Transforming Maternal Health (TMaH) Model Office Hour
August 21, 2024

>>Arbre'ya Lewis, SEA: Hello, and thank you for joining us today. The office hour will begin shortly.

Welcome to the Transforming Maternal Health, or TMaH, Model Office Hour. Before we dive in, I will briefly go over some housekeeping items. 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 is available at the bottom of the screen. During today's presentation, all participants will remain in listen-only mode. Please submit any questions you have throughout today's presentation in the Q&A pod displayed on the right side of the meeting room window.

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 about a week. 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 you may have about the TMaH Model. We have another office hour event coming up and would love to know what you all have questions about as we develop materials. Next slide, please.

Before we dive into content, I will review the agenda for today's office hour. Presenters will walk through two area of focus that the TMaH Model team has received several questions around. This includes the payment model and Regional Plan elements of the TMaH Model. We will have some overview information for each of these areas, and presenters will answer some of the questions that were received from registration and the TMaH email. As time allows, our presenters have reserved some time at the end of the call to review additional questions that have been received in other model focus areas. Due to time constraints, we may not get to every question, and the team will use the questions you share to inform future events and materials.

Please note, CMS is responsible for conducting all processes in a fair and equitable manner to ensure the integrity of the Notice of Funding Opportunity process. The TMaH Model Notice of Funding Opportunity contains the details needed for an applicant to understand the funding opportunity and submit a complete and compliant application. Applicant-specific guidance or interpretation of published information will not be provided during this office hour.

We will close out the event by sharing TMaH Model resources, including a registration link to register for the upcoming office hour event on September 12th, 2024, where the TMaH Model Team will be, answer additional questions related to the model.

Joining me today to present the TMaH Model Office Hour are Kevin Koenig, Jennifer Morone, Linda Streitfeld, and Djene Sylla. These presenters are reviewing your questions and comments about the TMaH Model and are excited to be hosting the office hour event to share information about the model. With that, I will now pass the event over to Kevin Koenig. Next slide, please.

>>Kevin Koenig, CMS: Thank you. Hi everyone, welcome. My name is Kevin Koenig, and I am the Payment Lead for the TMaH Model. First, a big thanks to everyone for submitting questions about the model. We noticed there were many related to the payment model approaches. So, I'll provide a quick summary of these approaches and review some of the questions we received. Next slide, please.

This slide describes a broad overview of TMaH's payment model phases. At a glance, TMaH will use a gradual implementation approach to support SMAs, Partner Care Delivery Locations, Partner Providers,

and other partners like managed care plans, as they build the infrastructure needed to implement TMaH requirements during the Implementation Period. Starting no later than Model Year 3, state Medicaid agencies will be expected to provide a portion of their Cooperative Agreement funding to pay Partner Providers and Partner Care Delivery Locations for activities related to TMaH elements and Pre-Implementation Period milestones. These will be called Provider Infrastructure Payments.

Provider Infrastructure Payments must be made for at least one year, beginning no later than Quarter 1 of Model Year 3. State Medicaid agencies may make these payments for more than one year, at the state's discretion. Please note that state Medicaid agencies will not receive additional funding beyond the annual cap, as listed in the TMaH Model Notice of Funding Opportunity, Table 6, and as will be listed on the next slide.

All Partner Providers and Partner Care Delivery locations in the test region that have agreed to implement the activities described in the *TMaH Model Notice of Funding Opportunity Section A.4.3.1* are potentially eligible to receive the Provider Infrastructure Payments. CMS will share the precise attribution methodology during the Pre-Implementation Period. Allowances regarding attribution of a beneficiary to more than one provider will be determined in partnership with state Medicaid agencies.

Starting in Model Year 4, Partner Providers and Partner Care Delivery Locations within the test regions will become eligible for Performance Incentive Payments for excellence on quality measures that align with model goals as well as achievement of cost benchmarks. These payments are to be paid by the participating state Medicaid agency, using the appropriate Medicaid authority and following CMS review processes. Cooperative Agreement funding cannot be used for the Model Year 4 Quality and Cost Incentive Performance Payments.

Using historical data, CMS will establish risk-adjusted quality and cost benchmarks on a pre-determined set of measures for calculating upside-only performance payment amounts. Partner Providers and Partner Care Delivery Locations may earn a percentage of a provider's total Medicaid payments for pregnancy-related services for TMaH-attributed beneficiaries.

By the end of Model Year 5, state Medicaid agencies will transition to a value-based payment model that reduces Medicaid and CHIP program expenditures as a result of poor maternity care through a replicable, sustainable, whole-person care delivery approach to pregnancy and childbirth. CMS will lead the design of the Model Year 5 value-based payment approach and use a process to engage participating state Medicaid agencies and key stakeholders in structured discussions to outline and then detail the Model Year 5 value-based payment approach. CMS will share more information with SMAs selected to participate about these discussions. Next slide, please.

