives designed to accomplish the objective in section 6071(a)(1) of the DRA to increase the use of HCBS, rather than institutional LTSS.

If the Recipient fails to make progress under the approved Work Plan as described in section 6071(c)(13)(C), the Recipient shall implement a corrective action plan reviewed and approved by CMS in accordance with CMS Standard Terms and Conditions.

Attachment A: MFP Qualified Home and Community-Based Services

The following are qualified HCBS eligible for the MFP-enhanced FMAP with corresponding descriptions:

State Plan Services

Home Health Services: Home health services are mandatory services authorized at section 1905(a)(7) of the Social Security Act (the Act) and codified in regulations at 42 C.F.R. § 440.70. Home health services include nursing services, home health aide services, medical supplies, equipment, and appliances, and may include therapy services (physical therapy, occupational therapy, speech pathology, and audiology).

Personal Care Services: Personal care services are optional services authorized at section 1905(a)(24) of the Act and codified in regulations at 42 C.F.R. § 440.167. Personal care services can include a range of human assistance provided to persons who need assistance with daily activities.

Self-Directed Personal Care Services: Section 1915(j) of the Act allows self-direction of state plan personal care services. Requirements are set forth in 42 CFR Part 441 Subpart J.

Case Management: Case management services, as defined under sections 1905(a)(19) and 1915(g) of the Act and codified in regulations at 42 C.F.R. § 440.169 and 42 C.F.R. § 441.18, assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services.

Rehabilitative Services: The rehabilitative services benefit is an optional Medicaid state plan benefit authorized at section 1905(a)(13) of the Act and codified in regulation at 42 C.F.R. § 440.130(d) as "medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level." Many mental health and substance use disorder services are authorized under this benefit. For MFP, rehabilitative services furnished in IMDs are not considered as qualified HCBS.

OBRA '89 Grandfathered Day Habilitation Programs (Adult Day Services) as Covered under Section 1905(a)(13) Rehabilitative and 1905(a)(9) Clinic Services: In states with Omnibus Budget Reconciliation Act of 1989 (OBRA '89) grandfathered status, day habilitation programs are covered under the clinic services (codified in regulation at 42 C.F.R. § 440.90) and/or the rehabilitative services state plan benefit (codified in regulation at 42 C.F.R. § 440.130(d)). OBRA '89 prohibits CMS from withholding FFP for day habilitation and related services offered under the state plan clinic or rehabilitative services benefit on behalf of persons with [intellectual or developmental disabilities] if the day habilitation program was approved in the state plan on or before June 30, 1989. Absent OBRA '89 status, a state may not cover day habilitation services under state plan 1905(a) services. Day habilitation programs (also known as adult day services) can be covered under HCBS state plan and waiver programs, and section 1115 demonstrations.

Private Duty Nursing (in-home only): Private duty nursing is an optional Medicaid state plan benefit authorized at section 1905(a)(8) of the Act and codified in regulation at 42 C.F.R. § 440.80 as "nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided: (a) by a registered nurse or a licensed practical nurse; (b) under the direction of the recipient's physician ; and (c) to a recipient in one or more of the following locations at the option of the State: **(1) his or her own home;** (2) a hospital; or (3) a skilled nursing facility."

The MFP-enhanced FMAP is only applicable when the service is provided in a recipient's **own home.**

Hospice Services: Hospice care is an optional benefit authorized at section 1905(a)(18) of the Act, that provides an array of services to individuals who are determined to be terminally ill due to a medical prognosis that his or her life expectancy is six months or less. Hospice services include, nursing, medical social services, physicians' services and counseling services. A full list of hospice services are defined in section 1861(dd)(1) of the Act. The hospice state plan benefit follows this provision.

Coverage of Services to Children with Autism Spectrum Disorder (ASD): Under the Medicaid state plan, services to address ASD may be covered under several different section 1905(a) benefit categories. Those categories include: section 1905(a)(6) - services of other licensed practitioners; section 1905(a)(13)(c) - preventive services; and section 1905(a)(10) - therapy services.

Other Licensed Practitioner Services: Other Licensed Practitioner services (OLP) services, authorized as an optional state plan benefit at section 1905(a)(6) of the Act and defined at 42 C.F.R. § 440.60(a), are "medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law."

Preventive Services: Preventive Services, authorized as an optional state plan benefit at section 1905(a)(13) of the Act and defined at 42 C.F.R. § 440.130(c), are "services recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice under state law to— (1) Prevent disease, disability, and other health conditions or their progression; (2) Prolong life; and (3) Promote physical and mental health and efficiency."

Therapy Services: Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders, may be covered under the Medicaid therapies benefit at 42 C.F.R. § 440.110. These services are authorized as optional state plan benefits at section 1905(a)(11) of the Act.

HCBS under Sections 1915(c), 1915(i), 1915(j) and 1915(k)

Section 1915(c): Waiver authority found at section 1915(c) of the Act gives states the option to offer LTSS in home and community-based settings to individuals who would otherwise require institutional care. States have broad latitude to determine the services to offer under waiver programs, consistent with the benefit package specified in section 1915(c)(4)(B) of the Act.

Section 1915(i): Section 1915(i) is an optional state plan benefit that allows states to provide HCBS to individuals who meet state-defined needs-based criteria that are less stringent than institutional criteria (and, if chosen by the state, target group criteria) as set forth in 42 CFR Part 441 Subpart M.

Section 1915(j)-Self-directed 1915(c) services: Section 1915(j) of the Act allows self-direction of HCBS otherwise available under a section 1915(c) waiver program that are provided to an individual who has been determined eligible for the self-directed option. Requirements are set forth in 42 CFR Part 441 Subpart J.

Section 1915(k): The section 1915(k) Community First Choice (CFC) state plan benefit provides certain individuals, who meet an institutional level of care, the opportunity to receive necessary personal attendant services and supports in a home and community-based setting. States receive an extra six percentage points of federal match for CFC service expenditures.

Other HCBS Options

Program of All-Inclusive Care for the Elderly (PACE): PACE provides comprehensive medical and social services to certain frail, elderly individuals, most of whom are dually eligible for Medicare and Medicaid. An interdisciplinary team of health professionals provides PACE participants with coordinated care.

Managed Long-Term Services and Supports (MLTSS): Managed LTSS (MLTSS) refers to the delivery of LTSS through capitated Medicaid managed care programs. Recipients can implement MLTSS using an array of managed care authorities, including a section 1915(a) voluntary program, a section 1932(a) state plan amendment, a section 1915(b) waiver, or a section 1115 demonstration. Any of those managed care authorities can be "paired" with state plan HCBS benefits offered under section 1905(a), 1915(i), 1915(j), or 1915(k) or an HCBS waiver program under section 1915(c).

Section 1945 Health Homes: The optional health home state plan benefit authorized under section 1945 of the Act includes various services that help to ensure the coordination of all primary services, acute care services, behavioral health (including mental health and substance use) services, and LTSS for individuals with chronic conditions, and thus help to ensure treatment of the "whole person." Section 1945 defines health home services as comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; individual and family support; referral to community and social support services, if relevant; and use of health information technology to link services, as feasible and appropriate.

Section 1115 Demonstrations: States can utilize section 1115(a) demonstration authority to test new strategies to promote the objectives of the Medicaid program. Section 1115(a)(1) of the Act allows the Secretary to waive compliance with the Medicaid requirements of section 1902 of the Act, including but not limited to statewideness and comparability, to the extent and for the period necessary to carry out the demonstration. In addition, section 1115(a)(2) of the Act allows the Secretary to provide FFP for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary. Any of the qualified HCBS described above are eligible for the MFP-enhanced match when authorized under an approved 1115 demonstration.

