DEPARTMENT OF HUMAN SERVICES

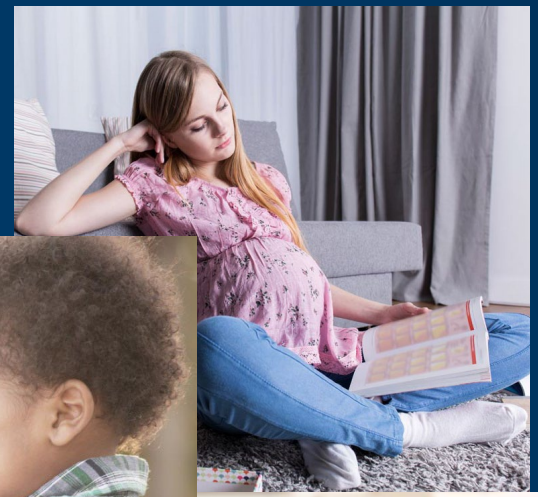
The Office of the Medicaid Medical Director

July 2025 TMaH Provider Listening Sessions

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.

Contents

- Welcome and Introductions
- MN TMaH Background
- TMaH Payment Design Strategy
- Establishing Provider Requirements
- Next Steps
- Appendices
  - A: TMaH Model Pillars, Required Elements and Associated Milestones
  - B: Examples of Provider Infrastructure Activities
  - C: TMaH Provider Key Terms



Welcome

Purpose of provider listening sessions:

- Share TMaH model updates
- Gather general questions about the model
- Provide a space for hospital, community, and traditional experience to inform model development

The feedback received will be used by MN DHS and CMS to tailor the model for Hennepin County.

<u>Introductions</u>

Please write in the chat:

- Name
- Pronouns
- Organization
- Role
- One hope you have for the TMaH model in Hennepin County

Recognition of past trauma and abuse

The state of Minnesota and the Department of Human Services recognize the trauma, medical abuse, 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 equity and antiracism 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 (OMMD)

- Nathan Chomilo, MD, FAAP, FACP | Medical Director/Sponsor/Project Co-Director
- Sarah Gareau, DrPH, MEd, MCHES | TMaH Project Director
- Nicole Peltzer, MPH |TMaH Community Engagement & Communications Coordinator
- Kristi Halvarson, MHA |Contract Specialist
- Leigh Grauman, MPH | Community Outreach Specialist
- Emmett Ruff, Megan Warfield-Kimball, Cara Schnick, Sierra Hill, Anne Walaszek, and many more!

DEPARTMENT OF HUMAN SERVICES

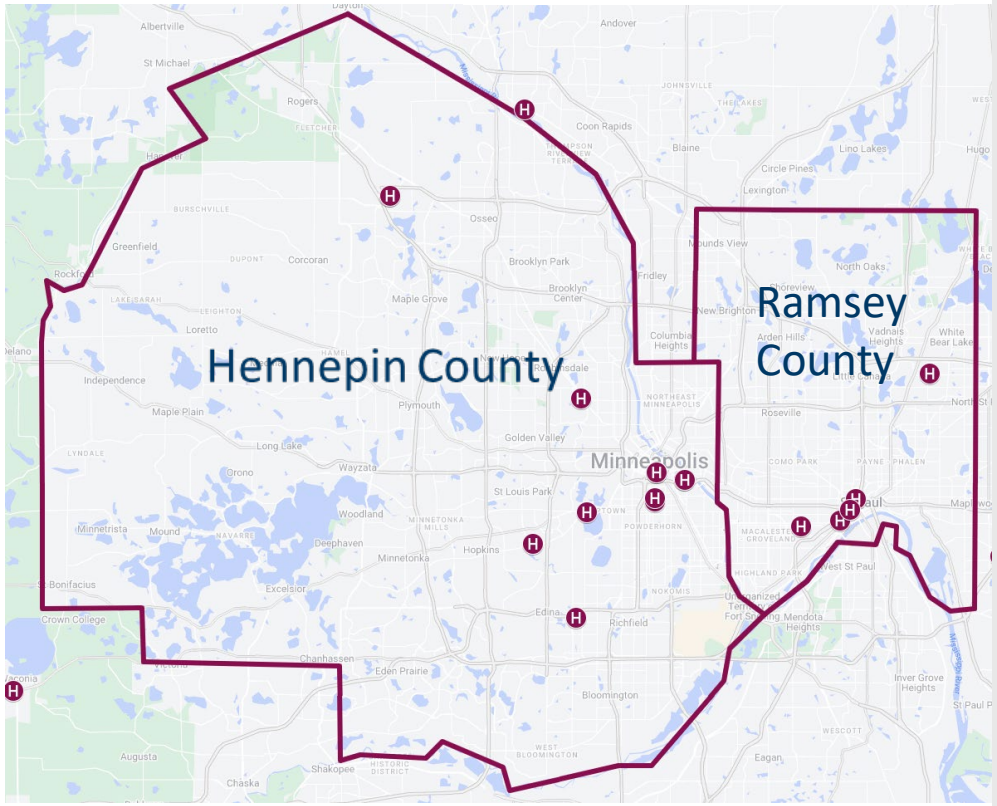
Transforming Maternal Health (TMaH) Model

