Appendix C: TMaH Required Milestones and Activities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pillar 1. Element 5: Implement Payment Model

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

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

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

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

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

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

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

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

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

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

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

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

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