TMaH Round Table

CMS Transforming Maternal Health (TMaH) Model: Mississippi MOMentum Initiative

MISSISSIPPI DIVISION OF MEDICAID

Transforming Maternal Care: Mississippi MOMentum Initiative

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Agenda

- The Maternal Health Landscape
- What is TMaH
- TMaH Goals
- Accountable Entities
- Provider Infrastructure Payments
- Value-Based Payment Model
- Timeline
- Q & A

Today's Roadmap

The Challenge

The maternal health landscape.

The Opportunity

How TMaH is transforming maternal care.

The Vision

The goals guiding our work.

Your Involvement

How you help shape healthier outcomes.

In Practice

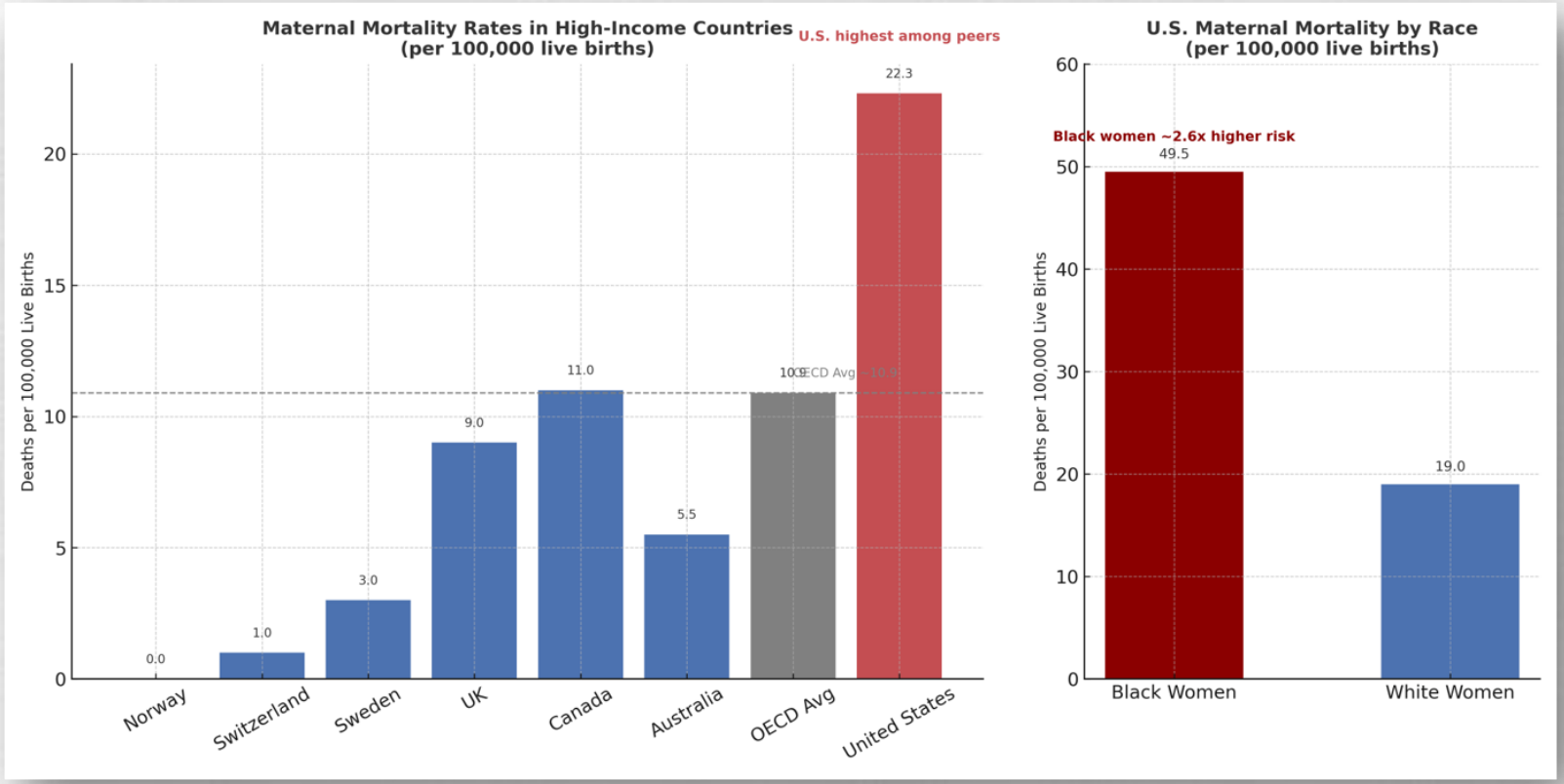
How PIP and VBP supports success.