The visual on this slide illustrates how funding will flow from CMS to state Medicaid agencies, and potentially award amounts that state Medicaid agencies may propose to spend in their Budget Narrative during the ten-year TMaH Model. CMS will award up to $17 million dollars to up to 15 state Medicaid agencies. Each state Medicaid agency will use their initial funding to plan and prepare for implementation. A Project Officer and a technical assistance team will be assigned to each state Medicaid agency to help make progress toward program milestones and to then implement the TMaH Model.

As noted on the prior slide, no later than Model Year 3, state Medicaid agencies will use a portion of their Cooperative Agreement funding to pay Partner Providers and Partner Care Delivery Locations for care delivery transformation activities. Then in Model Year 4, SMAs will implement their Quality and Cost Performance Incentive Payment approach. As noted earlier, by the end of Model Year 5, SMAs participating in the model will implement a sustainable, VBP arrangement. CMS will lead this design, in

collaboration with state Medicaid agencies, and other key interest groups. More on this collaborative process will be noted in an upcoming slide.

Please note that award amounts may vary based on factors such as the size and needs of Medicaid and CHIP populations to be served by the model, as well as the overall scope of the project as described in the application. All awards are subject to availability of funds. Annual budgets are subject to negotiation, and the maximum funding amounts listed in the graphic on this slide are not guaranteed. Next slide.

The visual on this slide illustrates how funding will flow from states to Partner Providers and Partner Care Delivery Locations in Model Year 3. States must execute a legal agreement or sub-award with a sub-recipient for the purpose of administering these Provider Infrastructure Payments.

States that operate their Medicaid programs via managed care may disperse funding through managed care organizations operating in the test region. States may also choose to disperse these payments to foundations or another entity that will in turn disperse payments to Partner Providers and Partner Care Delivery Locations.

In a fee-for-service state, states may execute agreements directly with Partner Providers and Partner Care Delivery Locations in the test region for the purposes of allocating Provider Infrastructure Payments. Next slide, please.

As noted earlier, in Model Year 4, Partner Providers and Partner Care Delivery Locations will become eligible for upside-only performance payments to be paid by state Medicaid agencies based on model year performance. Payment methodologies for these payments will be finalized during the Pre-Implementation Period and will be added onto existing provider reimbursement structures.

Partner Providers and Partner Care Delivery Locations may earn a percentage of a provider’s total Medicaid payments for pregnancy-related services for TMaH Model-attributed beneficiaries. CMS will use historic data to set a floor for these payment amounts, and states may then propose higher amounts, subject to CMS approval. The Performance Incentive Payment amount will be based on an aggregate score for quality performance, worth 80% of the total Performance Incentive Payment, and cost performance, worth 20%.

The performance measures used in Model Year 4 are low-risk cesarean delivery, maternal depression screening and follow-up, severe obstetric complications, and timeliness of prenatal and postpartum care. CMS will create cost and quality benchmarks using two-to-three-years of claims data and other data, as appropriate. State Medicaid agencies will be required to participate in financial and quality-focused meetings with CMS to facilitate this process. Next slide, please.

By the end of Model Year 5, state Medicaid agencies participating in the TMaH Model will transition from the current payment methodology in each state to a value-based payment model. As noted earlier, CMS will be leading the design of the TMaH payment model that SMAs are then expected to implement. We will work closely with SMAs and other key interested groups, such as providers, to gather input, insights, and feedback during the design of the TMaH payment model during the first three years. The TMaH payment model will also be informed by the Infrastructure Payments in Model Year 3, the Quality and Cost Performance Incentive Payments in Model Year 4, and the latest research on maternity value-based payment arrangements.

Understanding that states will have different policy contexts and constraints, CMS will also allow for some flexibility in the TMaH payment model details and implementation strategy across states. CMS will also individually review and grant state requests to implement the TMaH value-based payment model earlier than the timeline described in the NOFO, on a case-by-case basis.

With that, I am going to transition to a few questions that were submitted during registration and provide some responses.

Our first payment model question is: Given that state Medicaid agencies are at varying levels of implementation of value-based payment arrangements and maternal health initiatives, is the TMaH Model intended to support state Medicaid agencies that are in a more nascent stage in either or both of these areas? The answer is that states are at different and varying levels of implementation of the required or optional model elements, and all are welcome to participate and apply to the TMaH Model.

Question number two: May a state Medicaid agency exclude fee-for-service providers from model implementation in a managed care state? Yes, this will be at the state Medicaid agency's discretion and subject to CMS approval.

Another question that came in: May applicants propose to include only community birth settings, such as birth centers and home births, in the TMaH Model care delivery and payment model? And the answer is, no. The TMaH Model is designed to test interventions in both hospital and birth center settings. State Medicaid agencies must advance each required model element and achieve the Pre-Implementation milestones listed in *TMaH Model NOFO Table 3* by the end of Model Year 3, including those that apply exclusively to hospitals.

