

Minnesota Transforming Maternal Health Model (TMaH) Provider Application Questions

I. Application

How do locations apply?

Applications are **due on Wednesday, July 1** through the [TMaH website](#).

Is applying to TMaH a binding commitment?

Submitting a TMaH application demonstrates a soft commitment to participate in the model. If selected, applicants will work with DHS to complete final contracting requirements, including:

- Final budget awards for Provider Infrastructure Payments (PIP)
- State and federal contracting and compliance requirements
- Pre-award risk assessment
- Data use agreements
- Final memoranda of understanding (MOUs)

Is a budget required for the application?

No, budgets and budget justifications are not a part of the initial application. Final award amounts will be determined based on the number of accepted applicants, model requirements, and Centers for Medicare & Medicaid Services (CMS) approval.

Are all application attachments required?

- **Yes:** Attachments A–C are required. **Optional:** Named Partner section.

Who is eligible to apply as an Accountable Entity (AE) to participate in TMaH?

Organizations may include (but are not limited to):

- Hospitals
- Birth centers
- OB-GYN practices
- Mental health and substance use programs
- Federally Qualified Health Centers (FQHCs) and clinics
- Tribal health sites
- Other perinatal care delivery settings

Location & Service Requirements

- AE must provide **full spectrum of maternal care** (prenatal, delivery, and postpartum)
- Must serve **Medicaid beneficiaries in Hennepin County**

Licensing & Credentialing

- Licensed and/or credentialed and in good standing
- Must have (or obtain) a **National Provider Identifier (NPI)**

What is an Accountable Entity?

A TMaH Accountable Entity (AE) is the practice(s) accountable for care in the TMaH model. These are hospitals, clinics, or practices providing maternal health services, including OB-GYN practices, FQHCs, and birth centers.

Within TMaH, AEs are eligible for Provider Infrastructure Payments (PIP) to prepare for transformation to value-based payment (VBP). **Each AE must provide the full spectrum of perinatal care** (prenatal, delivery, and postpartum care), which can be provided among one or multiple organizations within the AE.

Option 1: Single Accountable Entity – One organization under one tax identification number (TIN) provides the full spectrum of perinatal care (prenatal, delivery, and postpartum)

Option 2: Joint Accountable Entity – Multiple partners collectively provide the full spectrum of care. Participating organizations contract through a single primary TIN, while maintaining their individual operations.

AE responsibilities:

- Meet cost and quality outcomes
- Comply with model reporting requirements and terms and conditions
- Distribute shared savings or recoup phased in losses

Is the AE required to meet all milestone activities in Appendix C: TMaH Required Milestones and Activities?

No. Appendix C is the list of required model elements the STATE is expected to meet by CMS. We encourage applicants to consider how to align existing work with model scope.

Who cannot be an AE?

- × **Individual clinicians.** But they can participate through an eligible location.
- × **Hospitals that do not provide prenatal or postpartum services.** But they can join with others to jointly provide the full spectrum of perinatal care.
- × **Practices/FQHCs where providers do not perform labor/delivery.** But they can join with others that provide delivery services.
- × **AEs below minimum delivery volume requirement.** CMS has proposed 30-50 annual births paid for by Medicaid/CHIP across the AE. This number is subject to change based on CMS guidance. We encourage those who may be below the minimum delivery threshold to partner with others to meet quota.

We encourage AEs to consider partnering to include a wide spectrum of perinatal team-based care.

This can include (but is not limited to):

- OB-GYNs, all types of midwives, pediatricians, physicians, fetal medicine specialists, and nurses
- Specialty providers for mental health, substance use, and diabetes and hypertension
- Cultural and traditional practitioners

- Support roles such as care coordinators, home visitors, patient navigators, doulas, and Community Health Workers
- Community organizations providing wrap around care

Can birth centers apply independently?

Yes. Birth centers:

- May serve as the **primary or sole Accountable Entity (AE) applicant.**
- Are **strongly encouraged to apply.**

CMS will provide further guidance on:

- Transfers for high-risk patients or delivery complications and related retrospective payment reconciliation.

Can hospitals serve as the primary or sole applicant in the AE?

- Yes, if they **provide the full spectrum of perinatal care** (prenatal, delivery, postpartum).
- Hospitals **can take part in more than one AE** to help others meet the full spectrum of care.

Key Hospital Requirements

- Partner organizations **determine how to split shared savings together.**
- Hospitals must **reinvest shared savings in perinatal services** (including clinical staffing, community health workers, care coordination programs, or other maternal health service enhancements).
- **Most shared savings** must go to providers delivering most of the prenatal/postpartum care.

AE Hospital Examples

Application 1: Single Accountable Entity

- Sole applicant: Hospital-owned obstetrician/gynecologist practice providing AE full spectrum of perinatal care

Application 2: Joint Accountable Entity

- Primary applicant: FQHC providing AE prenatal and postpartum services
- Secondary applicant: Hospital-owned obstetrician/gynecologist practice providing AE delivery services

How can Safety Net Providers participate?

Safety Net Providers, like Federally Qualified Health Centers (FQHCs), Tribal clinics, or wellness clinics, provide critical services. If the clinic does not provide delivery services, they **must partner with a delivery provider** to form or join an AE.