The Challenge

Maternal Health Landscape

"Despite spending more per capita on maternal health care than any other nation, the U.S. has disproportionately high rates of adverse pregnancy outcomes as compared to other high-income nations"

https://www.cms.gov/priorities/innovation/innovation-models/transforming-maternal-health-tmah-model



Maternal Health Landscape

"Many of the challenges facing maternal health cannot be solved by one provider or one organization. They require coordinated systems of care"

60%

of all deliveries in MS are covered by Medicaid.

72.6%

of pregnancy-related deaths were Medicaid Beneficiaries.

75.3%

were among black, non-Hispanic women.

82%

Were deemed preventable.

Source: MS Maternal_Mortality_Report_2025.pdf

Why Mississippi? Why Now?

Because we can do better. Mississippi sits higher than the national average of SMM rate and Maternal Mortality.

Sources: National Center for Health Statistics, Natality data, 2024; National Center for Health Statistics, Mortality data, 2019-2023; HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). December 2024. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcup-fast-stats.

29.7%

Low-Risk Cesarean Birth

Percentage of Cesarean births for first-time moms, carrying a single baby, positioned head-first, and at least 37 weeks pregnant.

68

PER 10,000 HOSPITAL DELIVERIES

Severe Maternal Morbidity

Rate of unexpected outcomes of labor and delivery that result in significant short or long-term health consequences.

39.7

PER 100,000 BIRTHS

Maternal Mortality

Rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends.

The Opportunity

What is TMaH?

TMaH is a CMS model.

"The CMS Innovation Center develops and implements payment and service delivery models and conducts Congressionally-mandated demonstrations to support health care transformation and increase access to high-quality care."

Innovation Models | CMS

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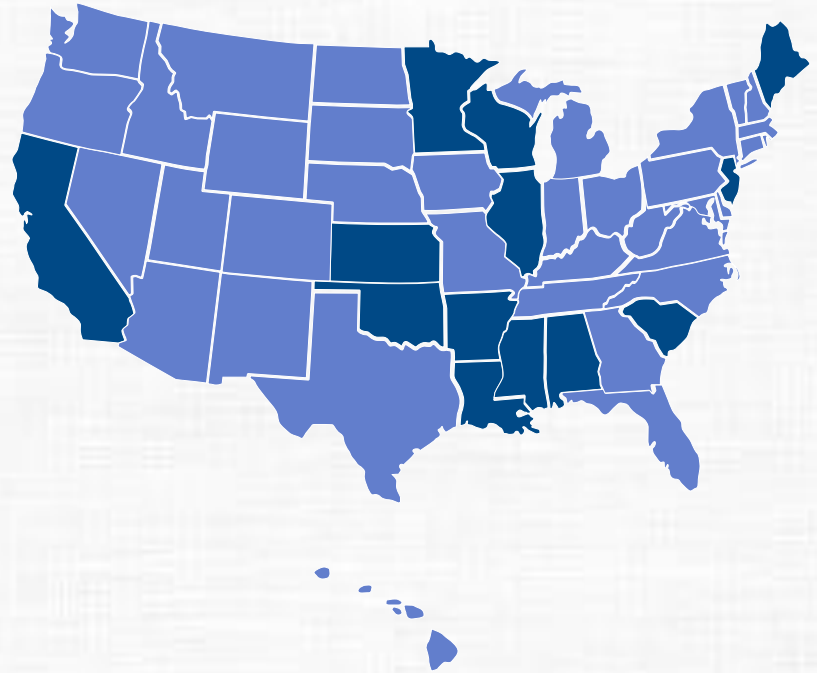
State Medicaid agencies awarded with targeted support in the form of

- Funding
- Technical assistance

MS TMaH Model = Mississippi MOMentum Initiative



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The Vision

TMaH Goals

Decrease low-risk cesarean section

Decrease severe maternal morbidity (SMM)

Decrease low birthweight infants (LBW)

Elevate the experience of care for those who are pregnant, giving birth, or postpartum

Streamline Medicaid and CHIP program expenditure

Guiding Pillars

Access, Infrastructure, and Workforce

- ✓ Increase access to birth centers and the midwifery workforce
- ✓ Increase access to community health workers and doulas
- ✓ Improve data infrastructure
- ✓ Develop payment model

Quality Improvement and Safety

- ✓ Support implementation of AIM patient safety bundles
- ✓ Support "Birthing Friendly" hospital designation
- ✓ Promote shared decision-making between mothers and providers

Whole-Person Care Delivery

- ✓ Increase risk assessments, screenings, referrals and follow-up for perinatal depression, anxiety, tobacco use, SUD, and upstream drivers of health
- ✓ Increase Home Monitoring of diabetes and hypertension
- ✓ Develop a Prevention & Quality Plan

Key Mississippi Approaches

Goal: Improve maternal outcomes through coordinated and personalized care.