MN TMaH Background

Learn More: TMaH Model Overview Fact sheet

Transforming Maternal Health (TMaH) Model

- TMaH is the newest CMS model designed to focus exclusively on improving maternal health care for Medicaid and Children's Health Insurance Program (CHIP) beneficiaries.
- MN was one of 15 state Medicaid agencies awarded the Cooperative Agreement with CMS in January 2025!
- Minnesota's Final Approved Region:
  Test Region = Hennepin County
  Comparison Region = Ramsey County



Required Elements of the model

Access, Infrastructure, and Workforce

- Increase access to midwifery workforce
- Increase access to birth centers
- Cover doula services *
- Improve data infrastructure
- Develop payment model

Quality Improvement and Safety

- Implement Alliance for Innovation on Maternal Health (AIM) patient safety bundles
- Support “Birthing-Friendly” hospital designation

Whole-Person Care Delivery

- Provide risk assessment, referral, and follow-up visit coverage for perinatal depression, anxiety, tobacco use, substance use disorder, and health-related social needs (HRSNs)
- Increase home monitoring of diabetes and hypertension

Optional Elements of the model

Access, Infrastructure, and Workforce

- Cover perinatal community health workers (CHWs) *
- Create regional partnerships in rural areas – N/A
- Cover certified midwives (CMs) and certified professional midwives (CPMs) *
- Expand Medicaid cover to 12 months postpartum *

Quality Improvement and Safety

- Promote shared decision making between patients and providers

Whole-Person Care Delivery

- Expand group perinatal care
- Increase use of home visits, mobile clinics, and telehealth
- Expand oral health care

Provider listening sessions: Question 1 (via chat or verbal share out)

- What general questions about the TMaH model or implementation would be beneficial to answer in an upcoming FAQ document?

