Transforming Maternal Health Model Overview Webinar
February 28, 2024

>>Jenni Duever, SEA: Hello everyone and thank you for joining us for today's Transforming Maternal Health Model Overview Webinar. We are excited to introduce some material about the TMaH Model with you this afternoon. I will get us started with a couple of general housekeeping items. Next slide, please.

To listen to today's presentation, it is recommended that you listen via your computer speakers. If this does not work, there is also a dial in option for viewers to listen through their phone. The dial in number and passcode for today's event are listed on the slide. Closed captioning for today's event is available at the bottom of the screen. During today's presentation, all participants will be in listen-only mode. Please feel free to submit any questions you have throughout today's presentation in the Q&A pod, displayed on the right side of the meeting room window. The TMaH team will collect questions submitted during today's event to inform future events and FAQs. Today's presentation is being recorded. If you have any objections, please hang up at this time. This slide deck, a recording of today's presentation and a transcript will be made available on the TMaH website in the coming days.

Finally, we will share a survey at the end of today's presentation. Please take five minutes to let us know how we did and share any questions that you have about TMaH. We have more events coming and would love to know what you think as we plan for these events. Thank you. Next slide, please.

Today's speakers include Ellen Lukens, Amanda Johnson, Adam Conway, Linda Streitfeld, Sarah Leetham, Kevin Koenig, and Frankie Devanbu. These speakers, and many others at CMS, have been working tirelessly and passionately over the past several months to develop and launch this innovative maternal health model. Thank you to the entire TMaH team and our CMS colleagues for their work.

Before we dive into content, let me give you a brief overview of the agenda for today's event. We will begin with a welcome from Ellen Lukens and Amanda Johnson with the CMS Innovation Center. Next, our presenters will share an overview of the TMaH three key areas of maternal health transformation and gradual implementation timeline. Following that, the TMaH Model will share more information about eligibility, TMaH's elements, and a quick timeline with upcoming dates to keep in mind related to the TMaH Model. We have reserved some time at the end of the call to answer questions related to TMaH that were submitted through webinar registration.

As a reminder, you can submit questions using the Q&A function at the bottom right hand corner of your screen. The TMaH Model uses the feedback and questions you share today to build future events and resources. Again, thank you for joining us today. We've got a great presentation planned for you. Now I'm going to pass the mic over to Ellen Lukens to formally welcome you to today's event. Next slide.

>>Ellen Lukens, CMS: Thank you, Jenni. Hi everyone. I'm very pleased to be here today to welcome you to the Overview Webinar on our new Transforming Maternal Health, or what we call TMaH, Model.

The CMS Innovation Center is continuing the Biden-Harris Administration's commitment to improve maternal health and birthing outcomes for pregnant and postpartum mothers and their newborns with the TMaH Model. Aligning with the White House blueprint for addressing the maternal health crisis, TMaH's 10-year care delivery model is designed to support state Medicaid agencies efforts to develop

and implement comprehensive approaches to pregnancy, childbirth, and postpartum care. The impact could be far reaching, as Medicaid covers nearly half of all births in this country.

At its core, the goal of the TMaH Model is to ensure that pregnant and postpartum mothers with Medicaid and CHIP coverage receive the personalized care they need and deserve to achieve improved health outcomes. The Transforming Maternal Health Model will build on the steps that CMS has already taken, and further our commitment to improving the health outcomes and care experiences for all pregnant people and their newborns across the country. The model not only aligns with the White House Blueprint for Addressing the Maternal Health Crisis, but also our own CMS Maternity Action Plan, which takes a holistic and coordinated approach across CMS to improve health outcomes and reduce inequities for people during pregnancy, childbirth, and the postpartum period.

I think we can all agree on the importance of the Transforming Maternal Health Model and our ongoing efforts to improve maternal health cannot be overstated. The US has the worst maternal mortality rate among industrialized countries, and recent evidence suggests that two out of three pregnancy-related deaths in this country are preventable. Additionally, across income and education level, women of color are disproportionately likely to experience poor outcomes. In some cases, Black and American Indian and Alaskan Natives are up to five times more likely to die due to pregnancy related causes than their white peers. We can, and must do better. And we hope this model will lay the groundwork for a future with better maternal and infant health outcomes.

With that, I will turn it over to Amanda and the TMaH Model Team to share more on the details of the new model. Amanda?

>>Amanda Johnson, CMS: Thank you, Ellen. Hi, everyone, my name is Amanda Johnson and I'm the Deputy Director of the State and Population Health Group at the CMS Innovation Center. Our team is leading the work on the Transforming Maternal Health Model.

As Ellen noted, and as you all know, there is a tremendous maternal health crisis in our country. According to the Centers for Disease Control and Prevention, in 2021, nearly 33 pregnant women died of childbirth complications per 100,000 live births, and 80% of the deaths could have been prevented. The risk of dying or having complications from childbirth is even higher for black and brown women.

CMS is well positioned to take a leadership role in tackling this disturbing trend and improving maternal health outcomes, given that Medicaid covers 41% of all births in the United States. We designed the Transforming Maternal Health Model to protect the health and wellbeing of pregnant women and their newborn infants. We are excited to have you all join this webinar today, for the overview of our TMaH Model. And with that, I will pass it over to Adam Conway. Thank you.

>>Adam Conway, CMS: Thanks for the welcome, Amanda. Hi, everyone, my name is Adam Conway, and I am the Director of this Division of State-Based Initiatives at the CMS Innovation Center.

Our team will share a brief overview of the TMaH Model. There is one disclaimer before we get started on our content, and that is that all the information we provide in this Model Overview Webinar is potentially subject to change. When published, the Notice of Funding Opportunity, or NOFO, will be the sole source of information about TMaH Model details, and the application process. Alright, with that, next slide, please.