Centers for Medicare & Medicaid Services
Standard[1] Grant/Cooperative Agreement[2] Terms and Conditions

GENERAL

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

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

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

   If the recipient cannot accept the terms, the recipient must notify the Grants Management Officer (GMO) within thirty (30) days of receipt of this award notice. Once an award is accepted by a recipient, the contents of the Notice of Award (NoA) are binding on the recipient unless and until modified by a revised NoA signed by the GMO.

3. **Terms and Conditions of Award.** This Award is subject to terms and conditions detailed in the award and to those cited and incorporated by reference, including:
   - Recipient Specific Terms and Conditions, if applicable
   - Program Terms and Conditions
   - Standard Terms and Conditions

   Recipients of Department of Health and Human Services' (DHHS) grants or cooperative agreement awards must comply with all terms and condition of their awards, including:
   (a) requirements of the authorizing statutes and implementing regulations for the program under which the award is funded
   (b) applicable requirements or limitations in appropriations acts

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

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

(c) terms and conditions included in the HHS Grants Policy Statement in effect at the time of a new, noncompeting continuation, or renewal award, or supplemental award, including the requirements of applicable HHS regulations
(d) any policies or requirements specific to the award; and
(e) any requirements included in the NOFO.

4. **Funding for Recipients.** All funding provided under this award must be used by the Recipient exclusively for the program referenced in the Notice of Award and described in the Notice of Funding Opportunity and outlined in the Recipient's approved application. This includes any approved revisions, as applicable, made subsequent to the Recipient's approved application.
   - Per 45 CFR §75.309(a), a non-Federal entity may charge to the Federal award only allowable costs incurred during the period of performance (except as described in 45 CFR §75.461) and any costs incurred before the HHS awarding agency or pass-through entity made the Federal award that were authorized by the Federal awarding agency or pass-through entity.
   - Funds available to pay allowable costs during the period of performance include both Federal funds awarded and approved carryover balances.
   - Federal award funds must supplement, not replace (supplant) nonfederal funds. All recipients who receive awards under programs must ensure that federal funds do not supplant funds that have been budgeted for the same purpose through non-federal sources. Applicants or award recipients may be required to demonstrate and document that a reduction in non-federal resources occurred for reasons other than the receipt of expected receipt of federal funds.
   - Any funds used for any purpose other than for the approved program, including disallowed costs, should be returned to the United States Treasury. Instructions for returning funds including interest earned in excess of $500 are available here.

5. **Uniform Administrative Requirements, Cost Principles, and Audit Requirements.** The NoA issued is subject to the administrative requirements, cost principles, and audit requirements that govern Federal monies associated with this award, as applicable, in the Uniform Guidance – 2 Code of Federal Regulations (CFR) § 200 as codified by HHS at 45 CFR § 75.

6. **The HHS Grants Policy Statement (HHS GPS).** This award is subject to the requirements of the HHS GPS that are applicable to the Recipient based on the Recipient type and the purpose of this award. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary.

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

Attn: HOTLINE, 330 Independence Ave., SW, Washington, DC 20201. Such reports are treated as sensitive material and submitters may decline to give their names if they choose to remain anonymous.

8. **Medicare and Medicaid anti-kickback** statute. Recipient is subject to this statute and acknowledges there is a risk of criminal and administrative liability under this statute, specifically under 42 U.S.C. § 1320-7b(b) Illegal remunerations. This statute states, in part, that:

   Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind-

   - in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a federal health care program, or
   - in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

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

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

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

11. **Reservation of Rights.** Nothing contained in this Award is intended or shall be construed as a waiver by the United States Department of Justice, the Internal Revenue Service, the Federal Trade Commission, HHS Office of the Inspector General, or CMS of any right to institute any proceeding or action against Recipient for violations of any statutes, rules or regulations administered by the Government, or to prevent or limit the rights of the Government to obtain relief under any other federal statutes or regulations, or on account of

any violation of this Award or any other provision of law. The Award shall not be construed to bind any Government agency except CMS, and this Award binds CMS only to the extent provided herein, unless prohibited by law. The failure by CMS to require performance of any provision shall not affect CMS's right to require performance at any time thereafter, nor shall a waiver of any breach or default result in a waiver of the provision itself.

ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

12. **Prior Approval Requirements.** CMS anticipates that the recipient may need to modify the recipient's award budget or other aspects of its approved application during performance to accomplish the award's programmatic objectives. In general, recipients are allowed a certain degree of latitude to rebudget within and between budget categories to meet unanticipated needs and to make other types of post-award changes, provided that the changes still meet the statutory program requirements and the regulatory requirements under 45 CFR 75, as applicable.

    Items that require prior approval (i.e. formal written approval) from the GMO, as stated in the Terms and Conditions of Award and HHS grant regulation 45 CFR 75, must be submitted in writing. Based on the nature, extent, and timing of the request, the GMO may approve, deny, or request additional material to further document and evaluate your request.

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

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

    Prior approval is required for <u>but is not limited to</u>:
    - Changes in Key Personnel and Level of Effort,
    - Budget Revisions (see also Standard Term and Condition *Revision of Budget and Program Plans*),
    - Changes in Scope,
    - Carryover Requests,
    - Travel Requests (as detailed below)

- For attendance at any conference[3], including those sponsored by CMS, recipients must submit a detailed breakdown of costs associated with attending the conference for prior written approval. All costs must be individually itemized. This breakdown should include all costs associated with travel to the conference and a brief narrative explaining the program related purpose/how attending the conference will further the objectives of the program.
- Note: All federally funded travel must be tracked through a travel log which includes: traveler/position, destination, length of stay, mileage, per diem, reason for the trip, airfare, and any other reimbursable expenses. Recipients must also consult and comply with requirements outlined under 45 CFR §75.474, *Travel Costs*.

- Purchase of Technology
  - Purchase of technology items (both those classified as equipment and those classified as supplies), over and above that which is already approved in the budget must be approved by the Grants Management Officer (regardless of acquisition cost).
  - Note: All technology items, regardless of classification as equipment or supply must still be individually tagged and recorded in an equipment/technology data. This database should include any information necessary to properly identify and locate the item. For example, serial # and location of equipment (e.g. laptops, tablets, etc.).
- No Cost Extensions;
- Lifting of Funding Restrictions;
- Removal of Corrective Action Plans;
- any costs to support rearrangement, alteration, reconversion, or capital expenditures (refer to 45 CFR §§75.439 and 75.462).

Activities that require prior approval are further detailed in HHS grant regulation 45 CFR §§ 307 and 474.

13. **Revision of Budget and Program Plans.** Recipients must consult and comply with requirements outlined under 45 CFR §75.308, *Revision of budget and program plans*. Please note that CMS is not waiving any prior approval requirements outlined in this section of the regulation or as stated in these Standard Terms and Conditions. Additionally, in accordance with §75.308(e), CMS requires prior approval for budget revisions where the transfer of funds among direct cost categories or programs, functions and activities in which the Federal share of the project exceeds the Simplified Acquisition Threshold ($250,000) and the **cumulative amount** of such transfers exceeds or is expected **to exceed 10 percent** of the

[3] OMB Memorandum M-12-12 employs, and HHS has adopted the following definition for a conference from the Federal Travel Regulation (FTR): A "conference" is defined as "[a] meeting, retreat, seminar, symposium or event that involves attendee travel. The term 'conference' also applies to training activities that are considered to be conferences under 5 CFR 410.404."

total budget as last approved. CMS cannot permit a transfer that would cause any Federal appropriation to be used for purposes other than those consistent with the appropriation.

