DEPARTMENT OF HUMAN SERVICES

The Office of the Medicaid Medical Director

Transforming Maternal Health Model (TMaH) Listening Sessions December 2025

This project is 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 $17 million 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.

Introductions
Please write in the chat:

- Name (Pronouns)
- Organization
- Role
- Poll: Rank your knowledge of TMaH

Welcome

Purpose:

- Share TMaH model updates
- Collect questions about model participation and payments
- Gather hospital, community, and traditional experience to continue to design model
- Show how we are incorporating feedback into model design and implementation

Recognition of past trauma and abuse

The state of Minnesota and the Department of Human Services (DHS) recognize the trauma and discrimination that have happened to our Black, Native/American Indian, people of color, disability, and LGBTQ+ communities, leading to distrust in medicine and social service providers.

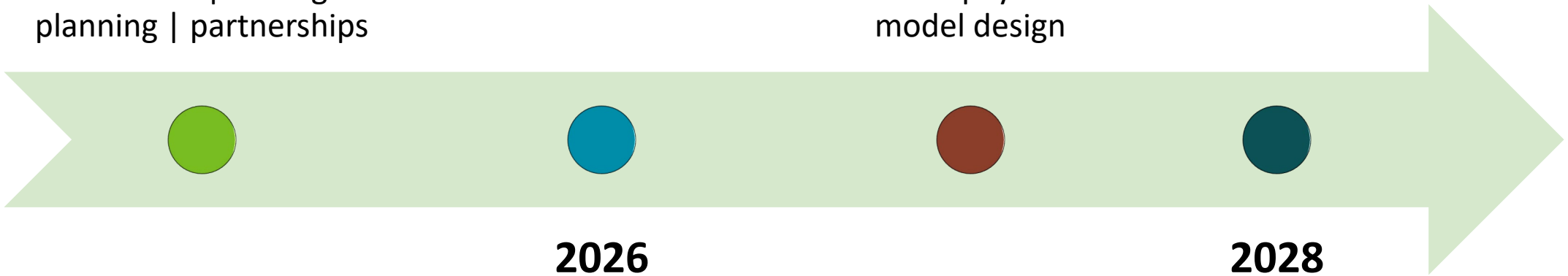
The work of healing requires that we are all actively committed to rebuilding trust with communities and bringing community members' voice to the table.

Note: These are goals and activities established by the Recipient and not dictated by CMS.

Introductions – Office of Medicaid Medical Director
MN TMaH Core Planning Team

- Nathan Chomilo, MD, FAAP, FACP | Medical Director/Project Co-Director
- Sarah Gareau, DrPH, MEd, MCHES | Project Director
- Nicole Peltzer, MPH | Community Engagement & Communications Coordinator
- Kristi Halvarson, MHA | Contract Specialist
- Emmett Ruff | Grant Manager
- Position posting soon | Data Analyst
- Key partners at DHS (Sara Bonneville, Liz Gipson, Chris Gibson, Leigh Grauman, Erin Flicker, Sonya Smith, Megan Warfield-Kimball, & Yasmin Yahye), MDH (Sierra Hill, Anne Walaszek, & Alison Moore), HCPH (Ashley Johnson), the BJC (Andrea Smith & Korina Barry), and the MN PQC (Susan Thompson)

TMaH timeline



Question 1: What is the most pressing issue impacting your ability to increase access to maternal health services through Medicaid/CHIP?

"Dollars should be funneled to locations already serving disproportionate numbers of people with social determinants of health impacting their lives."

Collective Design of TMaH

Learn More:
Collective Design Poster shared at 2025 Perinatal Quality Improvement Summit

Pillar 1: Access, Infrastructure, Workforce

What we heard	What we're doing
Credentialing, billing, and reimbursement	• Collaborating with CMS • Providing direct support, training, and technical assistance • Convening formal doula and beneficiary council • Planning TMaH data dashboard
Recruitment and retention	
Data infrastructure	
Community engagement	

See more details in Appendices.

Pillar 2: Quality Improvement and Safety

What we heard	What we're doing
Include culturally appropriate, harm reduction, and trauma-informed care approaches	• Providing technical assistance, training, and collaboration • Building partnerships • Including feedback in provider selection criteria • Collaborating with CMS
Standardize screening tools with room for tailoring by practice/scope/population	
Scale up models/pilots that work	

See more details in Appendices.