Next, we will provide a brief overview of the TMaH Model. Next slide, please.

In the United States, despite investing more per capita in maternal health care than any other nation, we face disproportionately high rates of adverse pregnancy outcomes compared to other high-income countries. As Amanda and Ellen both noted, the Centers for Disease Control and Prevention reports that more than 80% of maternal deaths are preventable. Pregnant women with low income and limited access to nutritious food experience higher rates of maternal mortality and conditions like pre-eclampsia, and gestational diabetes. Black individuals face barriers to preventative care, contributing to underutilization of crucial prenatal and postpartum services.

Targeted interventions are needed to address these disparities. For example, mild hypertension diagnosed early and treated during pregnancy reduces the risk for pre-eclampsia. The cost of pre-eclampsia in the US is roughly 2.2 billion dollars each year.

Inconsistent risk-stratified care and inadequate payment structures further hinder maternal health. State Medicaid agencies and managed care plans use a variety of approaches to manage cost and utilization of maternal health services. And several of these approaches failed to incentivize team-based care, or coordination across the pregnancy episode. We must incentivize personalized care to meet unique needs. A 2021 study in Archives of Women's Mental Health found that 33% of pregnant women in the US are not screened for perinatal depression, despite recommendations for universal screening. This study also found that patients who are uninsured, who are insured by Medicaid, or are black were less likely to be screened for perinatal depression.

There's also a dramatic shortage of maternal health care providers in the US, with only 11 OB-GYNs and four midwives per 1,000 live births. Less than half of rural US counties have obstetric services, creating maternal care deserts and limiting access for pregnant women. This emphasizes the need to increase qualified professionals. This collective landscape demonstrates the potential impact of TMaH, CMS's newest model, designed to partner with states to improve maternal health outcomes. Next slide, please.

In 2021, the Innovation Center released a Strategy Refresh consisting of five strategic objectives that guide the implementation of the Center's vision. On this slide, we want to briefly touch on how TMaH will complement the Strategy Refresh.

To drive accountable care, TMaH will work with participating SMAs and managed care plans to bring the current payment methodology to a value-based maternal health care payment methodology in which entities and providers are accountable for cost and quality of care. The model also provides technical assistance, or TA, to SMAs to expand and grow the maternal health workforce to implement the model of care which emphasizes the relationship between the patient and the provider.

To advance health equity, TMaH provides support to providers in rural and other high need areas and partners with participating SMAs to increase provider capability to screen for Health-Related Social Needs, to refer patients, and then track whether needs have been addressed. SMAs will select their implementation region in their NOFO application and providers and managed care plans will be selected based on location and provider type, subject to CMS approval.

TMaH supports innovation by supporting providing SMAs with Cooperative Agreement funding to support innovation systems that improve data sharing and collection. The model will support increased access to less medicalized provider options for low-risk pregnant women through enhanced

recruitment, training, and administrative support for midwives and doulas. In addition, the model will use a patient-reported outcome measure to capture the birthing person's experience in various health care settings and with a variety of provider types and administrative staff throughout the pregnancy and postpartum period.

TMaH will foster partnerships that build internal health care infrastructure and capacity. The Centers for Medicaid and CHIP services has been a strong design partner as well as many other federal partners. In addition, TMaH will provide technical assistance to enhance coordination and generate new connections between healthcare providers and community-based organizations in the implementation region or state. Next slide please.

TMaH's approach to maternal care delivery and payment transformation is centered on three key areas, including access to care, infrastructure and workforce, quality, improvement, and patient safety, and whole person care delivery. CMS will select up to 15 state Medicaid agencies to receive support and carry out TMaH elements by partnering with managed care plans, maternal health providers and supports, community-based organizations, hospitals, health systems, and additional agencies within the implementation region or across the state. Each area contains required elements of the model that SMAs will use TMaH resources to implement and monitor over the course of this ten-year model. TMaH also contains seven optional elements of transformation that SMAs can select from when applying to the Spring 2024 TMaH Notice of Funding Opportunity.

TMaH will test whether the interventions within these areas, that together form an innovative maternal health care delivery model, can be coupled with a new payment approach for provider participants to incentivize higher quality care, improved beneficiary experience, and ultimately improved outcomes during the pregnancy, birthing, and postpartum periods. Access, infrastructure and workforce will focus on helping SMAs assess and build capacity that connects pregnant and postpartum individuals to maternal care. TMaH will collaborate with SMAs to share maternal health, educational resources, and build community partnerships to support greater access to valuable resources, such as midwives, doulas, and birth centers.

Technical assistance and funding will be provided to states as they work to enhance data collection and linkage systems to improve information sharing. Quality improvement and patient safety will support state Medicaid agencies as they work with providers, hospitals and health systems to facilitate connections and implement evidence-informed care protocols that lead to safer births and improve overall experience for the mother and baby.

Finally, whole-person care delivery will focus on connecting patients to care based on their risk and their needs. CMS and our colleagues will support state Medicaid agencies to identify, implement and monitor comprehensive health screening and risk assessment protocols and increased coverage of care options to ensure that every mother receives care that is customized to meet their specific needs. We will review all three of these areas in more detail in the upcoming TMaH elements section. Next slide, please, thank you.

This slide presents an overview of TMaH’s gradual implementation approach. TMaH will consist of a Pre-Implementation Period, focused on tailored, state-specific technical assistance that will prepare awardees for the Implementation Period. Preparing state Medicaid agencies will then, or excuse me,

participating state Medicaid agencies will then transition to the value-based maternal care program that they have designed with CMS.