- Recipients with total costs below the simplified acquisition threshold may transfer up to 25% of the total current budget approved within and between approved direct cost categories per budget period without prior approval.
- CMS must review and approve rebudgeting among direct cost categories or programs, functions and activities of 25 percent or more of total costs of the last approved budget period (for the current budget period) for all federal awards.
- Once the rebudgeting threshold is reached, the recipient must request prior approval for all additional changes during that budget period.

14. **Conflict of Interest Policies.** Recipient must comply with the conflict of interest policy requirements outlined in **Attachment A** to these Standard Terms and Conditions. See also 45 CFR §75.112.

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

16. **Public Policy Requirements.** Public policy requirements are requirements with a broader national purpose than that of the Federal sponsoring program or award that an applicant/recipient must adhere to as a prerequisite to and/or condition of an award. Public policy requirements are established by statute, regulation, or Executive order. In some cases, these requirements relate to general activities such as preservation of the environment, while, in other cases they are integral to the purposes of the award-supported activities. The release of federal funds through a grant award does not constitute or imply compliance with federal statute and regulations. Funded organizations must ensure that their activities comply with all applicable federal regulations.

    All federal statutes and regulations relevant to federal financial assistance, including those highlighted in the HHS Administrative and National Policy Requirements.

17. **Non-Discrimination and Accessibility Requirements.** Recipients and subrecipients of federal financial assistance (FFA) from HHS are required as a condition of this award to complete an HHS Assurance of Compliance form (HHS 690).

    Recipient certifies that the organization has on file with the HHS Office of Civil Rights (OCR) a one-time Assurance of Compliance with the statutes described in this subsection. The Assurance, Form HHS 690, is filed for the organization and is not required for each application or award.

Subrecipients that receive funding from Recipients (including contractors under grants) rather than directly from CMS, are also required to file an HHS 690. Recipient is responsible for determining whether those organizations have the required Assurance on file and, if not, ensuring that it is filed with the HHS Office of Civil Rights (OCR).

The HHS 690 form may be filed electronically via the U.S. Department of Health and Human Services' Assurance of Compliance online portal here or be mailed to:

U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Ave., S.W. Room 509F
Washington, D.C. 20201

You will administer your project in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, disability, age, and comply with applicable conscience protections. You will comply with applicable laws that prohibit discrimination on the basis of sex, which includes discrimination on the basis of gender identity, sexual orientation, and pregnancy. Compliance with these laws requires taking reasonable steps to provide meaningful access to persons with limited English proficiency and providing programs that are accessible to and usable by persons with disabilities. The HHS Office for Civil Rights provides guidance on complying with civil rights laws enforced by HHS **and** HHS Non-Discrimination Notice.

- For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficient individuals, click here.
- For information on your specific legal obligations for serving qualified individuals with disabilities, including providing program access, reasonable modifications, and to provide effective communication, click here.
- For information on how HHS funded health and education programs must be administered in an environment free of sexual harassment, click here.
- For guidance on administering your project in compliance with applicable federal religious nondiscrimination laws and applicable federal conscience protection and associated antidiscrimination laws, click here.

Recipients should review and comply with the reporting and review activities regarding accessibility requests outlined in **Attachment B**, to these Standard Terms and Conditions.

18. **Prohibition on certain telecommunications and video surveillance services or equipment.** Recipients and subrecipients are prohibited to obligate or spend grant funds (to include direct and indirect expenditures as well as cost share and program) to:

    (1) Procure or obtain,

    (2) Extend or renew a contract to procure or obtain; or

    (3) Enter into contract (or extend or renew contract) to procure or obtain equipment, services, or systems that use covered telecommunications equipment or services

as a substantial or essential component of any system, or as critical technology as part of any system. As described in Pub. L. 115-232, section 889, covered telecommunications equipment is telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities).

i. For the purpose of public safety, security of government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities).

ii. Telecommunications or video surveillance services provided by such entities or using such equipment.

iii. Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of the National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise, connected to the government of a covered foreign country.

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

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

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

20. **Privacy and Security of Health Information.** The Recipient shall put all appropriate regulatory, administrative, technical, and physical safeguards in place before applicable

program activities begin to protect the privacy and security of individually identifiable health information. In doing so, regardless of whether it is a covered entity (CE) or business associate (BA) as those terms are defined under the HIPAA Privacy Rule, the Recipient shall ensure its own and its subrecipients' and contractors' policies and procedures are at least as stringent (i.e., protective of privacy) as those governing the use and disclosure of protected health information by HIPAA CEs and their BAs under 45 C.F.R. parts 160 and 164. The Recipient and its subrecipients should consult with their own counsel and refer to the HIPAA guidance materials for further information about the requirements in 45 C.F.R. Parts 160 and 164.

21. **Trafficking in Persons.** This award is subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, refer to **Attachment C** to these Standard Terms and Conditions.

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

23. **Mandatory Disclosures.** Consistent with 45 CFR §75.113, applicants and recipients must disclose in a timely manner, in writing to CMS, with a copy to the HHS Office of the Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Additionally, subrecipients must disclose, in a timely manner, in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to CMS and to the HHS OIG at the following addresses:

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

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

    AND

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

Fax: (202) 205-0604 (Include "Mandatory Grant Disclosures" in subject line) or
Email: MandatoryGranteeDisclosures@oig.hhs.gov

Failure to make required disclosures can result in any of the remedies described in 45 CFR §75.371, *Remedies for noncompliance*, including suspension or debarment (See 2 CFR parts 180 & 376 and 31 U.S.C. 3321).

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

24. **Suspension and Debarment Regulations.** Recipient must comply with 45 CFR §75.213, which states that non-federal entities and contractors are subject to the non-procurement debarment and suspension regulations implementing Executive Orders 12549 and 12689 at 2 CFR parts 180 and 376. These regulations restrict awards, subawards and contracts with certain parties that are debarred, suspended or otherwise excluded from or ineligible for participation in Federal assistance programs or activities.

25. **FY 2024 Appropriations Provision.** U.S. Department of Health & Human Services (HHS) recipients must comply with (a) all terms and conditions outlined in their grant award(s), including grant policy terms and conditions contained in applicable HHS Grants Policy Statements, and requirements imposed by program statutes and regulations, (b) Executive Orders, (c) HHS grant administration regulations, as applicable; and (d) any requirements or limitations in any applicable appropriations acts.

    This award is subject to the "Further Consolidated Appropriations Act, 2024" **H.R.2882**, for the Departments of Labor, Health and Human Services, and Education.

    Recipients must also review and comply with applicable General Provisions under Division D, Title II, for the Department of Health and Human Services (see General Provisions 202-241) and applicable General Provisions under Title V (see General Provisions 501-531 for the Departments of Labor, Health and Human Services and Education) included within the Appropriations Law. These provisions may apply to all recipients of HHS federal funding OR may apply directly to recipients of federal funding from one or more HHS agencies.

    Salary Limitations: As is noted under Division D, Title II, General Provisions, Section 202, none of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II. This salary cap applies to direct salaries. Please consult the following link to determine the applicable current salary cap.

26. **Health Information Technology (IT) Interoperability.**
    If award funding involves implementing, acquiring, or upgrading health IT for activities by any funded entity, Recipients and subrecipients are required to 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.

If award funding involves implementing, acquiring, or upgrading health IT for activities by eligible clinicians in ambulatory settings, or hospitals, eligible under Section 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.

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.

COST PRINCIPLES

Centers for Medicare and Medicaid Services (CMS) grant awards provide for reimbursement of actual, allowable costs incurred and are subject to the Federal cost principles in HHS grant regulations at 45 CFR Part 75, Subpart E. 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 particular set of cost principles depends on the type of organization. CMS 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 commercial (for-profit) organizations are subject to the cost principles located at 48 CFR subpart 31.2[4].