Increase Access to Doula Services

- Expand pregnancy and postpartum support through trusted community-based care partners
- Improve care navigation, engagement, and patient experience

Expand Remote Patient Monitoring for Diabetes & Hypertension

- Increase access to home monitoring tools for high-risk conditions
- Enable earlier intervention and stronger provider-patient connections

Conduct Risk Assessments

- Identify medical, behavioral health, SUD, and upstream drivers of health earlier
- Connect beneficiaries to appropriate services and support

Your Involvement

Why TMaH Benefits Providers in MS

The TMaH Model is designed to:

- **Provide maternal health providers with upfront funds** to invest in prevention
- **Improve patient outcomes by incenting screening, identifying of, and providing continuous care for high-risk** patients across the spectrum of physical and behavioral health
- **Reward maternal health providers for improved outcomes** and resultant cost savings

Accountable Entity (AE) Structure

What is an AE?

- Provider organizations that **deliver prenatal, labor and delivery, and postpartum care** and agree to be accountable for cost and quality outcomes under the TMaH VBP Model.
- Intended to be the providers with a **direct impact on patient care**. The model prioritizes practice-level accountability, where performance tracking and financial incentives can most directly support care improvement.

Ideal Candidate

- A practice that **provides all perinatal care services**, or that provides prenatal and postpartum care and then has a **partnership with practice** that performs labor and delivery care.
- Ex: A standalone OB/GYN practice, a hospital-based OB/GYN practice, or other practices that deliver prenatal care (e.g. birth centers, family medicine practices, FQHCs, rural health clinics).
- Practices that do not provide all perinatal care would be required to partner with a practice that offers the missing service in order to form an AE for the TMAH VBP Model.

Accountable Entity (AE) Structure

SMA or Managed Care Plan (MCP)

Option 1

AE is a single organization that provides ALL perinatal services

Primary Participant Organization (Org)

Org Taxpayer Identification Number (TIN): 111222333
Participant Providers defined by Medicaid IDs

Option 2

AE is made up of multiple organizations that collectively provide perinatal services

Primary Participant Org
Org TIN: 111222333
Participant Providers defined by Medicaid IDs

Participant Org(s)
Org TIN: 444555666
Participant Providers defined by Medicaid IDs

Even if multiple organizations come together, there must be a primary **single TIN** forming a business or relationship with SMA or MCP

The Primary Participant Organization may enter **contractual arrangements** with additional Participant Organization to meet delivery requirements

Attribution Methodology: Guiding Principles

- **Align patient attribution** to providers where **patients receive the majority** of their prenatal and postpartum **care**, ensuring providers are accountable and rewarded for preventive care
- **Establish clear accountability** for maternal care costs and outcomes by attributing patients to
- **Maximize attributable patients** by creating **flexible attribution pathways** that capture as many eligible births as possible within the TMaH VBP Model
- **Ensure** FQHCs, Indian Health Care Providers, and Rural Health Clinics can **meaningfully participate in attribution** where they play a central role in maternal care delivery
- **Create clear decision rules** for patients connected to multiple providers or AEs, including tie-breaking and reconciliation processes

Inclusion/Exclusion Criteria Rationale

- Included services are intended to incent use of preventive services and dis-incent overutilization of unnecessary services
- Certain services, such as behavioral health, SUD, home monitoring, doula, dental and lactation care, are intentionally excluded to avoid creating a disincentive
- Exclusion from episode of care costs means total costs are lowered, increasing likelihood of finding shared savings for the AE
- Other services, such as pediatric and neonatal care, are excluded because they are beyond the control of the provider

In Practice

TMaH Timeline Overview

Provider Infrastructure Payments	Infrastructure Building	Value-Based Payment Model
2027+	**2027-2028**	**2029+**