Pillar 3: Whole-person care delivery

What we heard	What we're doing
Include culturally relevant and trauma-informed care	• Providing direct support, training, and technical assistance • Including criteria into provider application • Collaborating on resources and peer support • Building education materials
Write clear protocols for screenings, referrals, and follow-up	
Improve collaboration between providers	
Expand access	
Address patient barriers	

See more details in Appendices.

Question 2: What are your initial reactions to what we heard?

What do you agree with?

What is missing?

DRAFT TMaH Payment Strategy

Learn More:
Payment Design Fact Sheet

TMaH includes 2 types of payments

Infrastructure payments

- Starting in March 2027, quarterly infrastructure payments will be given to partner locations
- Investment in care transformation activities to prepare for implementation and transition to value-based payment (VBP)

Value-based payment (VBP)

- Likely starting in 2028, VBP will replace how TMaH providers and locations are paid for certain maternal health services
- Payment strategy is currently being finalized in collaboration with the Centers for Medicare & Medicaid Services (CMS)

Provider Infrastructure Payments begin March 31, 2027

Amounts are expected to be based on the number of eligible beneficiaries served and risk-adjusted.

Infrastructure payments can go toward 6 areas:

- **Patient safety initiatives and maternal care assessments:** implementing AIM bundles, electronic (EHR) updates to streamline risk assessments
- **Quality measure reporting:** support and infrastructure for data reporting on quality measures
- **Data integration:** EHR upgrades and data infrastructure improvement, facilitating health information exchange, quality improvement dashboards, integration with CBOS to share screening and referral info
- **Team-based care:** Support regular shared care planning with entire maternal care team (prenatal, delivery, postpartum, specialty areas, wrap around care, etc.)

Infrastructure payments can go toward 6 areas:

- **Enhanced access to care:** Increase access to care in ways that meet needs of patients, like home monitoring, telehealth, group visits, home visits, or expanded hours
- **Connections to community-based organizations (CBOs):** Identification of community organizations to address social and mental health or substance use needs and integration into screening, referral, and follow-up

TMaH value-based payment (VBP) strategy

- **Share upfront funds** and revenue with providers to invest in prevention
- **Incentivize screening, identifying, and providing care** for high-risk patients across physical and mental health
- **Reward providers** for improved outcomes and cost savings

Note: The CMS VBP strategy may evolve over the next year. The following slides reflect the initial proposal.

Overview of the TMaH VBP Strategy

Perinatal Episode of Care design (EOC): defined set of services during prenatal period through 60-90 days postpartum. Likely starting in 2029, providers may receive 2 types of episode of care (EOC) payments:

1. **Monthly prospective payment (case rate)**
   - Case rate refers to a flat monthly fee for a predetermined set of routine pregnancy-related services calculated based on historical expenses
2. **Retrospective shared savings for the entire risk-adjusted EOC, including the case rate**

Services not included in the maternal health case rate are paid fee-for-service.

Retrospective payments will be tied to improvements on quality indicators

Outcomes of interest

- Reduced rates of low-risk cesarean deliveries
- Reduced incidence of severe maternal morbidity
- Reduced rates of low birthweight infants
- Improved experience of care