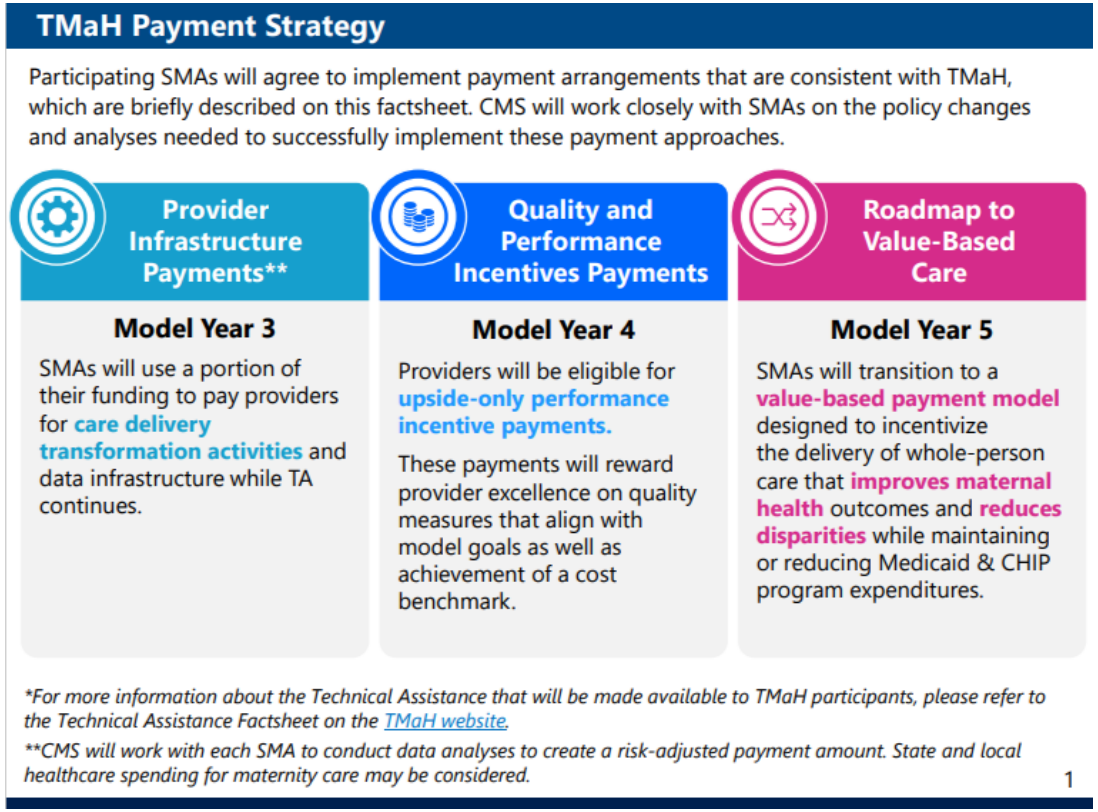
Learn More:
TMaH CMS FAQs

TMaH Payment Design Strategy

Learn More:
Payment Design Fact Sheet

TMaH Payment Design Strategy

- **Model Year 1 – 3:** Centers for Medicaid & Medicare (CMS) supports Minnesota to develop and implement the model
- **Model Year 3:** Provider Infrastructure Payments are made to providers to prepare a transition from the current payment system to a value-based payment model (with portion of funding to pay providers for care delivery transformation activities)
- **Model Year 4:** Quality and Performance Incentive Payments are made to eligible providers (upside-only performance incentive payments to reward quality and alignment with model)
- **Model Year 5 – 10:** Implementation



Provider Infrastructure Payment Priority Areas

Provider Infrastructure Payments will support care transformation activities in preparation for TMaH implementation, including:

- **Patient safety initiatives and maternal care assessments**
- **Quality measure reporting**
- **Data integration**
- **Team-based care**
- **Enhanced access to care**
- **Connections to community-based organizations (CBOs)**

Question 2 (Via Poll)

Provider Infrastructure Payments

Payments beginning March 31, 2027

- Risk-adjusted
- Amounts based on the number of eligible beneficiaries served
- Centers for Medicaid & Medicare (CMS) will finalize the Performance Incentive Payment methodology and implementation plan during the Pre-Implementation Period

Collection and reporting of data to TMaH and CMS

- **Quality measures** used for data reporting and to determine incentive payments (low-risk cesarean delivery, maternal depression screening and follow-up, severe complications and timeliness of care)
- **IRB approval** needed for collection and reporting of identifiable and protected health information

The following quality measure concepts will be used to determine Performance Incentive Payments in MY4

- Low-risk cesarean delivery
- Maternal depression screening and follow-up
- Severe obstetric complications
- Timeliness of prenatal and postpartum care

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.

Provider listening sessions: Question 3 (Via menti)

- What infrastructure and capacity gaps would you or your organization face in implementing TMaH care transformation activities?