The Pre-Implementation Period will take place during TMaH Model Years 1 through 3, and is anticipated to begin January 2025. The Pre-Implementation Period combines technical and financial supports to state Medicaid agencies and their partners to advance the TMaH delivery and payment model. Here, SMAs will identify managed care plans, maternal health providers and supports, and community-based organizations to receive technical assistance and infrastructure funds from TMaH. CMS will work with SMAs, who will in turn work with selected managed care plans, if applicable, maternal health providers, supports, and community-based organizations to implement TMaH. Some technical assistance from CMS and its contractors will be offered directly to managed care plans and providers, as well as community-based organizations.

State Medicaid agencies will be required to submit quarterly reports that detail their progress toward model implementation and specific operational activities during this time, and CMS and our contractors will provide technical assistance to support these activities. The implementation period will take place during TMaH Model Years 4 through 10, and is anticipated to begin in January 2028.

TMaH will build on the technical assistance provided to SMAs, managed care plans, maternal health providers, and community-based organizations during the pre-implementation to achieve the key payment reform and interventions developed in a state-specific value-based payment model. State Medicaid agencies will have the option to implement TMaH regionally or statewide, and these options are going to be described in more detail on an upcoming slide.

In Model Year 4, providers will receive incentive payments for reaching select quality and patient safety benchmarks. And beginning in Model Year 5, state Medicaid agencies will implement their state-specific value-based alternative payment model.

And with that, we would love to hear from the audience. And I'm going to turn over the event at this point to Linda Streitfeld who will take us into our first poll question. Linda?

>>Linda Streitfeld, CMS: Thank you, Adam. Hello everyone, I'm Linda Streitfeld and I'm the Model Lead for the Transforming Maternal Health or TMaH Model. And I'm excited to share more information about the model.

But first, for today's event, we want to make this very engaging, so we have a couple of poll questions where we'd love to hear your feedback and your interests related to the TMaH Model. We'll use the feedback from today's event, including your poll responses, to build future events and develop materials about the model. Your responses to the poll questions will be anonymous.

And here is the first poll question: Is your state interested in applying to the Transforming Maternal Health Model? So, we'd love to know, especially for representatives on the line from state Medicaid agencies, whether you're interested in applying to the model. We have a few options to select from and please continue to use the Q&A function to share any additional feedback or questions with our team. We'll give you some time now to respond. Looks like we're closing the poll in just a few seconds. And the poll is closed. Thank you to everyone who participated. It's exciting to see the interest in the model. And we really appreciate your feedback. Next slide.

We'll use the next few slides to share more about the benefits of participation and eligibility requirements for the model. Next slide.

CMS designed TMaH to build a supportive structure for state Medicaid agencies to work with partners in their state to advance maternal health priorities that fit their patient populations. We have some of the benefits of participating in the TMaH Model listed here.

First, TMaH will bring provider infrastructure payments to fruition in Model Year 3. Infrastructure funding and resources will be available for state Medicaid agencies to support certain infrastructure investments such as internal staffing and analytics support. Each Medicaid agency will be eligible to receive up to 17 million dollars over the ten-year model timeframe. This includes the three years of tailored technical assistance support from a team of policy and analytic experts as states work to build an implementation plan.

TMaH will allow Medicaid agencies to implement at the statewide level or within a certain region or regions of their state. States will work with CMS to develop a maternity value-based payment arrangement for a substate or a statewide implementation approach. Supporting states as they identify and work to address health disparities is also a benefit to participating in the model. The technical assistance will support critical health interventions and help SMAs to evaluate progress toward addressing disparities for underserved populations. SMAs will receive state-specific technical assistance to support providers in each TMaH implementation region, including rural, tribal, and other high need areas. The goal is to build work force and infrastructure to support their patient populations. SMAs will track progress toward improving identified health disparities using the Health Equity Plan.

There will also be opportunities for collaboration and learning so that awardees and partner organizations can share knowledge and resources. This includes a CMS learning system strategy that will provide resources and guidance for SMAs, managed care plans, providers, and community-based organizations participating in the model. Next slide.

CMS will accept applications for TMaH only from state Medicaid agencies. Those SMAs will work with managed care plans in states where that applies, as well as with maternal health providers and supports to implement the model. Again, state Medicaid agencies are the only eligible applicants to the CMS Notice of Funding Opportunity that will be released soon. We're welcoming applications from Medicaid agencies in all US states in Washington DC and the territories. And we'll issue awards for up to 15 states.

Managed care plans in the selected states will collaborate with SMAs to create and implement a plan to participate in TMaH in states where Medicaid is run through managed care. In addition to managed care plans, maternal health providers and supports will be critical to the success of the model. This includes health systems, hospitals, birth centers, federally qualified health centers, maternal quality advocacy organizations, tribal providers, safety net providers, and community-based organizations. And we'll release more information about TMaH's participation requirements in that NOFO, which will become available in the spring of this year. Next slide.

State Medicaid agencies may implement the model, as we noted, either regionally at a sub-state level, or statewide. CMS is encouraging sub-state awards because these allow for the most rigorous evaluation, but both types of applicants will be considered. Proposals for TMaH implementation will of course be subject to CMS approval.

For the sub-state award, applicants will propose a region specified by zip codes in their application. This option will allow for an in-state comparison group to evaluate TMaH's impact on maternity care experience and outcomes. Patients receiving maternity care services, including prenatal, birth, and postpartum, will not be allowed to overlap between the implementation and comparison groups within a state.

For full state awards, SMAs will work with CMS to define an out-of-state comparison group that is similar in some important ways; demographic composition, resource availability, population size and density, birth outcomes and disparities, and Medicaid policy. In this case, all the TMaH interventions and services will be offered across the entire state. This includes the technical assistance, expansion of all TMaH services, and the value-based payment model. Next slide.

And now I'll walk us through TMaH's three areas of focus and the required model elements under each. We'll also review the optional elements of transformation that states may select when applying to TMaH. Next slide.