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.

For-profit entities which receive the preponderance of their federal awards from HHS may contact the Division of Financial Advisory Services (DFAS), Indirect Cost Branch, to negotiate an indirect cost rate. Otherwise, for-profit organizations are limited to the 10% de minimis rate in accordance with 45 CFR §75.414(f).

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

[4] There are no cost principles specifically applicable to grants to for-profit organizations. Therefore, the cost principles for commercial organizations set forth in the FAR (48 CFR subpart 31.2) generally are used to determine allowable costs under CMS grants to for-profit organizations. As provided in those costs principles, allowable travel costs may not exceed those established by the FTR. The cost principles in 45 CFR 75, Appendix IX, determine allowable costs under CMS grants to proprietary hospitals.

- Cost sharing or matching any other State or Federal funds.
- Providing 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.
- Providing 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.
- 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 in accordance with 45 CFR §75.476.
- Profit to any recipient even if the recipient is a commercial (for-profit) organization. Profit is any amount in excess of allowable direct and indirect costs.
- Lobbying. 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.
    - Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR §93.
    - Recipients must also comply with lobbying restrictions outlined in the applicable Appropriations Law.
- Costs of promotional items and memorabilia, including models, gifts, and souvenirs;
- Costs of advertising and public relations designed solely to promote the non-Federal entity.
- Meals unless in limited circumstances such as:
    - Subjects and patients under study;
    - Where specifically approved as part of the project or program activity (not 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.

POST AWARD MONITORING AND REPORTING

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

    Recipients must demonstrate satisfactory performance during the previous funding cycle(s) to be issued additional year funding; or, in the case of multi-year awards where all funding is

issued in the first year, to ensure continued access to funding. Recipients should refer to the NOFO and Program Terms and Conditions for additional information on satisfactory progress.

Additionally, as is noted in 45 CFR Part 75, CMS annually conducts a review of risks posed by applicants prior to award (applicant should review the factors in their entirety at §75.205). At-risk recipients, including those which do not comply with reporting requirements or have outstanding audit findings, may not receive a non-competing continuation award.

Alternatively, recipients could receive decreased funding, or their award could be terminated in accordance with 45 CFR 75.372 "Termination" if they are non-compliant with the terms and conditions of award.

29. **Reporting Requirements.** Recipients must comply with the reporting requirements outlined in the Standard **and** Program Terms and Conditions of award. Failure to submit reports on time may be basis for withholding financial assistance payments, suspension, termination or denial of continued funding. Recipient's failure to timely submit such reports may result in a designation of "At-risk" for the recipient organization and may jeopardize potential future funding from the U.S. Department of Health and Human Services. The general information and guidance for financial and programmatic reporting provided below supplements the specifics included in the Program Terms and Conditions.

A. PROJECT AND DATA INTEGRITY

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

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

At any phase in the project, including the project's conclusion, the Recipient, if requested by the CMS Project Officer, must deliver to CMS materials, systems, or other items used, developed, refined or enhanced in the course of, or under the award. The Recipient agrees that CMS must have a royalty-free, nonexclusive and irrevocable license to reproduce, publish, or otherwise use and authorize others to use the items for Federal government purposes.

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

This award is subject to the requirements of 2 CFR part 25, Appendix A which is specifically incorporated herein by reference. Recipient must maintain current information in the system at all times when an award is active or if there is an application pending review.

Recipient must review and update the information **at least once a year** after the initial registration to remain active, and more frequently if required by changes in the information. This requirement flows down to subrecipients and contractors under awards or subawards.

C. RESPONSIBILITY AND QUALIFICATION REPORTING (R/Q) (formerly FAPIIS)

Recipients that have active federal contract, grant, or cooperative agreement awards with a cumulative value greater than $10,000,000 are **required** to disclose semi-annual information about criminal, civil, and administrative proceedings that have, within the last five years, been the subject of a criminal, civil, and/or administrative proceeding at the federal or state level in connection with a federal award that resulted in a conviction or finding of fault or liability. 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 on SAM.gov.

Additional Guidance

- Responsibility/Qualification Information
- Federal Awarding Agency Review of Risk Posed by Applicants, 45 CFR 75.205

Note: Recipients must accurately address the proceedings questions as part of the registration process in SAM.

D. SUBAWARD REPORTING AND EXECUTIVE COMPENSATION (FFATA)

This award is subject to the reporting requirements of the Federal Funding Accountability and Transparency Act of 2006 (Public Law 109-282), as amended by Section 6202 of Public Law 110-252 and implemented by 2 CFR Part 170. Recipients must report information for each first-tier subaward of $30,000 or more in Federal funds and executive total compensation for the Recipient's and Subrecipients' five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170. Information about the Federal Funding Accountability and Transparency Act Subaward Reporting System (FSRS) is available at www.fsrs.gov. For the full text of the award term click here.

E. FINANCIAL REPORTING

HHS recipients must record recipient expenses in real-time as well as submit quarterly, semi-annual, or annual expenditure FFRs as described below.

Recipients report on Federal expenditures, Recipient Share (if applicable), and Program Income (if applicable and/or allowable) at least annually via the Payment Management System. Instructions on how to complete the FFR can be found here. (after logging on) Frequency of expenditure reporting, whether quarterly, semi-annual or annual, is stipulated in the Program Terms and Conditions of award.

- Expenditures information is reflected through completion of lines 10.d through 10.o of the FFR.
- The expenditures FFR must also include information on indirect costs if approved as part of grant award (line 11).
- As appropriate, all lines of the form must be completed/verified. CMS will review and either approve or reject the expenditure report submitted. If rejected, Recipient must take appropriate action to correct the issue and resubmit the report.

Quarterly and semi-annual expenditure reports are due no later than 30 days following the applicable period. Annual expenditure FFRs are due no later than 90 days following the applicable budget period end date or 12-month period for multi-year budget periods and final FFRs are due no later than 120 days following the period of performance end date.

The final FFR must show cumulative expenditures under the award and any unobligated balance of federal funds and as appropriate, all other parts of the form must be completed.

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

F. PROGRAMMATIC REPORTING

In accordance with 2 CFR §200.301, *Performance Measurement*, Recipients must measure recipient's performance to show achievement on program goals and objectives, share lessons learned, improve program outcomes, and foster adoption of promising practices. Program goals and objectives should be derived from program planning and design. See Program Term and Conditions for specific details.

G. PUBLIC REPORTING (STEVENS AMENDMENT)

Recipients, consistent with the language of the Stevens Amendment, when issuing statements, press releases, publications, requests for proposals, bid solicitations, and other documents – such as toolkits, resource guides, websites, and presentations (hereafter "statements") – describing the projects or programs funded in whole or in part with U.S. Department of Health and Human Services (HHS) federal funds, must clearly state: (1) the percentage and dollar amount of the total costs of the program or project which will be funded with Federal money; and (2) the percentage and dollar amount of the total costs of the project or program that is funded by non-governmental sources.

When issuing statements resulting from activities supported by HHS financial assistance, the recipient entity must include an acknowledgement of federal assistance using one of the following or a similar statement (see immediately below). For additional supplemental information, please see Standard Term and Condition 29. (H) *Acknowledgement of Sponsors (Disclaimer and Review Requirements)*.

If the HHS Grant or Cooperative Agreement is NOT funded with other non-governmental sources:

This **[project/publication/program/website, etc.] [is/was]** supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling **$XX** with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

The HHS Grant or Cooperative Agreement IS partially funded with other nongovernmental sources:

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

The federal award total must reflect total costs (direct and indirect) for all authorized funds (including supplements and carryover) for the total competitive segment up to the time of the public statement.