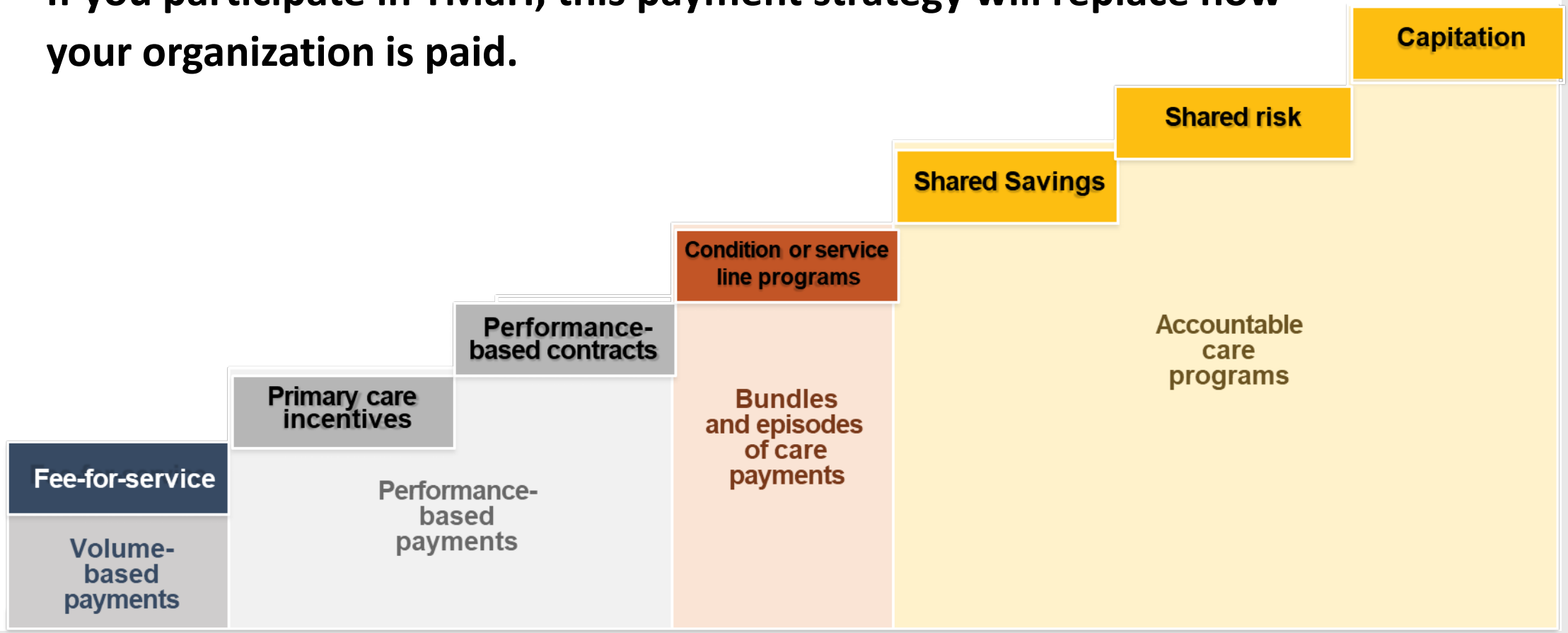
All 15 measures can be found in the Appendices.

Additional measures may be added as part of the formal CMS evaluation.

Please note: CMS reserves the right, in its sole discretion, to suspend, suppress, substitute or remove any quality measure from TMaH Model.

Participating entities agree to be accountable for quality of care and show improvement over time

If you participate in TMaH, this payment strategy will replace how your organization is paid.



Question 3: What general questions do you have about **infrastructure payments** and/or the draft **value-based payment strategy**?

Question 4: What would your organization or partners need in this shifting landscape to participate in a value-based payment strategy?

Getting ready for provider applications

Learn More:
TMaH Maternal Health Care Team

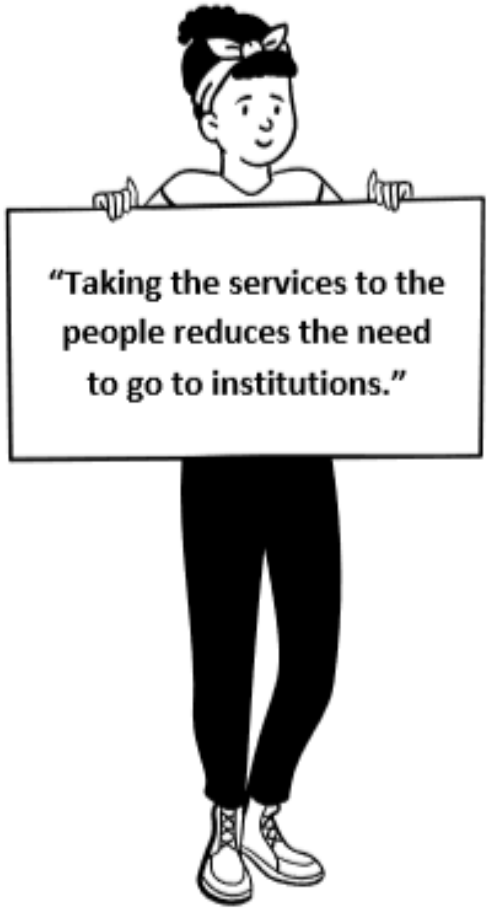
Recruiting systems, hospitals, birth centers, and FQHCs to participate

- At least one historically based hospital system with at least 1,000 annual deliveries paid for by Medicaid committed to model participation
- Birth centers
- FQHCs
- Tribal health clinics

What could an accountable entity application look like?