  Transformation activities: Patient safety initiatives and maternal assessments, Quality measure reporting, Data integration, Team-based care, Enhanced access to care, and connections to community-based organizations (CBOs)

Join at menti.com

Code: 9555 2347

Establishing Provider Requirements

To Take Part in the TMaH Model, providers must:

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

Learn More:
Maternal Health Care Team
Fact Sheet

Impact on Maternal Health Care Teams

TMaH Model will support state Medicaid agencies to strengthen the maternal health workforce by examining workforce capacity and reimbursement, expanding coverage and training availability, and incentivizing team-based care. Examples of potential impact are listed below.

OB-GYNs	The model's focus on team-based care will support OB-GYN practices to integrate midwives and doulas. Expanded access to innovations including remote patient monitoring and telehealth will support risk-appropriate care for patients.
Midwives	The model will include capacity and workforce building for midwives to identify options for recruitment and expanded coverage of licensed midwives in the state. CMS will support participating state Medicaid agencies as they analyze payment for maternal health and increase access to the midwifery workforce.
Doulas	States will receive support to identify a strategy to cover doula services using the appropriate Medicaid authority and develop a plan to grow the doula workforce. The model aims to increase access and comprehensive care for patients by expanding coverage and payment options for doula services.
Perinatal Community Health Workers	States will have the option to receive TA related to rate development and payment analyses to support coverage of perinatal community health workers. In addition, participants may decide to receive TA related to expansion of group perinatal care, such as guidance on how to offer virtual group care.

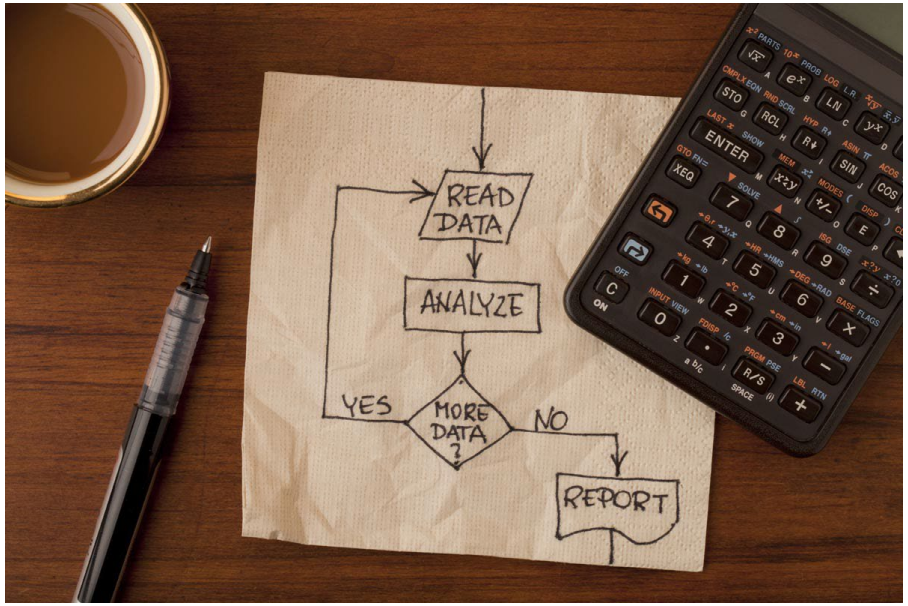
Who Will Receive Payments?

- Practices or clinics caring for patients in the TMaH model will receive Provider Infrastructure payments.
  - These funds will help prepare to implement the model.
  - These can include OB-GYN practices, federally qualified health centers, and birth centers.
  - A single practice or clinic or multiple can come together as an “accountable entity” to join the model.
  - CMS is developing guidance on how state Medicaid agencies (SMAs) can direct a portion of these infrastructure payments to hospitals or other care delivery locations as appropriate.
- These practices or clinics will be held accountable to certain quality standards/measures in Model Years 4 and beyond.

Other partners include Managed Care Entities (MCEs), other maternity care supports (i.e., CBOs), and future RFP recipients.