Any amendments by the recipient to the acknowledgement statement must be coordinated with the HHS Awarding Agency.

If the recipient plans to issue a press release concerning the outcome of activities supported by HHS financial assistance, it should notify CMS in advance to allow for coordination.

H. ACKNOWLEDGEMENT OF SPONSORS (DISCLAIMER AND REVIEW REQUIREMENTS)

All publications, press announcements, posters, oral presentations at meetings, seminars, and any other information-dissemination format, including but not limited to electronic/digital media (e.g. social media platforms) that is related to this project must include a formal acknowledgement of support as well as a disclaimer as stated above in Term and Condition, 29. (G) *Public Reporting (Stevens Amendment)*. It is the policy of the Department of Health and Human Services (HHS) that the results and accomplishments of the activities it funds should be made available to the public. The Recipient is expected to make the results and accomplishments of its activities available to the research community and to the public at large.

(a) The Recipient shall submit the following to the CMS Project Officer for review and comment unless specified otherwise in the Program Terms and Conditions:
   (i) At least 30 days prior to its release:

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

(ii) At least 7 days prior to release:

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

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

(c) It is the policy of the Department of Health and Human Services that the Recipient must communicate to CMS how the dollar amounts and funding percentages are calculated, including whether or not indirect costs have been incorporated. Recipient must submit this information to CMS for review and comment for each applicable type of result/accomplishment according to the same timeline schedule outlined in 17(a).

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

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

I. USE OF DATA AND WORK PRODUCTS (REPORTING)

At any phase of the project, including the project's conclusion, the Recipient, if so requested by the CMS Project Officer, shall submit copies of analytic data file(s) with appropriate documentation, representing the data developed/used in end-product analyses generated under the award. The analytic file(s) may include primary data collected, acquired or generated under the award and/or data furnished by CMS. The content, format, documentation, and schedule for production of the data file(s) will be agreed upon by the Principal Investigator/Project Director and the CMS Project Officer. The negotiated format(s) could include both file(s) that would be limited to CMS's internal use and file(s) that CMS could make available to the general public.

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

If the Principal Investigator/Project Director determines through this research that a significant new finding has been developed, he/she will communicate it to the CMS Project Officer before formal dissemination to the general public. The Recipient shall notify CMS of research conducted for publication.

J. TANGIBLE PERSONAL PROPERTY REPORTING

The Tangible Personal Property Report (SF-428) is a standard form to be used by awarding agencies to collect information related to tangible personal property when required by a Federal financial assistance award. This form allows recipients to request specific disposition of federally-owned property and acquired equipment. This form also provides a means for calculating and transmitting appropriate compensation to CMS for residual unused supplies. The form consists of the cover sheet (SF-428) and three attachments to be used as required: Annual Report, SF-428-A; Final (Award Closeout) Report, SF-428-B; and a Disposition Request/Report, SF-428-C. A Supplemental Sheet, SF-428-S, may be used to provide detailed individual item information.

Recipients are required to complete the SF-428, SF-428-B and the SF-428-S (as applicable) at the time of award closeout. The report covers federally owned property, acquired equipment with an acquisition cost of $5,000 or more, and residual unused supplies with a total aggregate fair market value exceeding $5,000 not needed for any other federally sponsored programs or projects.

K. PATENTS AND INVENTIONS

In accordance with 45 CFR §75.322(c), all Recipients are subject to applicable regulations governing patents and inventions, including government-wide regulations issued by the Department of Commerce at 37 CFR part 401. If applicable, Recipients must report any inventions on an annual basis using the non-competing continuation application or annual progress report for multi-year budget periods.

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

- The Statement must include all inventions which were conceived or first actually reduced to practice under the grant or award, from the original effective date of support through the date of completion or termination.

- The Statement shall include any inventions reported previously for grants and cooperative agreements as part of a non-competing continuation application or annual progress report.
- Recipients must also provide details about all inventions that have been licensed but not patented, and include details on income resulting from HHS-funded inventions and patents.

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

L. AUDIT REPORTING

i. The audit requirements in 45 CFR Part 75, Subpart F apply to each 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 45 CFR 75 and must submit an audit reporting package to the Federal Audit Clearinghouse (FAC), the OMB designated repository of record. In accordance with 45 CFR 75.513(c)(1), HHS grant awarding agencies are required to ensure that single or program-specific audits are completed and reported by recipients within nine months after the end of the audit period (recipient fiscal year end date). **Recipients must comply with the following:Within 3 business days of submission of the audit reporting package to FAC**, provide certification (to include evidence of submission) as a Grant Note in GrantSolutions labeled: "HHS FAC Certification" (Subject)/ "FAC_CERT_mm.dd.yyyy" (File Name).

OR

ii. **Upon the Recipient's audit reporting package deadline**, the Recipient must certify in writing to the GMS that their entity did not meet the $750,000 threshold during its FY. This certification is uploaded as a Grant Note in GrantSolutions labeled: "FAC Certification" (Subject)/ "FAC_CERT_mm.dd.yyyy" (File Name).

Records must still be available for review or audit by appropriate officials of CMS, pass-through entity, and Government Accountability Office (GAO).

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

Commercial Organizations (for-profits including for-profit hospitals) should consult §75.216 for limitations on profit and program income. As explained in 45 CFR §75.501(i) and §75.216, commercial organizations have two options regarding audits:

(1) A financial related audit (as defined in the Government Auditing Standards, GPO Stock #020-000-00-265-4) of a particular award in accordance with Government Auditing Standards. In those cases where the recipient receives awards under only one HHS program, or, if awards are received under multiple HHS programs, a financial related audit of all HHS awards in accordance with Government Auditing Standards; or
(2) An audit that meets the requirement contained in 45 CFR part 75, subpart F (as explained above).

Commercial organizations should submit audits directly to the following electronic address:

AuditResolution@hhs.gov with a copy to KC_OIG_Audit@cms.hhs.gov and the Grants Management Specialist identified in Federal Awarding Agency box #9 on the Notice of Award.

Do not send audits for commercial organizations to the Federal Audit Clearinghouse (FAC).

As explained under 45 CFR§75.501(h), *For-profit subrecipient,* since this part does not apply to for-profit subrecipients, the pass-through entity is responsible for establishing requirements, as necessary, to ensure compliance by for-profit subrecipients. The agreement with the for-profit subrecipient must describe applicable compliance requirements and the for-profit subrecipient's compliance responsibility. Methods to ensure compliance for Federal awards made to for-profit subrecipients may include pre-award audits, monitoring during the agreement, and post-award audits. See also §75.352 Requirements for pass-through entities.

For information related to potential consequences for failure to apply with the aforementioned audit requirements, please see the section titled *Remedies for Non-Compliance* within these Standard Terms and Conditions and 45 CFR §75.371, *Remedies for noncompliance.*

SUBRECIPIENT PASS-THROUGH REQUIREMENTS

The recipient, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to subrecipients, in accordance with 45 CFR § 75.351 – 75.352, Subrecipient monitoring and management.

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

31. **Affirmative Duty to Track All Parties to the Award**. Recipient must at a minimum regularly track all subrecipients, including subrecipient key personnel as well as subcontractors in the System for Award Management (SAM).

As provided in 2 CFR part 180 and implemented in 2 CFR part 376, the recipient must check the System for Award Management (SAM) as follows to ensure that it does not make a subaward to an entity that is debarred, suspended, or ineligible:

- For all first-tier subawards regardless of potential value. Agencies must also require first tier- subrecipients and lower-tier subrecipients to check SAM.gov and
- For all first-tier procurement contracts with a value of $25,000 or more and all lower tiers of subcontracts under covered non-procurement transactions (2 CFR 376.220).