This will look familiar. We pulled it back up as a reminder of the three areas of focus for TMaH's transformative approach to maternity care, including access, infrastructure, and workforce, quality improvement and safety, and whole-person care delivery. In the next slides, we'll walk through each focus area and review the required and optional elements, and provide an overview of how CMS will support participating SMAs as they work to implement care transformation. Next slide, please.

The first section we'll walk through is access, infrastructure, and workforce. Adequate provider capacity and coverage are critical for access to care and the provision of whole-person care across the prenatal, pregnancy, delivery, and postpartum continuum. TMaH's required elements are listed here and we also describe the supports that will be available to states under TMaH to help accomplish these changes.

TMaH will support states as they assess the maternal healthcare workforce capacity, including for midwives and doulas. SMAs will identify opportunities for recruitment and expanded coverage of licensed midwives in the state. CMS will support payment analyses for potential fee schedule updates, and for the creation of billing pathways for midwives and obstetricians to consult with maternal fetal medicine specialists. TMaH will provide guidance to SMAs around connecting with local and state resources to expand opportunities and marketing around midwives. And in addition, TMaH will support coverage of and referral to childbirth preparation education classes.

TMaH will support SMAs to increase access to birth centers. Birth centers include free-standing birth centers and those that are alongside midwifery units. Birth centers show promising outcomes for low-risk clients, demonstrating increased access to quality care and improved patient experience and satisfaction. SMAs are also encouraged to examine birth center reimbursement rates and establish a plan for more sustainable reimbursement rates for birth centers. Types of technical assistance include payment analyses for determining fee schedule updates, and guidance for establishing sustainable reimbursement rates for birth centers.

As of January 2023, ten states and Washington DC cover doulas, and several other states are working toward this goal. TMaH will provide support to SMAs to cover doula services through Medicaid authorities, including payment analyses and guidance on payment levels. CMS will help SMAs establish doula advisory councils to support expanded opportunities and to guide implementation. We'll also

provide guidance and training for doulas to support Medicaid enrollment, reimbursement structures, and billing pathways. And in addition, TMaH will support the development of provider awareness and educational resources to create a supportive environment for doula care.

Studies of previous CMS Innovation Center models have highlighted the continued need for award recipients to improve the collection, integration, and use of data. TMaH participants will receive technical assistance and funding to improve data infrastructure and data linkage, such as linking Medicaid claims to vital records, linking data from federal food and housing programs and hospital discharge data. TMaH will provide guidance to providers and other organizations around data privacy, permitted uses of data, and patient disclosures. Also, TMaH will offer support to improve the collection and stratification of demographic data.

Also under this key area, is the development of a state-specific payment model. SMAs will collaborate with CMS to develop a payment model to transition from the current payment methodology, such as fee-for-service, to a value-based payment model design for maternity care services. Using historical data, CMS will guide discussions on the specification of a state-specific model, including which Medicaid authority to use, and support analytics to forecast the impact of potential payment parameters on utilization, cost, and quality. TMaH will help SMAs as they facilitate engagement, communicate the payment model implementation plan, and assist with managed care contracts for maternal health quality and access improvement, as appropriate. Next slide.

The next key area is quality improvement and safety. TMaH will support SMAs as they partner with Perinatal Quality Collaboratives, also known as PQCs, to implement evidence-informed maternal health interventions, and help their hospitals and health systems to attain the “Birthing-Friendly” designation.

The first required element under this area involves support to encourage implementation of patient safety bundles to make births safer, to improve maternal health outcomes, and save lives. PQCs are the infrastructure for statewide quality improvement, working together with hospital teams and other facilities, with communities and patients with lived experience. They use collaborative learning, trainings, toolkits, and patient safety bundles, such as those developed by AIM, to equitably improve quality of care and outcomes. TMaH will assist in facilitating connections between SMAs and their PQCs to support quality improvement in the model. This will include implementation of patient safety bundles recommended by Health Resources and Services Administration, working with the state PQCs.

In addition, TMaH will provide guidance to hospital and health system partners on how to attain the CMS “Birthing-Friendly” hospital designation by aligning with criteria, and identifying collaboratives for participation. TMaH will also provide guidance on marketing and displaying the designation on provider directories. Next slide.

The third area of TMaH focuses on whole-person care delivery. TMaH will support participating SMAs as they assess and plan to overcome challenges related to elements of personalized maternal health care. These might be home visits and partnerships with community-based organizations that use screening data to support patients who need additional medical and non-medical supports.

The first element under this area is home monitoring of diabetes and hypertension. Adequate monitoring and control of chronic conditions and depression during the pregnancy and postpartum period is critical to TMaH. SMAs will receive technical assistance to analyze existing Medicaid coverage

and reimbursement for home monitoring, to ensure collaborating providers can track and monitor chronic conditions remotely. CMS will assist SMAs in operationalizing the implementation of home monitoring and offer guidance for obtaining funding to cover the cost of telehealth platforms, training, and equipment for home monitoring of diabetes and hypertension. In addition, CMS will assist SMAs in partnering with public health departments, and other organizations, in the implementation of home monitoring.

The next required element under this area is risk-appropriate care. Participating SMAs will set up protocols to risk assess and screen, refer and follow-up for perinatal depression, tobacco use, substance use disorder, and Health-Related Social Needs. CMS will provide resources to evaluate care delivery patterns and utilization, to guide development of medical and social risk assessments, to inform risk-appropriate care. SMAs will receive support to assess gaps in community resources for addressing behavioral health and Health-Related Social Needs in the model population. CMS will also provide guidance to ensure that workflows and quality measures include recommended screening and follow-up from maternal depression, anxiety, and substance use disorder.

And finally, the last required element under this key area, is the development of a Health Equity Plan. CMS will support SMAs as they identify health disparities and develop a Health Equity Plan including resources for data analysis to understand disparities, identify and track specific improvement goals, address data collection and infrastructure gaps, and ensure that patients are having their translation and transportation needs met.