- Feedback highlights opportunity to improve collaboration
- TMaH is encouraging delivery locations, providers, and community organizations to partner and apply together to align with model objectives
- Infrastructure payments and value-based payments would be split
- This accountable entity would be responsible for:
    - meeting cost and quality outcomes
    - complying with model terms and conditions
    - distributing shared savings

Strengthening connections to community-based organizations (CBOs)



- Feedback shows consensus that **strengthening connections to CBOs is a top priority** in Hennepin County
- CBOs provide direct services that align with TMaH model
- How can CBOs be included in the TMaH model?
  1) Include CBO(s) directly in application and detail how the collaboration will function
  2) Demonstrate in application which CBOs are named partners and how infrastructure payments will be used to strengthen connection

Incentives for model participation

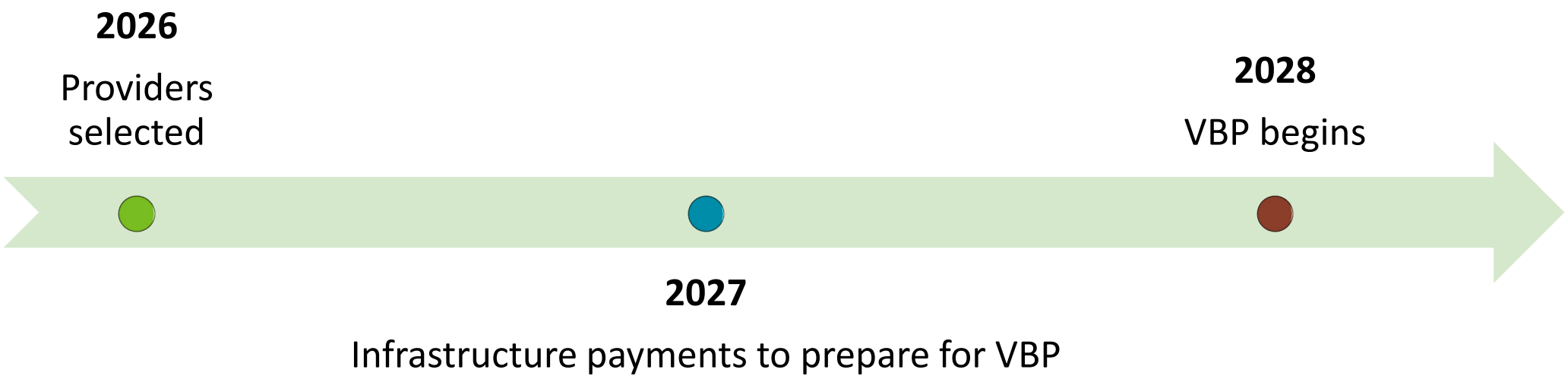
1. **Improve timeliness** of reimbursement
2. **Support** with credentialing, billing, and reimbursement
3. **Address pay** for midwives and OB-GYNs
4. **Increase reimbursement** amounts
5. **Improve collaboration** between providers
6. **Support billing pathways** for care coordination
7. **Identify billing pathways** for community-based organizations (CBOs)
8. **Enable data sharing** between model participants
9. **Provide infrastructure payments** to prepare for model implementation and VBP

Question 5: Are there other participation incentives we missed?

What needs to be included for your role or organization to participate?

Getting ready for TMaH provider applications

- 2026: Releasing provider applications and contracting providers by July
- 2027: Contracted providers receive infrastructure payments in March
- 2028: Move to a value-based payment system



Draft TMaH provider selection criteria policy

Population served: those experiencing highest chances of poor outcomes, feedback and data show priority populations are Black and Indigenous patients and families

Commitment to TMaH model: Implement AIM safety bundles (where applicable), strengthen whole-person care delivery, improve collaboration

Community trust: partnership with community organizations, history of respectful care, and shared decision making between patients and providers

Commitment to culturally appropriate and trauma informed care: culturally appropriate and trauma informed care and partnerships with cultural, Black, or Indigenous birth workers

What's next?