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

The Recipient shall provide the CMS PO and Grants Management Specialist with the National Provider Identifier (NPI), Tax ID, and EIN, as applicable, of all Key Personnel and/or entities to the award that may include subrecipients. This list shall be provided to CMS as a Grant Note in GrantSolutions within **thirty (30) days** from the start of the award and must be maintained in real time throughout the award.

32. **Pass Through Entities, Subrecipients, and Contractors.** As outlined in 45 CFR §75.351, *Subrecipient and contractor determinations*, a pass-through entity must make case-by-case determinations whether each agreement it makes for the disbursement of Federal program funds casts the party receiving the funds in the role of a subrecipient or contractor. A pass-through entity means a non-Federal entity that provides a subaward to a subrecipient to carry out part of a Federal program (45 CFR §75.2, *Definitions*). As described in 45 CFR §75.351, a subaward is for the purpose of carrying out a portion of a Federal award and creates a Federal assistance relationship with the subrecipient while a contract is for the purpose of obtaining goods and services for the non-Federal entity's own use and creates a procurement relationship with the contractor. Characteristics for both types of relationships are included in 45 CFR §75.351. All pass-through entities must ensure that every subaward is clearly identified to the subrecipient as a subaward and includes the information outlined in 45 CFR §75.352, *Requirements for pass-through entities,* at the time of subaward and if any of these data elements change, include these changes in subsequent subaward modifications.

33. **Subrecipient Equal Treatment.** The Recipient must comply with 45 CFR Part 87, including the provision that no State or local government Recipient nor any intermediate organization receiving funds under any program shall, in the selection of service providers, discriminate for or against an organization's religious character or affiliation.

34. **Recipient's Responsibility for Subrecipients.** The Recipient is responsible for the performance, reporting, and spending for each Subrecipient in accordance with 45 CFR Part 75 Subpart D - Subrecipient Monitoring and Management. The Recipient will:

- ensure the timeliness and accuracy of required reporting for each site of service and Subrecipient under the award
- be responsible for the performance and progress of each site of service or Subrecipient toward the goals and milestones of the program
- take necessary corrective action for any site of service or Subrecipient that is not meeting the goals and milestones of the program, as set forth in the NOFO.

REMEDIES FOR NONCOMPLIANCE

35. **Non-compliance.** If a Recipient fails to comply with Federal statutes, regulations, or the terms and conditions of a Federal award, the HHS awarding agency or pass-through entity may impose additional conditions, as described in 45 CFR §75.207, *Specific award conditions*. If CMS or the pass-through entity determines that noncompliance cannot be remedied by imposing additional conditions, CMS or the pass-through entity may take one or more actions as set forth in 45 CFR §75.371, *Remedies for noncompliance*. Remedies include termination of the award.

36. **Termination.** The Federal award may be terminated in whole or in part as stated in 45 CFR §75.372.

    CMS and the recipient may terminate the award through mutual agreement, in which case the two parties must agree upon the termination conditions, including the effective date and, in the case of partial termination, the portion to be terminated. Alternatively, the recipient may notify CMS, or the pass-through entity, setting forth the reasons for such termination, the effective date, and in the case of partial termination, the portion to be terminated.

    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.

CLOSEOUT

37. **Withdrawal.** If the Recipient decides to withdraw from this award prior to the end of the period of performance, it must provide written notification (both hard copy and via email) to the CMS Grants Management Specialist at least fifteen (15) days in advance of the date of official withdrawal and termination of these terms. The letter must be signed by the AOR and other appropriate individuals with authority. CMS will not be liable for any withdrawal close-out costs that are borne by the Recipient. Recipients have three (3) days to return all unused grant funds.

38. Disposition of Federally Owned Property, Equipment, and Residual Unused Supplies. Upon completion (or early termination) of a project, Recipient must take appropriate disposition actions. Recipients of funding from CMS should proceed in accordance with the guidance provided within this term and condition.

Recipient must complete and submit the **SF-428 Cover Letter, SF-428-B Tangible Personal Property Report, Final Report** (also see Standard Term and Condition, 29. (J) *Tangible Personal Property Reporting*). The Tangible Personal Property Report (SF-428) is a standard form to be used by awarding agencies to collect information related to tangible personal property when required by a Federal financial assistance award. This form allows recipients to request specific disposition of federally-owned property and acquired equipment. This form also provides a means for calculating and transmitting appropriate compensation to CMS for residual unused supplies. As noted in 1.b of this report, if your agency is in possession of Federally-owned property or acquired equipment (defined as nonexpendable personal property with an acquisition cost of $5,000 or more under the award), you must also submit a **SF-428-S, Supplemental Sheet**, that lists and reports on all Federally-owned or acquired equipment under the specific grant or cooperative agreement award. If there is no tangible personal property to report, select "d." in section 1 of the SF-428-B and indicate "none of the above." Recipient must request specific disposition instructions from CMS if the Recipient has federally-owned property or if the following guidance is insufficient for the Recipient to properly complete disposition.

- Items of equipment with a current per unit fair market value of $5,000 or less may be retained, sold or otherwise disposed of with no further obligation to CMS.
- Except as provided in 45 CFR §75.319(b), items of equipment with a current per-unit fair market value in excess of $5,000 may be retained by the non-Federal entity or sold. If there is no longer a use for the equipment under the original project or program or for other activities currently or previously supported by CMS or other HHS awarding agencies, except as otherwise provided in Federal statutes and regulations, CMS is entitled to an amount calculated by multiplying the current market value or proceeds from sale by CMS's percentage of participation in the cost of the original purchase. If the equipment is sold, CMS may permit the non-Federal entity to deduct and retain from the Federal share $500 or ten percent of the proceeds, whichever is less, for its selling and handling expenses.
- Reportable Residual Unused Supplies, which in the aggregate exceed $5,000 in fair market value which cannot be used by the original project or program nor are needed for other activities currently or previously supported by CMS, other HHS awarding agencies, or another Federal agency, must be retained by the Recipient for use on other activities or sold, but Recipient must, in either case, compensate the Federal government for its share. CMS is entitled to an amount calculated by multiplying the current fair market value or proceeds from sale by CMS's percentage of participation in the cost of the original purchase.
- In certain instances, the non-Federal entity may transfer title to the property to the Federal government or to an eligible third party subject to prior approval by CMS. In such cases, the non-Federal entity must be entitled to compensation for its attributable percentage of the current fair market value of the property.

39. **Records Retention.** Financial records, supporting documents, statistical records, and all other non-Federal entity records pertinent to a Federal award must be retained for a period of three years from the date of submission of the final expenditure report or, for Federal awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report, respectively, as reported to the HHS awarding agency or pass-through entity in the case of a subrecipient. HHS awarding agencies and pass-through entities must not impose any other record retention requirements upon non-Federal entities. The only exceptions are stated in 45 CFR §75.361.

Centers for Medicare & Medicaid Services
Standard Grant/Cooperative Agreement Terms and Conditions
Attachment A

Conflict of Interest Policy

CMS requires recipients to establish safeguards to prevent employees, officers, or agents of the non-Federal entity such as consultants, contractors, members of governing bodies, and others who may be involved in grant-supported activities from using their positions for purposes that are, or give the appearance of being, motivated by a desire for private financial or other gain for themselves or others, such as those with whom they have family, business, or other ties. These safeguards must be reflected in written standards of conduct. Except as provided below, CMS does not require a recipient to establish separate standards of conduct if it maintains such standards for its non-grant-supported activities, as long as those standards are consistent with State, local, and tribal laws and regulations, and cover, at a minimum, expected conduct in regard to financial interests, gifts, gratuities and favors, nepotism, and such other areas for governmental organizations as political participation and bribery.