So now that we've reviewed the required TMaH elements, our team would like to hear from the audience. So let's go into our second poll question where we'd like to get your feedback. Next slide.

For those of you on the line with us today, we'd like to know which of these implementation options sounds most appealing to your state. As a reminder, your poll responses will be anonymous. So, is your state thinking about implementing the model at a sub-state or regional level, or statewide? And we'll give you a minute to respond to the poll. We'll be closing in just a few seconds. And we're out. Thank you for those responses. And we have one more poll coming up. Next slide, please.

TMaH includes seven optional elements of care transformation that are intended to help SMAs improve care delivery and access to care, especially in rural areas. In their application, SMAs may select one or more optional elements to focus on. Excuse me. But to be clear, states are not required to choose any of the optional elements.

The first four fall under our key area of access infrastructure and workforce. So the first is coverage of midwives and certified professional midwives. For SMAs that select this optional element, TMaH will support them to cover certified midwives and certified professional midwives who are licensed in the state through the appropriate Medicaid authorities. Similarly, SMAs may also decide to focus on the coverage of perinatal community health workers, or CHWs, and TMaH will provide additional guidance to cover perinatal CHWs through the appropriate Medicaid authorities.

SMAs may decide to focus on the creation of regional partnerships in rural areas among birth centers, community-based organizations, community hospitals, and larger hospital systems for risk management. SMAs will also have the option to receive technical assistance to support amending state plans for

Medicaid expansion to 12 months postpartum. We're happy to report that most states have already taken this step. But if not, we're happy to support states who would like to do that.

The next two optional TMaH elements fall under quality improvement and patient safety. CMS will provide technical assistance to interested state Medicaid agencies to develop and implement patient decision aid resources to enhance shared decision-making, and guidance to promote those decision aids across the patient population. SMAs may also decide to focus on the expansion of group perinatal care, and CMS will offer support in amending state plans to cover this type of care.

The last two optional elements fall under the third area, whole-person care delivery. SMAs may select to focus on expansion of oral health care, an intervention with known benefits for maternal outcomes. CMS will provide TA to identify barriers in perinatal access to oral health care, including provider education and payment analysis.

And finally, we'll have an optional focus on increased use of home visits, mobile clinics, and telehealth to expand care access, and options for risk-appropriate care. CMS will provide guidance to SMAs using Medicaid authorities in connection with home visits for prenatal and postpartum care, and on how to work with managed care plans to offer home visiting services. CMS and contractors will also work with SMAs to provide guidance to expand scope to new outreach clinics in rural communities.

And now we'll go to our final poll question for today's event. Next slide.

On the previous slide, we reviewed the optional TMaH elements that SMAs can select from in their application. For those of you on the line with us today, especially those representing Medicaid agencies, we'd like to know which of the optional elements is your state most interested in, in using our resources to implement. Again, your poll responses will be anonymous. So we've listed the optional elements here. Please select one or two that best apply. And we'll give you a minute to respond. We'll be closing in 10 seconds. Thank you so much for your responses there. Next slide, please.

The TMaH Model provides SMAs with state-specific support in the form of funding and technical assistance in order to improve maternal health care and birth outcomes while reducing associated health disparities. SMAs will receive up to 17 million dollars total over the ten-year model, including up to 8 million in the Pre-Implementation Period, and up to 9 million during the Implementation Period. Our Section 3021 funds will be dispersed to state Medicaid agencies through a Cooperative Agreement with CMS. A portion of this funding, along with technical assistance, will flow to providers in the implementation region in Model Year 3.

We've listed some of the Cooperative Agreement funding uses, including Medicaid staff time, IT infrastructure investments, and staff training. State Medicaid agency participants can use funding for their own internal staffing, analytics, and model implementation activities. Starting in Model Year 3, SMA participants will use a portion of this Cooperative Agreement funding to pay participating providers for care delivery transformation activities related to TMaH. Award recipients will submit quarterly reports that detail progress on model implementation and operational activities in accordance with the Cooperative Agreement.

Now I'm going to pass to Sarah Leetham, who will give us an overview of the technical assistance, learning, and resources. Next slide, please.

>> Sarah Leetham, CMS: Thanks Linda. Hi all, my name is Sarah Leetham and I am a Social Science Research Analyst with the Centers for Medicaid and CHIP Services. I'm excited to share some information about the types of state-specific technical assistance and resources that are available under the upcoming TMaH Model.

TMaH will provide tailored technical assistance to participating state Medicaid agencies to support the care transformations that were described on the previous three slides. Technical assistance will be provided to state Medicaid agencies during the Pre-Implementation Period. A multidisciplinary team of experts, contracted by CMS, will work with state Medicaid agencies managed care plans and providers during this time to meet the required and optional TMaH elements for the implementation region.

State Medicaid agencies may select one or more optional elements to focus on in their application. We will evaluate optional elements on a case-by-case basis. TMaH's technical assistance will include one-on-one, tailored support to state Medicaid agencies to support state-specific policy barriers, infrastructure, and workforce needs, data sharing landscapes, and other elements that may vary based on each state. This technical assistance is intended to meet states individual readiness, as CMMI realizes each state will have varying learning needs across the required elements.

Each state Medicaid agency will report on progress toward implementation periodically. TMaH will support state Medicaid agencies as they build their own TMaH-aligned payment strategy using data and insights from the Pre-Implementation learning and technical assistance period. Technical assistance will include coaching on payment analysis and analytic forecasting to support development and evaluation of the TMaH Model elements. CMS will also provide guidance for state Medicaid agencies and their partner organizations to engage community-based organizations to address Health-Related Social Needs.