Please also note that CMS requires that in the test region, the average number of combined annual Medicaid and CHIP covered births between calendar years 2015 to 2020 must be no less than 1,000. This requirement is based on the assumption that the majority of Medicaid-covered births in the test region will be attributed to the model. Therefore, applicants should consider the number and size of Partner Providers and Partner Care Delivery Locations participating in the model. Also, important to note is the requirement that all managed-care organizations operating in the test region are required Partner Organizations.

The fourth and final question we'll cover: How will CMS determine the amount of the Provider Infrastructure Payments? So, CMS will provide technical assistance to states on the methodology for determining the Provider Infrastructure Payment amount and necessary supporting data analyses. The amount requested by states specifically for Provider Infrastructure Payments will be based on the number of participating Partner Providers and Partner Care Delivery Locations in the test region and the estimated average risk-adjusted per-member-per-month amount, using historic data as a baseline.

CMS will develop the methodology for calculating these risk-adjusted Provider Infrastructure Payments and a floor for payment amounts but will allow states flexibility in determining the exact amount, subject to CMS approval. Funding for Provider Infrastructure Payments will be available at the beginning of the model year to state Medicaid agencies with approved budgets who have qualified for non-competing continuation Cooperative Agreement funding. State Medicaid agencies must execute a legal agreement, or sub-award, with sub-recipients for the purpose of administering Provider Infrastructure Payments. Such sub-recipients may include a managed care entity, foundations, or another entity dispersing payments to Providers and Partner Care Delivery Locations. For more information on Provider Infrastructure Payments, refer to *TMaH Model Notice of Funding Opportunity, Section A.4.3.1*.

With that, it is my pleasure to turn the baton to Jennifer Morone, who will share more information about the Regional Plan. Jennifer, the floor is yours.

>>Jennifer Morone, CMS: Thank you, Kevin. Hello, everyone. Thanks for joining us in today's office hours. My name is Jennifer Morone. I'm the Social Science Research Analyst supporting the TMaH Model.

Today, I'm going to review a few slides that describe the TMaH Model's regional implementation plan requirements described in the Notice of Funding Opportunity application. We know that some of you had some really wonderful questions about these options. And so, I'm also going to review some related questions that were submitted prior to today's event. Next slide, please.

State Medicaid agencies interested in applying for the TMaH Model will submit their Regional Plan with their TMaH Model application within the Project Narrative section. States must propose to implement the model either statewide or in a sub-state region specified by zip codes or counties. Proposals for TMaH Model test region will be subject to CMS approval.

We want you to note though, that the identified test region must average no fewer than 1,000 combined Medicaid and CHIP covered births per year. This average should be based on the average number of births in that region during the calendar years 2015 through 2020. CMS encourages applicants to select a region that includes rural, underserved, and tribal areas in its proposed test region, where this is appropriate or feasible.

Sub-state implementation is preferable for evaluation reasons, as this will allow us to have within-state comparison groups. Having within-state comparison groups allows the evaluation to control for the individual state's laws, policies, and contexts over the course of the model for both the sub-state analysis and patient-level impacts analyses. With that said, CMS does understand that in some states and territories the minimum number of 1,000 annual births may not occur in any sub-state region, and therefore certain states or territories may actually need to implement the model state- or territory-wide in order to meet the 1,000 births per year minimum requirement. We can go on to the next slide.

So, for both statewide and sub-state implementation, applications must propose a comparison group based on their selected Regional Plan. States can select sub-state implementation with an in-state comparison group, or full state implementation with an out-of-state comparison group.

On this slide, we'll focus on sub-state implementation. For sub-state implementation, with an in-state comparison group, states will propose a test region comprised of zip codes or counties as well as a comparison region in their NOFO application. The identified tests and comparison regions do not need to be geographically contiguous.

Sorry everybody, it sounds like I may have been muted. So, we are going to go back and adjust. We'll start back at the non-contiguous geographical location. Sorry about that, looks like the Zoom cut out.

So, for states that want to propose for sub-state implementation, I think where I left off is describing that that the test and comparison regions do not need to be geographically contiguous. And if multiple, multiple regions or similar areas, are needed to be combined to meet the 1,000 births requirement, those also don't need to be geographically contiguous.

And so, we're moving along with that when we show you a map here, and that's an example of a non-geographically contiguous region. And this is from our InCK Model. And it's just important to note that the intervention and comparison groups should be separated enough, though, that the patients would not be expected to use the same health care providers or hospitals. In other words, their service use for maternity care should not overlap. Having in-state comparison groups allows the model evaluation to control for individual state laws, policies and context over the course of the model when regional and patient-level impact analyses are conducted.