Definitions:

"Principal Investigator/Project Director (PI/PD)" means the individual(s) designated by the recipient to direct the project or program being supported by the grant. The PI/PD is responsible and accountable to officials of the recipient organization for the proper conduct of the project, program, or activity. This designation also includes co-principal investigators/co-project directors, and any other person at the organization who is responsible for the design, conduct, or reporting of grant activities funded or proposed for funding by CMS.

"Significant financial interest" means anything of monetary value, including, but not limited to, salary or other payments for services (e.g., consulting fees or honoraria); equity interest (e.g., stocks, stock options or other ownership interests); and intellectual property rights (e.g., patents, copyrights and royalties from such rights).

This term does not include:

a. salary, royalties or other remuneration from the applicant organization;

b. income from seminars, lectures, or teaching engagements sponsored by public or non-profit entities;

c. income from service on advisory committees or review panels for public or nonprofit entities;

d. an equity interest that, when aggregated for the PI/PD and the PI/PD's spouse and dependent children, meets both of the following tests: does not exceed $10,000 in value as determined through reference to public prices or other reasonable measures of fair

market value, and does not represent more than a 5% ownership interest in any single entity; or

e. salary, royalties or other payments that, when aggregated for the PI/PD and the investigator's spouse and dependent children, are not expected to exceed $10,000 during the prior twelve-month period.

The term "or other interest" means a non-financial benefit which results in a potential or real conflict of interest. The potential or real conflict of interest poses the same possible harms received from a financial conflict of interest such as bias due to personal gain. Such benefits may be received from a tangible or intangible personal benefit.

"Organizational conflicts of interest" means that because of relationships with a parent company, affiliate, or subsidiary organization, the non-Federal entity is unable or appears to be unable to be impartial in conducting a procurement action involving a related organization.

"Responsible representative" means the individual(s), named by the applicant/recipient organization, who is authorized to act on behalf of the applicant/recipient and to assume responsibility for the obligations imposed by federal laws, regulations, requirements, and conditions that apply to CMS grant awards.

Requirements:

The majority of CMS' grant programs are not supported by Public Health Service (PHS) funding; therefore, CMS is not subject to the requirements of 42 CFR Part 50, Subpart F, "Promoting Objectivity in Research." Notwithstanding, CMS expects grant activities (including research activities) to be free from bias by any conflicting interest of the PI/PD and any other person regardless of title or position, who is responsible for the design, conduct, or reporting of grant activities which may include collaborators or consultants.

Recipient's conflict of interest policies must reflect the following:

- Have a written and enforced administrative process to eliminate conflicting financial or other interests with respect to CMS grant/cooperative agreement funds awarded. This process should ensure:
    - The merits for determining a conflict of interest are clearly articulated in writing – i.e., the assigned reviewer(s) can reasonably determine that a significant or other interest could directly and significantly affect the design, conduct, or reporting of CMS-funded grant activities. This process should be inclusive of the appearance of such conflicts.
    - Each PI/PD discloses to a responsible representative of the Recipient all significant financial and/or other interests including personal relationships of the PI/PD (for example, PI/PD's spouse, dependent children, etc.): (i) that would reasonably appear to be affected by the grant activities funded or proposed for

funding by CMS; or (ii) in entities whose financial or other interests would reasonably appear to be affected by such activities.

  - One or more objective persons (1) reviews the potential conflict of interest; (2) determines whether a potential (appearance of) or real conflict of interest exists; and (3) establishes what conditions, or restrictions, should be imposed to eliminate the conflict of interest.
  - This information is conveyed to the Responsible Representative for the organization who is designated to act on behalf of the applicable CMS award.

- Prior to expending funds under a new CMS award, the Responsible Representative must inform the applicable CMS Grants Management Specialist and Project Officer of any real or potential conflict of interest. The report must detail Recipient's plan to eliminate the conflict prior to spending CMS funding on the activities in question.
- Require that similar reports for subsequently identified conflicts be made within 30 days of identifying them. Funding for those specific activities should cease until the aforementioned steps are completed.
- Require that continual updates be made for any real or potential conflicts of interest not fully resolved. Recipient must make additional information available to the CMS Grants Management Specialist and Project Officer, upon request, as to how it is handling (or had handled) the real or potential conflict of interest.
- Recipients must maintain records of all disclosures and of all actions taken to resolve conflicts of interest for at least three years beyond the termination or completion of the grant to which they relate, or until the resolution of any CMS action involving those records, whichever is longer.
- The Recipient's policy must include adequate enforcement mechanisms, and provide for sanctions where appropriate.

Recipient may resolve such conflicts of interest through one or more of the following options outlined below. This is not an exhaustive list and Recipient may pursue other remedies.

- Modification of approved project to remove potential or real conflict of interest.
- Termination of agreement or other services that create potential or real conflict of interest.
- Removal of individuals with potential or real conflict of interest.
- Severance of relationships that create potential or real conflicts of interest.
- Divestiture of significant financial interests.

Recipient must ensure that CMS award funds are administered in accordance with conflict of interest policies that meet, at a minimum, the standards outlined above, inclusive of pass-through entities, subrecipients, contractors, or collaborators. Each entity must have its own policies in place that meet these requirements or mandate that the PIs/PDs working for such entities follow those of the Recipient.

Procurement:

The Recipient must also maintain written standards of conduct covering conflicts of interest and governing the actions of its employees engaged in the selection, award and administration of contracts in accordance with 45 CFR §75.327 General procurement standards. No employee, officer, or agent may participate in the selection, award, or administration of a contract supported by a Federal award if he or she has a real or apparent conflict of interest. Such a conflict of interest would arise when the employee, officer, or agent, any member of his or her immediate family, his or her partner, or an organization which employs or is about to employ any of the parties indicated herein, has a financial or other interest in or a tangible personal benefit from a firm considered for a contract. The officers, employees, and agents of the non-Federal entity may neither solicit nor accept gratuities, favors, or anything of monetary value from contractors or parties to subcontracts. However, non-Federal entities may set standards for situations in which the financial interest is not substantial or the gift is an unsolicited item of nominal value. The standards of conduct must provide for disciplinary actions to be applied for violations of such standards by officers, employees, or agents of the non-Federal entity.

If the non-Federal entity has a parent, affiliate, or subsidiary organization that is not a state, local government, or Indian tribe, the non-Federal entity must also maintain written standards of conduct covering organizational conflicts of interest.

Centers for Medicare & Medicaid Services
Standard Grant/Cooperative Agreement Terms and Conditions
Attachment B

Accessibility Provisions

CMS and its recipients are responsible for complying with federal laws regarding accessibility. The grantee may receive a request from a beneficiary or member of the public for information in accessible formats. All successful applicants under this announcement 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 must post a message at a conspicuous location on the website no later than **30** business days after award that notifies your customers of their right to receive an accessible format to include appropriate auxiliary aids and services or language assistance services. Sample language may be found here. Your notice shall be crafted applicable to your program, but must state that your program provides appropriate auxiliary aids and services and language assistance services free of charge when necessary for compliance with § 1557 or its implementing regulation, to participants, beneficiaries, enrollees, and applicants of the program, and to members of the public. The notice must be in English and at least the 15 languages most commonly spoken by LEP individuals within the State and be provided in alternative formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication. Note that § 1557 and its implementing regulation also require that this notice be provided on an annual basis to certain parties; upon request; and in a prominent physical location in at least 20-point san serif font, placed where it is reasonable to expect individuals seeking services to read or hear it; and in certain other electronic and written communications.
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. Process in a timely manner as required to fulfill the request.
        ii. If the Recipient believes it is unable to fulfill an accessible format request, CMS may work with the Recipient to provide the accessible format as funding and resources allow. Recipient shall refer the request to CMS within **3** business days if unable to provide the request. Recipient 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 "Recipient (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. CMS may respond to the request and provide the information directly to the requester.

iii. The Recipient must 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 the Recipient believes it is unable to fulfill an accessible service request, CMS may work with the Recipient to provide the accessible service as funding and resources allow. Recipient shall refer the request to CMS within **3** business days if unable to provide the service. Recipient 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 "Recipient (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. You must 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 the Recipient believes it is unable to fulfill an alternate language format request, CMS may work with the Recipient to provide the alternate language format as funding and resources allow. Recipient shall refer the request to CMS within **3** business days if unable to provide the request. Recipient 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 "Recipient (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 must 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 the Recipient believes it is unable to fulfill an alternate language service request, CMS may work with the Recipient to provide the alternate language service as funding and resources allow. Recipient shall refer the request to CMS within **3** business days if unable to provide the service. Recipient 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 "Recipient (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 must 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.