In addition to the tailored, state-specific support, TMaH participants will have access to the TMaH Learning Community. CMS will offer opportunities for peer-to-peer engagement and group learning, such as case studies, an online collaboration platform, and webinars. State Medicaid agencies and their partners, managed care plans or CBOs, will be able to participate in affinity groups and cross-awardee model learning opportunities.

With that, let me turn it to Frankie Devanbu, to discuss the health equity approach in TMaH. Next slide, please.

>>Frankie Devanbu, CMS: Hi, my name is Frankie Devanbu, and I'll be going over the health equity planning for TMaH.

So the overall goal of the model is to reduce disparities in severe maternal morbidity among pregnant and postpartum Medicaid beneficiaries. CMS will partner with state Medicaid agencies to work in areas with a high need, to design and deliver interventions that have shown, that are evidence-based or promising, for improving on identified disparities in the health of Medicaid and CHIP beneficiaries. On this slide, we shared some of the steps that TMaH will take to address health disparities in maternal health outcomes, and to improve patient experience.

At the time of the NOFO application, applicant state Medicaid agencies will answer some questions related to the health disparities in their region. We designed these questions to prepare them for building a Health Equity Plan. As you mentioned earlier in the call, health equity planning is a required

model activity, and CMS will support state Medicaid agencies to develop, implement, and evaluate the plan over the 10 years of the model.

The first three years of the model will be a Pre-Implementation Period, during which the state Medicaid agencies will receive technical assistance to build out their Health Equity Plans. This might include conducting analysis to better understand the health disparities in the state or implementation region, identifying goals and tactics, tracking, tracking progress, and expanding on existing health equity related activities. The Health Equity Plan that we create will guide ongoing efforts in data collection, staff and hiring, strategic community engagement, and leadership engagement.

TMaH's Implementation Period will then start, from Model Years 4 through 10, and during this time, state Medicaid agencies will continue to set up and implement the interventions designed in the Pre-Implementation Period in the Health Equity Plan. These might include Health-Related Social Needs screenings, data collection, referral pathways, as well as patient safety improvements.

With that, I'm excited to pass over to my colleague, Kevin, who will walk us through a brief introduction on the TMaH payment model. Kevin?

>> Kevin Koenig, CMS: Thank you so much, Frankie. Hi, everyone, my name is Kevin Koenig, and I'm the Payment Lead for the TMaH Model Team. I'll walk us through an introduction to the TMaH Model payment structure. Next slide, please.

This slide describes a broad overview of TMaH's payment structures, and we'll go into each one in more detail. At a glance, we will be building the foundation for the payment model over several years, as we support SMAs and their partners in TMaH. Starting in Model Year 3, and during the Pre-Implementation Period, SMAs will use a portion of their Cooperative Agreement funding to pay participant providers for activities related to advancing TMaH elements.

In the next phase, SMAs will provide upside-only performance incentive payments for providers who meet a set of quality measure benchmarks, as well as achievement of a cost benchmark, based on Model Year 4 performance. This will help prepare providers, which includes OB-GYN practices, hospitals, health systems, birth centers, safety net providers, and others in the implementation region or state, for the Roadmap to Value-Based Care, that CMS will design in partnership with SMAs. By the end of Model Year 4, and in the second year of the Implementation Period, SMAs will implement a value-based payment model that incentivizes the delivery of whole-person care, improves maternal health outcomes, and reduces disparities. Next slide.

During Model Year 3, SMAs will disperse a portion of their Cooperative Agreement funding to participating providers within the implementation region or state to support activities related to TMaH elements. These risk-adjusted infrastructure payments will be paid to SMAs and then dispersed to providers to support the activities listed here, subject to CMS approval. Categories of activities include patient safety initiatives and maternal care assessment, quality measure reporting, data integration, and data-driven maternity care, team-based care, enhanced access to care, and connections to CBOs to address HRSNs and behavioral health needs.

This funding is designed to help participant providers build the required capacity and infrastructure needed to implement TMaH. For example, participant providers may use provider infrastructure payments to support team-based care between maternity care providers and community-based

organizations. TMaH will provide TA and resources to support partnerships with community-based organizations that can help meet patients' unique health and social needs. Additionally, a maternity care provider may seek guidance on how to identify and engage a potential behavioral health partner to refer positively screened patients. TMaH will support SMAs as they work to build this guidance.

Infrastructure funding can also be used to support providers telehealth platforms and support an alternative to traditional office visits and increase access to care. Data infrastructure and linkage is critical to the success and evaluation of TMaH, so providers may need additional funding to report and integrate data into interoperable systems. Next slide, please.

Next, in the next phase, SMAs will pay providers in the implementation region or state, based on quality and cost performance on a retrospective basis, based on Model Year 4 performance. The total performance incentive will be based on the provider's reported performance on quality measures, as well as achievement of a cost benchmark. More information on TMaH's quality performance measures will be included in the spring 2024 NOFO.

And states will receive one-on-one TA from analytic experts and CMS to create costs and quality benchmarks using two-to-three years of Medicaid claims, and other administrative data. CMS will work with SMAs during the Pre-Implementation Period to refine the Performance Incentive Payment methodology and implementation plan. Next slide, please.

By the end of Model Year 5, SMAs will transition from the current payment methodology in each implementation region or state, to a value-based payment model that supports investments in patient care infrastructure and rewards performance on quality and cost measures. CMS will work with SMAs to develop the payment methodology, which will be informed by infrastructure payments, quality and cost-performance incentive payments, as well as the latest research on maternity value-based payment arrangements. The Year 5 payment model may include risk-adjusted prospective payments to providers with retrospective reconciliation on quality and cost outcomes. Next slide, please.

With that, I'm excited to share a timeline for application for the TMaH Model and share next steps for those interested in the model. Next slide, please.