- Sharing follow-up survey
- Publishing TMaH website
- Releasing RFPs
- Producing TMaH application FAQs
- Convening managed care plan workgroup
- Launching beneficiary advisory and doula steering councils
- Posting TMaH provider partner and provider delivery location applications

Stay posted for these updates by joining our listserv. Email us and ask to subscribe:

TransformingMaternalHealthModel.dhs@state.mn.us

Thank you

- **Please take our follow up survey** by scanning the QR code or clicking the link in the chat
- **Please connect with us** to meet or join our TMaH listserv:

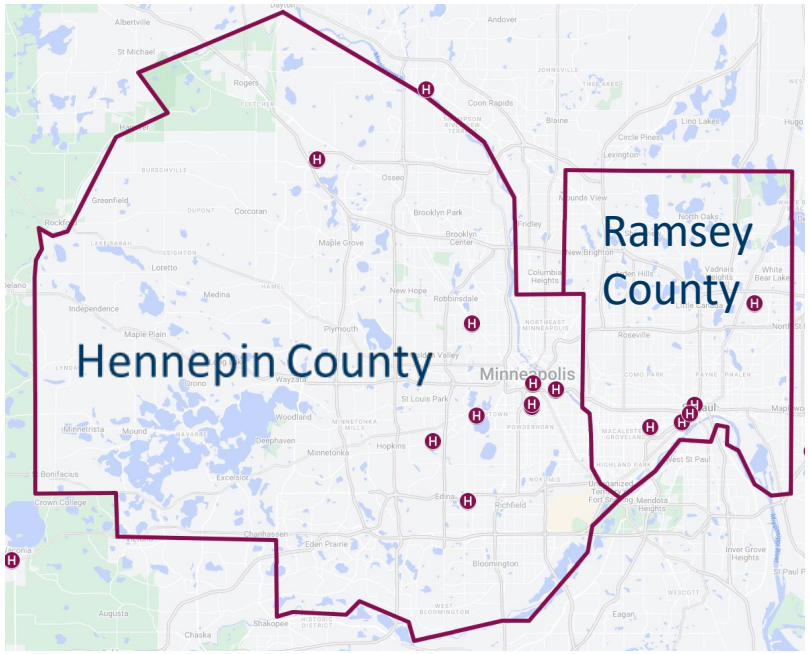
TransformingMaternalHealthModel.dhs@state.mn.us

DEPARTMENT OF HUMAN SERVICES

Appendices

Transforming Maternal Health (TMaH) Model

- Centers for Medicare & Medicaid Services (CMS) value-based payment model
- To improve maternal health outcomes and delivery of whole-person care
- Awarded to MN in January 2025
- For people insured by Medicaid, called Medical Assistance (MA), and Children's Health Insurance Program (CHIP)
- 10-year model piloting in Hennepin County



TMaH Model Pillars, Required Elements and Associated Milestones

	Pillar 1: **Access, Infrastructure, and Workforce**	Pillar 2: **Quality Improvement and Safety**	Pillar 3: **Whole-Person Care Delivery**
Required	• Increase access to the midwifery workforce • Increase access to birth centers • Cover doula services[1] • Improve data infrastructure • Develop payment model	• Support implementation of AIM patient safety bundles • Support "Birthing-Friendly" hospital designation	• Increase risk assessments, screening, referral and follow-up for perinatal depression, anxiety, tobacco use, substance use disorder, and health-related social needs (HRSNs) • Increase home monitoring of diabetes and hypertension • Develop Health Equity Plans
Optional	• Cover[2] certified midwives (CMs) and certified professional midwives (CPMs) in the state • Cover[3] perinatal community health workers (CHWs) • Create regional partnerships in rural areas • Extend Medicaid coverage to 12 months postpartum	• Promote shared decision-making between patients and providers	• Expand group perinatal care • Increase use of home visits, mobile clinics, and telehealth • Expand oral health care

[1]Include Doula Services among those eligible for Medicaid payment.
[2]Include certified midwives and/or certified professional midwives among the provider types eligible for Medicaid payment.
[3]Include perinatal community health worker services among those eligible for Medicaid payment.

Collective Model Design

The Office of the Medicaid Medical Director (OMMD) launched various engagement strategies in 2024–2025 to inform model design and implementation.