First Biannual Report to CMS

- Must draft provider participation standards
  - Policy detailing standards for selecting providers
  - Identify process for noncompliance
  - Define monitoring process
    - Review of quality metrics
    - Patient satisfaction surveys and/or feedback
    - Audits of medical records
    - Site visits
- Due July 30, 2025



Provider listening sessions: Question 4 (Via menti)

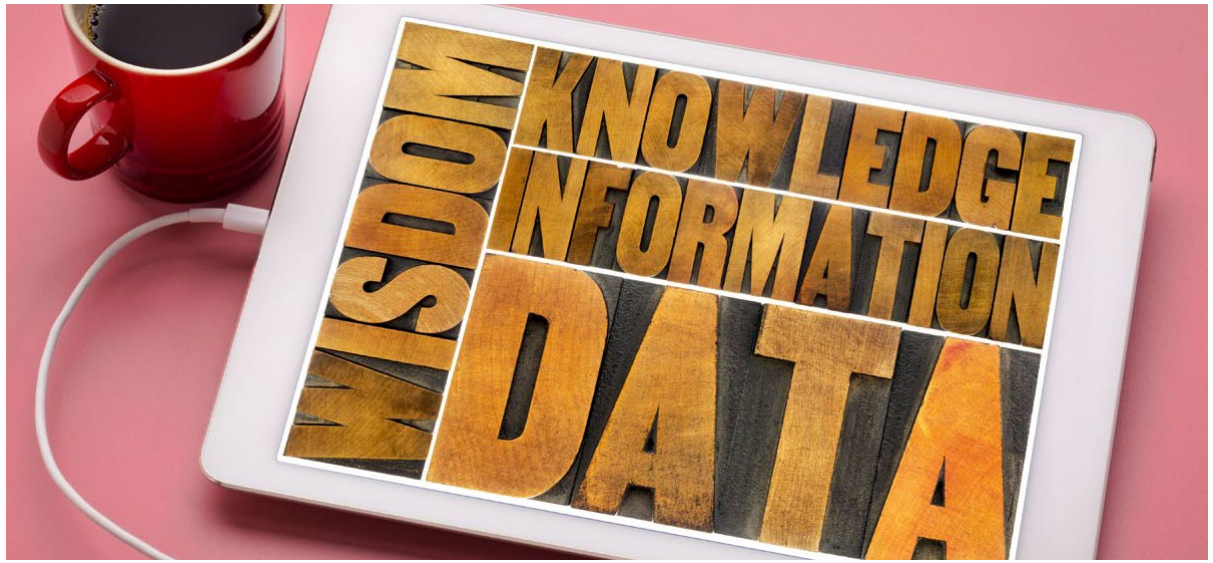
- **What criteria do you feel should inform provider selection for the TMaH model?** (e.g., licensure/certification, experience, commitment to model/evidence-based guidelines, reporting, traditional experience, and clinical need)

Join at menti.com

Code: 9555 2347

Provider listening sessions: Question 5 (Via Poll)

What compliance and monitoring requirements would you like to see? (e.g., quality indicators, key informant interviews, surveys, implementation metrics, audits, site visits, other?)



Next Steps

- Session slides
- Provider TMaH pre-implementation survey
- December TmaH provider listening sessions/ FAQs
- Centers for Medicaid & Medicare (CMS) upcoming guidance
  - Register for Value Based Payment 101 geared towards smaller providers (Coming soon!)
- Subaward RFPs for community engagement, data and infrastructure, and other model implementation activities

Stay connected:
Email your name, role, and organization to
transformingmaternalhealthmodel.dhs@state.mn.us
with subject line,
Join the TMaH listserv

TmaH pre-implementation survey QR code

The Office of the Medicaid Medical Director

Please connect with us:

TransformingMaternalHealthModel.dhs@state.mn.us

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Appendices

Appendix A: 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.

Appendix B: 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)

Appendix B: 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

Appendix C: TMaH Provider Key Terms

The following definitions apply for purposes of these Program Terms and Conditions:

- **"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.
- **"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.

Appendix C: 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.
- **"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.
- **"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.