This slide walks us through an application timeline for state Medicaid agencies who are the only eligible participants to apply directly to the TMaH NOFO, which will be released in Spring 2024. Once the NOFO is posted, the TMaH application window will open, and interested state Medicaid agencies will be encouraged to submit their interests using the grants.gov website. State Medicaid agencies will have until the NOFO closes in the summer, to submit their application to participate. Interested state Medicaid agencies can follow the steps listed on this slide, including signing up for the TMaH listserv, to stay up to date about TMaH and learn about the application. If you're interested in the model, be sure to sign up to prepare for the application ahead of time.

The Model's Pre-Implementation Period is anticipated to begin in January 2025, and the Implementation Period is anticipated to begin in January 2028. Our team will be sharing additional resources, such as upcoming events and resources, to help interested stakeholders understand the TMaH Model before the application window closes. As a reminder, any questions related to the TMaH Model are welcome at TMAHModel@cms.hhs.gov.

With that, I'm excited to transition us to the Q&A portion of today's event. I'll pass it back to Linda, who will facilitate the discussion. Next slide, please.

>> Linda Streitfeld, CMS: Thank you, Kevin.

We have covered a lot of content today, and I want to thank all of you for all the great questions that we've received so far and for your attention during this webinar. We're now going to answer some questions that we received during webinar registration. Please feel free to share any questions through the Q&A pod to the right of your screen. We're going to be taking note of all the questions and try to ensure that future materials help address any common themes.

So, the first question that we received through registration is: What Health-Related Social Needs services could be covered or promoted through this initiative, thinking along the lines of 1115 HRSN waivers? So first, at a minimum, TMaH will require reporting on screening for three domains of Health-Related Social Needs that impact all people, including pregnant and postpartum people. And those three are food insecurity, housing instability, and transportation. We will require the use of a validated health IT and encoded HRSN screening instrument, such as the Accountable Health Communities HRSN Screening Tool or the PRAPARE tool, unless a specific instrument is required by state law.

Now, for guidance regarding authorities that state Medicaid agencies can use to address identified needs, we would refer you to the November 2023 guidance from the Centers for Medicaid and CHIP Services, titled “Coverage of HRSN Services in Medicaid and the Children's Health Insurance Program.” Our team may be able to put that link in the chat, and if not, we'll make sure that it is listed on the website or goes out to the listserv.

The next question is: How will TMaH SMAs work with the state Perinatal Quality Collaboratives? This is an important question, and we know that SMAs and the PQCs have different relationships in different states. It'll be important to strengthen those relationships to ensure that SMAs are aware of the AIM safety bundle work that's being proposed and can support the PQCs, the hospitals and the providers to get those safety bundles working in hospitals, while being careful not to duplicate or supplant any funding that might be in place through HRSA, ACOG, CDC, or some other entity. As with many of the TMaH interventions, some of this will be done state-by-state, and we’ll be providing TA to help them make those connections.

Another question is: Whether there is any advance insight to what the application involves, so that states can prepare to gather information or approvals? So, I don't want to be specific at this time around details, because the Notice of Funding Opportunity will include all of those details about what states will need to include in their applications. However, states should be considering their maternal health policy, priorities, their ability to manage the model, their plan to implement in either a sub-state or statewide way. You can see from our overview, that the model pillars are sort of the heart of things. So looking at where the state stands on each of those elements is a good idea as well as thinking about what entities a state would need to work with and how you could start connecting with those.

So next I'm going to turn it to Adam to take the next few questions. Adam.

>>Adam Conway, CMS: Thanks, Linda, and I have to admit I was looking at some of the questions that are coming in live. These are really helpful, so please keep them coming. It helps us to develop high quality materials that answer as many questions as possible. So thank you for that.

Next question we got was about how this model, Transforming Maternal Health, intersects with or works with other new CMMI models. This is a question that we have, have heard a lot lately. And so we're I'm glad to provide some high-level guidance here. In general, states are able to operate multiple models if they have the capacity to do so. Depending on the combination of models under consideration, there may be different participation options or exclusions that states will need to think about, such as exclusions or overlap policies at different levels, you know, statewide, sub-state, or at the provider level, or even the beneficiary. Some model combinations just cannot work well together as it would make it very difficult for CMS to evaluate the effects or where it could result in duplicative payments.

Because of these nuances, we do encourage states to reach out to us directly, the email is in the chat there. If you have questions about operating TMaH with another model in your particular state, we'd be happy to discuss what is or is not allowable in different combinations of models. And I will say that we do anticipate providing more specific guidance about this and other model interactions on our website in the coming months.

The next question I see is: Do you need to be a Medicaid expansion state in order to apply? Linda touched on this. Just say it again, no, a state does not need to have expanded Medicaid to all low-income people in order to apply. In addition, applicants are not required to extend Medicaid coverage to 12 months postpartum, which many states have not done. We do want to be clear that CMS is strongly encouraging Medicaid coverage to 12 months postpartum, however.

Kevin, it looks like you've tagged a couple of questions that are coming up. Can I turn it over to you?

>>Kevin Koenig, CMS: Yes, thank you, Adam.

The next question we have here is: Can grant funds be used for hiring additional staff to carry out work for the grant? If so, are there restrictions? So yes, SMAs may use money to hire personnel to support model implementation. As part of the application process, applicants will be required to submit a detailed budget that explains how the position will support the implementation of the model. The NOFO will have other information about hiring as well.

The next question I have here is: How will the model address perinatal mental health conditions, screening, and treatment? So a required element of the model is screening and referral for behavioral health needs. And providers may use provider infrastructure payments to support their engagement with CBOs that can help address social and mental health or behavioral health-related needs of beneficiaries and integrate them into screening, referral, and follow-up activities. Lastly, one of the inpatient safety bundles is perinatal mental health conditions, which may be implemented in a hospital.