These efforts included:

- community listening sessions (N=350)
- Medical Assistance (MA) member survey (N=44)
- hospital, provider, and community listening sessions (N=96)
- provider practice survey (N=50)
- intentional follow up meetings (N=70+)

Pillar 1: Access, Infrastructure, Workforce

What we heard	What we're doing
Credentialing and billing navigation: Billing pathways for support services and community organizations, support with credentialling and billing navigation	• Collaboration with CMS to incorporate wrap-around care into TMaH payment model • Direct support for credentialling, billing, and reimbursement • Workforce survey
Provider Payment: Sustainable reimbursement rates across perinatal providers, improve pay parity for midwives and OB-GYNs	• Shared recommendation to CMS to include enhanced reimbursement in TMaH payment model design
Recruitment and retention: birth center staff, BIPOC birth workers	• Convening formal doula advisory council in 2026 with MDH • Workforce survey • Direct support for credentialling, billing, and reimbursement • Direct technical assistance for recruitment and retention

Pillar 1: Access, Infrastructure, Workforce

What we heard	What we're doing
Data infrastructure: Streamline and standardize data systems across participating practices, support data sharing for participating providers, additional data reporting support for smaller providers, statewide maternal health data dashboard	• Direct support of existing data stewards • Working to enhance cross agency data linkages • Planning phase of TMaH data dashboard • Direct support of data infrastructure for smaller/independent health care providers
Community engagement: Patient education to increase awareness of covered services, continued transparency with partners	• Forming perinatal beneficiary TMaH advisory council in 2026 • Beneficiary education campaign planning to increase awareness of covered services • New perinatal benefits one-pager coming soon from OMMD • Direct support of patient engagement efforts • July and December 2025 Listening sessions and survey • Over 70 outreach meetings

Pillar 2: Quality Improvement and Safety

What we heard	What we're doing
Importance of culturally appropriate, harm reduction, and trauma-informed care approaches	• Technical assistance, training, and collaboration • Partnership with MNPQC • Host hypertension training • Implement hypertension safety bundle • Conduct blue band project implementation • Leaving room for tailoring by practice, scope, and population • Added to provider selection criteria
Standardize screening tools for model with room for tailoring by practice, scope, and priority population	
Scale up models that work (Ex. FQHC, midwifery models of care, tailored pilots)	

Pillar 3: Whole-person care delivery

What we heard	What we're doing
Culturally relevant and trauma-informed care: Need additional training and tailored approaches for Black and Brown populations	• Direct support of training and technical assistance for providers • Including commitment to providing appropriate care and shared decision making into provider application
Clear protocols for screenings, referrals, and follow-up: • Create TMaH protocols for screenings and referrals for risk assessments and follow up (Ex. Resource guide for providers build into HER) • Improve care coordination and follow up between maternal providers, specialty care, health-related social needs referrals, and community-based organizations (CBOs) • Improve bi-directional referrals between hospitals and birth centers (e.g. hospitals referring low-risk patients to birth centers)	• Host Perinatal Behavioral Health/SUD/Tobacco Risk Screening & Referral Community of Learning (COL) • Implementation plan being written in 2026 to inform TMaH screening, referral, and follow-up protocols • Provider education campaign around maternal health resources and services • Storytelling campaign for providers around quality improvement

Pillar 3: Whole-person care delivery

What we heard	What we're doing
Improve collaboration between providers	• Direct training and technical assistance for providers • Including commitment to collaboration between provider types into applications • Implementing shared care planning
Expand access: • extending hours • purchasing medical and training equipment • piloting tailored home visiting programs	• Direct support of existing evidence-based work through competitive RFP process
Address patient barriers to accessing care, including transportation, childcare, housing support, baby supplies, food, and more	• New perinatal benefits one-pager coming soon from OMMD • Education campaign planning to increase beneficiary awareness of covered services • Strengthen connections to CBOs within model

Who can receive payments?

- There will be a competitive application to participate in the TMaH model.
- TMaH will accept partner providers, partner provider care delivery locations, and partner organizations who provide:
  - Prenatal, labor and delivery, or postpartum services
  - Care for perinatal patients insured by Medicaid/CHIP
    - These can include hospitals, OB-GYN practices, federally qualified health centers, and birth centers
- CMS encourages a single practice or clinic or multiple to come together as an accountable entity to join the model.