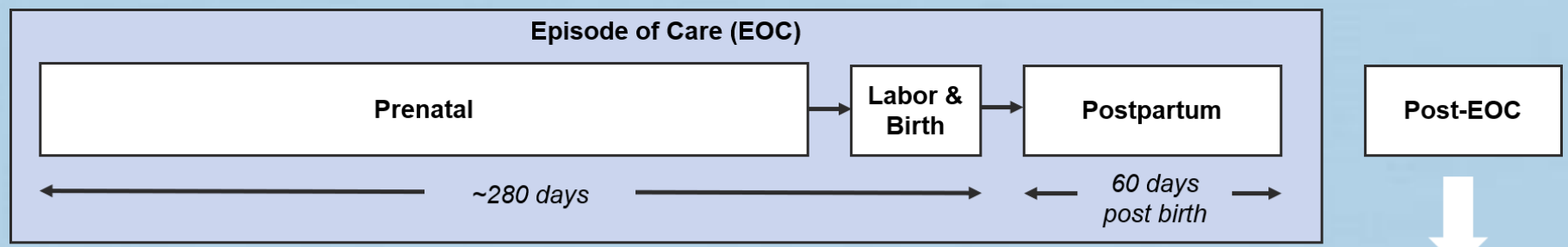
Provider Infrastructure Payments (PIPs)

- Enable practices to **develop infrastructure** and capabilities needed for model participation
- All SMAs will implement PIPs to **prepare practices** for TMaH VBP Model participation in 2029 and beyond
- These payments are intended to **build long-term VBP capabilities**, not just support TMaH

PIPs Can Be Used For:

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

The Role of Quality in the TMaH VBP Model



Retrospective shared savings (or phased-in losses)

Reconciliation of EOC × **Quality Adjustment** = **Shared Savings** (phased-in losses)

Annually, the total cost of completed perinatal EOCs are **reconciled against the target price and adjusted for quality performance.** Total cost includes professional and facility claims.

Quality measures are a core part of VBP because they align provider incentives with better care and ensure that cost savings are achieved through improved outcomes.

TMaH VBP Model Quality Measures

*Measures confirmed by CMS to be used in the VBP Model initially
These measures are tied to the TMaH VBP Model, but CMS will also monitor additional measures to support broader care management and outcome goals

PRENATAL

Model Goals

- Increase engagement in prenatal care
- Increase screening, follow up, and management of comorbidities

Measures

- Timeliness of prenatal care*
- Depression screening and follow-up*
- Maternal hypertension control

LABOR & BIRTH

Model Goals

- Decrease rates of low-risk c-section
- Decrease maternal morbidity
- Decrease rates of low birth-weight infants

Measures

- Low-risk c-section*
- Low birth weight
- Maternal morbidity (e.g., obstetric complications)

POSTPARTUM

Model Goals

- Increase engagement in postpartum care
- Increase screening, follow up, and management of comorbidities

Measures

- Timeliness of postpartum care*
- Depression screening and follow-up
- Maternal hypertension control

The Path Forward

Mississippi TMaH Model — Provider Roadmap

2026 (MY2) through model conclusion in 2034 (MY10) • CMS TMaH Payment Strategy phases noted

2026
MY2

Perinatal Provider Training
Continued training — OPS sponsorship (carryover from MY1)

Remote Patient Monitoring
Plan & scale UMMC's model; expand via MCOs (standardized for quality)

CNMs
Close coverage-gap barriers

PCHWs
Fund limited certification trainings

Care Coordination Platform
Integrate MS DOM — MCOs — Providers

OB SOC
Support quality reporting / incentivize providers

2027
MY3

Billing Code Changes
ACOG maternal-health coding changes take effect

Provider Infrastructure Investments*
Quality-reporting development; prep for risk-adjusted payments

CMS Payment Strategy (MY3–MY4)
Provider Infrastructure Payments + Quality & Performance Incentive Payments made to eligible providers

2028
MY4

Transition / preparation year
Bridge to VBP launch

2029
MY5

Value-Based Payment (VBP) begins
Postponed from 2028 (ACOG coding); CMS continuing to explore prospective monthly payments

CMS Payment Strategy (MY5–MY10)
SMAs implement their Roadmap to Value-Based Care

2030–2034
MY6–MY10

Roadmap to Value-Based Care
SMAs implement their Roadmap to Value-Based Care (CMS TMaH Payment Strategy, MY5–MY10)

Sustained value-based payment
VBP continues through model conclusion in 2034

** Provider Infrastructure Investments. Internal-facing items (staffing expansion, travel) excluded per scope. CMS payment-phase framing per CMS TMaH Payment Strategy: MY1–MY3 SMA technical assistance; MY3–MY4 provider payments; MY5–MY10 Roadmap to Value-Based Care.*

Let's Talk!

Q & A