And I have one more before Linda I'll pass it back to you. Can organizations or businesses apply for funding to implement the model? So no, only state Medicaid agencies can apply for the model, but we encourage organizations interested in TMaH to work with their SMA to support implementation.

Linda, I'll pass it to you.

>>Linda Streitfeld, CMS: Thanks, Kevin.

I see a question about the expectations and timeline for evaluation of the model. So CMS will conduct a formal evaluation of each state's performance to assess model impact. This evaluation would cover the whole performance period from the start of the Pre-Implementation Period through the end of program operations. This is part of CMMI's statutory charge, and this evaluation would not affect any of the performance payments under TMaH. So I hope that answers that question.

I'm also seeing a question about whether there would be a patient survey involved in the model. And the answer is, yes. We think it's really important to try to assess whether the model influences how women experience maternity care, especially for communities with historically worse outcomes. So we're still researching options in this space, but we do expect to include a patient-reported outcome or patient-reported experience survey measure. And I'll just note that there will be technical assistance available to help states and providers implement those surveys once they are chosen.

Here's a really important question about how the model differentiates between doulas and midwives, and among the three types of nationally certified midwives. So broadly, we understand that midwives and doulas have very different scopes of work. They have different licensure and different certification requirements. And, that there are important distinctions among midwives. So, starting with the doula services, as you probably know, there's a lot of evidence around the efficacy of doulas to improve outcomes across a full range of conditions and circumstances. And that is why as part of the model, states will be required to cover doula services if they're not already doing so.

As to midwives, Medicaid requires that states cover Certified Nurse Midwives. This model is going to require that each state look at the current situation with an eye toward improving access to midwifery care and we're going to help with that. Maybe it means revising how midwives are paid or smoothing out the administrative processes to help them get paid more quickly and easily. We are not requiring that any state add new certification categories to the midwives it already covers, but if states are interested in what it might look like to cover other licensed midwives like certified midwives or certified professional midwives, we will certainly offer technical assistance to help states figure that out.

Here's a question about how TMaH addresses the health disparities facing minority populations. And we've talked a bit about those disparities during the webinar today. So as Frankie noted, as part of the model, each state is required to develop a Health Equity Plan. And this will start with an assessment of disparities to better understand the issues facing each community. And then part of our technical assistance will be aimed at helping states to design and commit to a Health Equity Plan that is tailored for each state.

So Kevin, I'm going to hand it back to you.

>>Kevin Koenig, CMS: Thank you, Linda. So let me get to a few more questions and then we'll wrap up.

One question was: How does this model support maternal health in rural areas? Well, first, TMaH is aiming to increase access to care by broadening the maternal health workforce and advancing the use of telehealth to support, for example, home monitoring for beneficiaries with gestational diabetes or hypertension. Additionally, SMAs may elect to receive technical assistance to advance home visiting, mobile clinics, or regional partnerships in rural areas among birth centers, health centers, community hospitals, larger hospitals, health systems, CBOs and others.

The next question is: Is this a care model or a payment model, or both? TMaH is both a care delivery and payment approach. During the Pre-Implementation Period, SMAs and partners will be working to advance care delivery structures, such as doula services, comprehensive screening and referral pathways, and building partnerships with CBOs to address HRSNs, and then establishing a process for advancing a payment approach. No later than Model Year 3, SMAs will use a portion of Cooperative Agreement funding to pay providers for care delivery infrastructure changes. And then, transitioning to upside-only payments for a set of quality and cost benchmarks based on Model Year 4 performance, before leading into a longer term, VBP approach, which we'll work with SMAs to design and structure.

The last question we have here: What technical resources does CMS provide for state Medicaid agencies to successfully implement the TMaH Model? CMS will be providing rigorous one-on-one tailored policy and analytic TA to help states meet a list of milestones for each element by the end of the Pre-Implementation Period. We understand that states may be at different starting points for each model element. And that the TA needs to be specific for their unique circumstances in order to advance the model elements successfully. In addition to one-on-one TA, CMS will offer opportunities for peer-to-peer engagement and group learning. More information about the TA can be found in a factsheet available on our model website.

So that concludes today's TMaH Overview Q&A session. You are also welcome to submit additional questions to the TMaH Model helpdesk, at TMAHModel@cms.hhs.gov. And with that, Cat, I'll pass it over to you.

>>Cat Fullerton, SEA: Wow, what a great discussion. Just want to thank everyone for submitting questions. We hope this event was helpful in clarifying information about the model. Next slide, please.

As we close, we'd like to share some additional information and resources with you. We have a reminder of the TMaH email address here on the slide. And that is TMAHModel@cms.hhs.gov. The TMaH team will review all the feedback and questions submitted into the Q&A during the webinar today and use this information to inform future events and materials.

We have also provided the TMaH Model website, which contains many helpful resources for you to learn more. This includes a TMaH Overview Factsheet, which describes an introduction to the model. A Payment Design Factsheet that introduces the model's payment structure. And a Technical Assistance Factsheet, that describes the resources available to state Medicaid agencies and their implementation partners in TMaH. CMS has also created a patient journey map that follows an example patient, Jaya, along her pregnancy journey in the TMaH Model. This map demonstrates how the model can positively impact patient experience.

To stay up to date on the TMaH Model, sign up for the TMaH Model listserv using the link on this slide. We will announce upcoming events, resources, and more information about the NOFO using the listserv. And you can learn about these as they become available by signing up. Next slide, please.

Lastly, I want to thank everyone on this call for joining today's webinar. We are proud to share more information on the TMaH Model over the coming weeks and months. Please let us know how we did today by participating in a quick survey after the call. The link is posted in the chat now and it will also pop up after you close this webinar. We would love to hear from you.

Thanks again for attending today's TMaH Overview Webinar. This concludes today's event.