Getting ready for TMaH provider applications

- Must be enrolled as a MN Medicaid provider and/or be contracted with a local managed care plan
- Be licensed and/or credentialed and in good standing with applicable state and federal oversight bodies and must have or obtain a National Provider Identifier through the National Plan and Provider Enumeration System to bill for services

Getting ready for TMaH provider applications

- Provide baseline data showing past performance on prenatal and postpartum visits, sever maternal morbidity, cesarean section, low birthright and prematurity, as applicable to practice
  - Note: Applications do not need to demonstrate low rates of quality metrics but a commitment to improve movement on those over time.
- Ability to track and report required maternal health quality indicators and be IRB-compliant
  - Note: Applications can also demonstrate how infrastructure payments and/or partnerships will help organizations get ready to meet data requirements.

Center for Medicare & Medicaid Services (CMS) accepts draft provider selection & compliance policies drafted from partners and community

Listening sessions, survey results, and outreach meeting feedback was used to draft provider selection criteria policy and compliance & monitoring requirements submitted to CMS. These draft policies were approved in August 2025.

Provider selection criteria will be used to recruit and select providers to participate in the MN TMaH model.

Community feedback showed consensus that a competitive TMaH application will demonstrate:

- experience serving high need populations
- strong community trust
- willingness to partner and strengthen collaboration across provider types
- implementation readiness and dedication to providing whole-person care
- a commitment to improving access to traditional and cultural care

Examples of Provider Infrastructure Activities

Activity Type	Infrastructure Payments	Desired Care Delivery Implementation
Data Integration	**Rural OB-GYN Practice** invests in updates to their electronic health record (EHR) to exchange maternal health data with their state health information exchange (HIE)	**OB-GYN** within a large urban practice coordinates care with a rural clinic and obtains medical records via the state HIE for a beneficiary with complex conditions
Quality Measure Reporting	**OB-GYN Practice** works with a vendor to establish a real-time care delivery monitoring and quality improvement dashboard	**OB-GYN and Midwife** spend additional resources working on quality measure reporting to inform future data sharing agreements that improve the speed of quality improvement across different provider types over time
Connections to Community-Based Organizations (CBOs)	**Birth Center** spends time and resources developing connections with a CBO providing food and housing support to meet their populations' needs	**Midwife** works with beneficiary to connect them to CBO resources (e.g., food and transportation)

Examples of Provider Infrastructure Activities (Cont.)

Activity Type	Infrastructure Payments	Desired Care Delivery Implementation
Team-Based Care	**OB-GYN Practice** restructures patient care delivery flow to integrate all members of the team and become multidisciplinary	**All members of the maternal health care team** function to full capacity, expanding the roles of the RN, doula, community health worker, etc. to increase collaboration
Enhanced Access to Care for beneficiaries	**FQHC** hires and trains an additional administrative staff member and clinician to expand weekday and weekend hours	**OB-GYN and Midwife** schedule prenatal and postpartum care visits with beneficiaries who have limited access to transportation during normal business hours
Patient Safety Initiatives & Maternal Care Assessment	**Hospital** develops a work plan to implement the Safe Reduction of Primary Cesarean Birth Alliance for Innovation on Maternal Health (AIM) patient safety bundle	**OB-GYN and Hospitalists** use new processes and training to support spontaneous onset and progress of labor and vaginal birth

TMaH Quality Measures 2028

Quality Measures	Potential Measure Specifications
1. Low-risk cesarean delivery	Vital statistics or Joint Commission PC-02: https://manual.jointcommission.org/releases/TJC2023A1/MIF0167.html
2. Maternal depression screening and follow-up	NCQA (PDS-E): https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/postpartum-depression-screening-and-follow-up/ or CMS: https://ecqi.healthit.gov/ecqm/ec/2024/cms0002v13
3. Severe obstetric complications	Joint Commission PC-07: https://p4qm.org/measures/3687e
4. Timeliness of prenatal and postpartum care (PPC)	NCQA: https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/prenatal-and-postpartum-care-ppc/

TMaH Quality Measures 2029

Quality Measures	Potential Measure Specifications
1. Low Birthweight	Vital statistics (< 2,500 grams)
2. Contraceptive Care for Postpartum Women	HHS OPA: https://opa.hhs.gov/research-evaluation/title-x-services-research/contraceptive-care-measures
3. Blood Pressure Control	NCQA CBP: https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/controlling-high-blood-pressure-cbp/
4. Preterm Birth	Vital statistics (< 37 weeks gestation)
5. NICU Rate	Billing record
6. Emergency Department Utilization among Postpartum Beneficiaries	Billing record
7. Screening for perinatal anxiety	Billing record or provider report
8. Tobacco use screening	Billing record or provider report
9. Substance use screening	Billing record or provider report
10. Health-related social needs screening	Billing record or provider report
11. Patient-reported experience measure	CAHPS survey or TMaH survey

TMaH Provider Key Terms

The following definitions were included in the notice of award.