FQHC and Tribal Partner participation

The TMAH VBP Model will phase in downside risk over time. Unique reimbursement structures for FQHCs and Tribal Health Providers require flexibility related to phased-in downside risk and potentially the case rate payment. CMS guidance for flexibility is still being finalized.

3 proposed pathways for FQHC participation:

Option 1: Umbrella Approach – FQHC joins an AE – such as a health system or integrated OB group – that holds the financial risk and redistributes incentives.

Option 2: Limited Risk/Reward – FQHC forms or joins AE but is only exposed to minimal shared risk/reward to a proportion of payment above PPS (the Medicaid Prospective Payment System).

Option 3: No Risk/Reward – FQHC forms or joins AE without upside/downside risk through care delivery requirements, quality reporting, and access measures. Under this approach, FQHCs would not be eligible for Provider Infrastructure Payments. Over time, FQHCs could participate in Options 1-2.

2 proposed pathways for Tribal Health participation:

Option 1: Umbrella Approach – Tribal providers join an AE that takes on downside risk on behalf of the Tribal provider.

Option 2: No Risk – Tribal providers are eligible for shared savings if they reduce costs and improve quality, but downside risk is not required.

How can Community-based Organizations (CBOs) participate?

We encourage inclusion of CBOs to participate as the perinatal services they provide are strongly aligned with the TMAH model.

Option 1: AE – If AE eligibility requirements are met.

Option 2: Named Partner – AE can list CBOs as a Named Partner if eligibility requirements are not met and detail collaboration further in application.

How can telehealth, home monitoring, home visiting, oral health, and mobile units participate?

The model aims to strengthen access to whole-person care through home monitoring for diabetes and hypertension, home visiting, mobile clinics, oral health, and telehealth services. Inclusion of these services is strongly encouraged. The key is that the AE must – through one location or multiple—cover the full spectrum of perinatal care: prenatal, postpartum, and delivery.

II. Payment Model Status

Reflective of feedback provided by participating states and pending changes to obstetric billing codes (effective January 1, 2027), CMS made the following [changes to provisional VBP model guidance](#) as of April 2026:

- **VBP implementation is delayed to 2029**, instead of 2028, allowing states and participating provider locations more time to prepare for the transition to a value-based payment model.
- **Delayed Prospective Case Rate Payments:** The prospective monthly case rate will be **delayed for at least the first two years of implementation** (2029–2030).
- A **retrospective episode-of-care model** will begin **January 1, 2029**.

How will shared savings be distributed?

The AE can propose in the application how they will jointly distribute shared savings.

Will the TMaH Model include downside risk?

- The model **will phase in downside risk over time**.
- Early years will include **upside-only incentives** only.

Will the payment model change?

CMS will likely continue to make changes to build the most effective model. We encourage applying now to allow ample time to prepare for full implementation, including training and technical assistance. We have extended the application deadline to July 1, 2026 (previously June 1, 2026). Final contracts will not be finalized until final model guidance has been released by CMS.

III. Program

What are Provider Infrastructure Payments (PIPs)?

Practices that join TMaH will be eligible for Provider Infrastructure Payments. These dollars will help fund care delivery transformation needed for value-based care. Selected participants do not need to finance these investments on their own.

PIP payments can be used for transformation activities approved by CMS, including but not limited to:

- **Patient Safety Initiatives and Maternal Care Assessment** such as implementation of AIM safety bundles or EHR system upgrades required for risk assessments
- **Quality Measure Reporting** for model quality measures such as low-risk cesarean delivery, screening for maternal depression and follow-up, severe obstetric complications, or timeliness of care
- **Data integration to support maternity care** such as EHR upgrades to meet model reporting requirements or to facilitate health information exchange or integration with community organizations to share screening and referral information and feedback loops
- **Team-Based Care** such as regular care team meetings with various providers as appropriate
- **Enhanced Access to Care** such as alternatives to traditional office visits to meet patient needs including home monitoring, telehealth initiatives, group perinatal visits, home visits, or expanded hours
- **Connections to Community Based Organizations** to address social needs, mental health, and substance use and integration into screening, referral, and follow up activities

How does TMaH interact with other programs?

Applicants are encouraged to demonstrate how TMaH activities will build upon existing programs and maintain compliance with state and federal requirements. Locations **can participate in more than one** program.

TMaH is designed to **align with—not replace—** programs such as:

- Directed Payment Program (DPP)
- Integrated Care for High-Risk Pregnancies (ICHRP)
- Integrated Health Partnerships (IHP)
- Innovations for Maternal Health Outcomes in Minnesota (I-MOM)
- Other VBP models

Provisional Guidance

CMS guidance regarding reconciliation of potential duplication of shared savings payments across value-based programs is forthcoming.

- **Provider Infrastructure Payments** amounts will not be impacted by participation in other programs.
- **Shared savings cannot be duplicated** across programs and will be actuarially reconciled by DHS.
- TMaH funds must **supplement—not duplicate—existing funding**.

For additional questions:

- Email transformingmaternalhealthmodel.dhs@state.mn.us.
- Visit our [website](#) for program background, materials, and resources.
- Sign up for [our listserv](#) by emailing a request to join.

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