Centers for Medicare & Medicaid Services
Standard Grant/Cooperative Agreement Terms and Conditions
Attachment C

Award Term – Trafficking in Persons

a. **Provisions applicable to a recipient that is a private entity.**

1. You as the recipient, your employees, subrecipients under this award, and subrecipients' employees may not—

   i. Engage in severe forms of trafficking in persons during the period of time that the award is in effect;
   ii. Procure a commercial sex act during the period of time that the award is in effect; or
   iii. Use forced labor in the performance of the award or subawards under the award.

2. We as the Federal awarding agency may unilaterally terminate this award, without penalty, if you or a subrecipient that is a private entity –

   i. Is determined to have violated a prohibition in paragraph a.1 of this award term; or
   ii. Has an employee who is determined by the agency official authorized to terminate the award to have violated a prohibition in paragraph a.1 of this award term through conduct that is either—
      A. Associated with performance under this award; or
      B. Imputed to you or the subrecipient using the standards and due process for imputing the conduct of an individual to an organization that are provided in 2 CFR part 180, "OMB Guidelines to Agencies on Governmentwide Debarment and Suspension (Non-procurement)," as implemented by our agency at 2 CFR part 376.

b. **Provision applicable to a recipient other than a private entity.** We as the Federal awarding agency may unilaterally terminate this award, without penalty, if a subrecipient that is a private entity—

1. Is determined to have violated an applicable prohibition in paragraph a.1 of this award term; or
2. Has an employee who is determined by the agency official authorized to terminate the award to have violated an applicable prohibition in paragraph a.1 of this award term through conduct that is either—
   i. Associated with performance under this award; or

ii. Imputed to the subrecipient using the standards and due process for imputing the conduct of an individual to an organization that are provided in 2 CFR part 180, "OMB Guidelines to Agencies on Governmentwide Debarment and Suspension (Nonprocurement)," as implemented by our agency at 2 CFR part 376.

c. **Provisions applicable to any recipient.**

1. You must inform us immediately of any information you receive from any source alleging a violation of a prohibition in paragraph a.1 of this award term.
2. Our right to terminate unilaterally that is described in paragraph a.2 or b of this section:

   i. Implements section 106(g) of the Trafficking Victims Protection Act of 2000 (TVPA), as amended (22 U.S.C. 7104(g)), and
   ii. Is in addition to all other remedies for noncompliance that are available to us under this award.

3. You must include the requirements of paragraph a.1 of this award term in any subaward you make to a private entity.

d. **Definitions.** For purposes of this award term:

1. "Employee" means either:
   i. An individual employed by you or a subrecipient who is engaged in the performance of the project or program under this award; or
   ii. Another person engaged in the performance of the project or program under this award and not compensated by you including, but not limited to, a volunteer or individual whose services are contributed by a third party as an in-kind contribution toward cost sharing or matching requirements.
2. "Forced labor" means labor obtained by any of the following methods: the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.
3. "Private entity":
   i. Means any entity other than a State, local government, Indian tribe, or foreign public entity, as those terms are defined in 2 CFR 175.25.
   ii. Includes:
      A. A nonprofit organization, including any nonprofit institution of higher education, hospital, or tribal organization other than one included in the definition of Indian tribe at 2 CFR 175.25(b).
      B. A for-profit organization.

4. "Severe forms of trafficking in persons," "commercial sex act," and "coercion" have the meanings given at section 103 of the TVPA, as amended (22 U.S.C.7)

State Of New Hampshire

DIVISION OF PERSONNEL
Department of Administrative Services
54 Regional Drive, Suite 5
Concord, New Hampshire 03301

CHARLES M. ARLINGHAUS
Commissioner
(603) 271-3201

LORRIE A. RUDIS
Director of Personnel
(603) 271-3261

October 16, 2024

Barabara McCann, Director of Human Resources
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

Regarding: Request to establish two full-time temporary 11-9150 Social and Community Service Managers-4, pay schedule SOC11, position numbers 9T3367 and 9T3368, and one full-time temporary 21-1090 Miscellaneous Community and Social Service Specialists-7, pay schedule SOC11, position number 9T3369

Dear Ms. McCann,

After the review of your agency's materials and proposed position information, the Division of Personnel approves the requests received on 9/23/2024 for the DHHS to establish three full-time temporary positions: 9T3367 and 9T3368 classified as 11-9150 Social and Community Service Managers-4 and 973369 classified as 11-9150 Social and Community Service Managers-3.

These positions are being established for the Bureau of Adult and Aging Services (BAAS), which was awarded a planning grant to support its administrative needs for participating in Medicaid's Money Follows the Person demonstration program.

This funding will support the following three positions:

Position #9T3367, 11-9150 Social and Community Service Managers-4, a Housing Continuum Administrator, will facilitate the development, coordination, and implementation of an integrated housing and residential support continuum of care across programs operated within DHHS, as well as those operated by external community-based organizations. This position will serve as a liaison between DHHS and community-based organizations, oversee the development of a data dashboard, and coordinate program operations

Position #9T3368, 11-9150 Social and Community Service Managers-4, a Long Term Care Quality Assurance Coordinator, will develop and administer agency goals and objectives for BAAS by planning, developing, and implementing long-term quality assurance and quality improvement policies, operational strategies, and interpreting data to draw conclusions that impact programs, funding, and service delivery. This position will resolve complaints and grievances across BAAS programs, evaluate program operations for effectiveness, and monitor contract and grant compliance.

Position #9T3369, 21-1090 Miscellaneous Community and Social Service Specialists-7, a Person-Centered Planning Liaison, will develop, implement, and oversee comprehensive Person-Centered Planning practices throughout programs and services administered by BAAS. This position will provide technical assistance and support to partner

agencies, collaborate with stakeholders to create systems, review and evaluate planning documentation, and develop and distribute reports and summaries of monitoring activities.

The proposed duties are like those of other positions within the same Occupational Group and level currently operating at the agency and throughout the state classified system. They appropriately parallel the Broad Group Specification. The role is also appropriate within the agency's proposed organizational structure.

These position numbers will be inactive until you receive funding approval from the Fiscal Committee per RSA 124:15.

It will be your responsibility to bring the request for funding before the Fiscal Committee. You may use this letter as confirmation of our decision. Once you have obtained Fiscal Committee approval, please notify the Division of Personnel Operations Section at CentralHRProcessing@nh.gov.

Thank you.

Sincerely,

Marianne Rechy

Marianne Rechy
Classification & Compensation Administrator

Cc: Lorrie Rudis, Director of Personnel
Joanne Lydick, Administrator of Operations