- **Birth Center** means a health facility that is not a hospital, where childbirth is planned to occur away from the pregnant person's residence and that is licensed or otherwise approved by the State to provide prenatal, labor and delivery, or postpartum care and other ambulatory services.
- **Community-Based Organization (CBO)** means a public or private not-for-profit organization that provides specific resources and services to the community or to a targeted population within the community. CBOs include but are not limited to community health centers, childcare providers, home visiting programs, state and local domestic violence coalitions, domestic violence shelters, and related domestic violence programs, food banks, and those organized to provide homeless services, other Health Related Social Need services, maternal education and training services or to advocate for community improvement.

TMaH Provider Key Terms (Cont.)

- **Doula Services** means emotional, physical, and informational support during pregnancy, delivery, and after childbirth, provided by a non-clinical trained professional. Services established under the TMaH Model must include, but are not limited to, the following:
  - **Prenatal Services:** Promoting health literacy and understanding of the normal process of pregnancy and fetal development; assisting with the development of a birth plan; supporting personal and cultural preferences around childbirth; providing emotional support and encouraging self-advocacy; reinforcing practices known to promote positive outcomes such as breastfeeding; coordinating referrals or linkages to community-based support services to address health-related social needs;
  - **Labor and Delivery Services:** Providing physical comfort measures, information, and emotional support; advocating for Beneficiary needs; being an active member of the birth team; and
  - **Postpartum Services:** Education regarding newborn care, nutrition, and safety; supporting breastfeeding; providing emotional support and encouraging self-care measures; supporting individuals in attending recommended medical appointments; coordinating referrals or linkages to community-based support services to address health-related social needs.

TMaH Provider Key Terms (Cont.)

- **Health Related Social Need" or HRSN** refers to social and economic needs that individuals experience that affect their ability to maintain their health and well-being. TMaH is specifically focusing on adverse social conditions in the domains of food insecurity, housing insecurity, and transportation needs that negatively affect a person's health or health care.
- **Home Monitoring** means the use of digital technologies to collect health data from patients in one location and electronically transmit that information securely to providers in a different location.
- **Partner Provider** means a maternal health provider or practice providing maternity care services to Medicaid and CHIP beneficiaries in the TMaH Model. These providers may include but are not limited to obstetrician-gynecologists, midwives, physicians, fetal medicine specialists, nurses, mental and behavioral health practitioners, and other clinical and support staff, such as doulas, lactation consultants, and Perinatal Community Health Workers.

TMaH Provider Key Terms (Cont.)

- **Partner Provider Care Delivery Locations** means locations where maternity care services are provided to Medicaid and CHIP beneficiaries by Partner Providers. These locations may include but are not limited to hospitals, Birth Centers, obstetrician-gynecology practices, mental and behavioral health practices, rural health clinics, FQHCs, Tribal sites and other points of care.
- **Partner Organizations** means non-clinical organizations that will partner with Recipient and/or Partner Providers and Partner Provider Care Delivery Locations to implement the TMaH Model, including but not limited to state public health departments, Perinatal Quality Collaboratives, maternal mortality review committees, managed care plans, Community-Based Organizations, universities and other non-clinical organizations.
- **Perinatal Community Health Worker** means a trusted member or close associate of the birthing community who serves as a liaison with health and social services to facilitate access to services and improve the quality and cultural competence of service delivery. Such workers build individual and community capacity by increasing patients' health knowledge and self-efficacy through activities such as outreach, community education, informal counseling, social support and advocacy.

TMaH Provider Key Terms (Cont.)

- **Provider Infrastructure Payment** means a payment made by the Recipient to Partner Providers and Partner Provider Care Delivery Locations to support care delivery transformation. Such payments may only be used by providers for the activities described in Section A.4.3.1 of the TMaH NOFO and are subject to CMS approval.
- **State Doula Support Council** means a group convened by the relevant state Medicaid agency to advise the state Agency on how best to increase the number of nonclinical trained professionals performing Doula Services who are trained, practicing, and enrolled as Medicaid providers. The State Doula Support Council shall not advise the Federal government, including CMS or CMS contractors, on any matter.