Any applicants interested in sub-state implementation, please note that in states where managed care has been implemented in Medicaid or CHIP, all of the managed care plans operating in the test region must participate. However, if only one managed care plan operates in that test region, then only that managed care plan must participate in the model. Yeah, next slide, please.

Now we are going to review statewide implementation. So, for applicants interested in statewide implementation, with an out-of-state comparison group, they should plan to offer technical assistance, or TA, expansion of all TMaH Model services, and the value-based payment model across their entire state. For these reasons, states interested in statewide implementation will explain how they will plan to implement all elements of the model across the entire state all together, in their application.

Statewide model applicants should also note that all of the data needed to match comparison populations may not be available from other states that are serving as their comparison states. And so, this limits the model evaluation. We have pulled some guidance for how to develop a list of potential comparison states in their TMaH Model application on this slide. I know this is of particular interest, and we've had some questions. You'll see that states interested in the statewide implementation option should propose at least three other states that they believe are comparable in demographic composition, resource availability, population size and density, birth outcomes and disparities, and Medicaid policy, that could be considered as their comparison states. Next slide.

I'm going to pivot to answer a few questions we received regarding the Regional Plan portion of the application. The first question I'd like to answer today is: What information is required for the application when seeking to implement the model statewide? Could you provide details on proposed out-of-state comparison states in the Regional Plan section of the application?

The answer to this question is that, for statewide implementation, details are only needed for the applicant state, not for the comparison states. For more information on the Regional Plan, we encourage applicants to refer to the *TMaH Model Notice of Funding Opportunity Section D.3.1.4*, which describes how state Medicaid agencies choosing statewide implementation, should propose at least three other states that they believe are comparable in demographic composition, resource availability, population size and density, birth outcomes and disparities, and Medicaid policy.

Again, statewide applicants only need to list three states they believe are similar. State Medicaid agencies do not need to provide details of the proposed comparison states. They should suggest these three comparison states based on familiarity with similarly situated peer states, and from publicly accessible information sources.

Additionally, statewide applicants do not need to know if the proposed comparison states are participating in other CMMI models. This leads to the second question that we got which asks: For purposes of the model evaluation, may a state Medicaid agency propose a comparison state that is participating in one of the other CMMI models where overlap between the model, two models, is not allowed?

And the answer to this question is that, because several CMMI models are still in the application phase, states may not be aware of potential overlap. Those state Medicaid agencies proposing to implement the model statewide are asked to include three alternative comparison states in their application to assist the evaluation of the TMaH Model. Again, these three states should be similar to their state based on demographic composition, resource availability, population size and density, birth outcomes and disparities, and Medicaid policy.

Now, because no single state will be a perfect comparison to the participant state, this is why the evaluation team will use the three proposed comparison states provided by the applicant as a starting point in determining the appropriate comparison state, or group of states. For more information on the Regional Plan, please refer to *TMaH Model Notice of Funding Opportunity, Section D.3.1.4*, which we popped in the chat.

The third question we received was: If a state Medicaid agency proposes to implement the model in a sub-state region, must the comparison region also contain a minimum of 1,000 annual births? The answer to this question is, yes. Both the sub-state test and comparison regions must meet the minimum 1,000 average Medicaid and CHIP annual births requirement. And if multiple non-geographically contiguous regions must be used in aggregate to create one larger collective comparison group, this collective grouping must also have an annual average of at least 1,000 Medicaid and CHIP births per year.

The fourth question we received was: State Medicaid agencies can choose to implement the model statewide or sub-state, but the application also states sub-state implementation is strongly preferred for evaluation purposes. Will CMS prioritize applicants, applications from states that choose sub-state implementation?

The answer to this question is that, based on our experience at the Innovation Center, sub-state models do tend to be more valuable, and more likely to have adequate funding. This is why we would prefer sub-state applications where sub-state implementation is feasible. States are encouraged to apply with an implementation plan that makes sense for their specific circumstances, and provide adequate justification and budget information, outlining how they will implement the model either in their full state or chosen sub-state region.

The last question we received, before we're going to dive into the open Q&A, was: Is it acceptable to propose a staggered start where some state regions would start implementing the model at different times, versus having the region start all at once?

And the answer to this question is, no. State Medicaid agencies can consider either a full state implementation or sub-state implementation. For purposes of this model test, award recipients must start the model across the whole test region, either their sub-state or their full state. At the same time, if elements of the model are successful and the state wants to expand them to other in-state regions, precluding the use of model funding, they're welcome to do so. However, they cannot implement model interventions in the comparison regions, as this would contaminate the comparison sample. Next slide, please.

So, with that, I'm going to pass the office hour back over to Linda Streitfeld, the Project Lead for the TMaH Model, who will facilitate the remaining Q&A portion we have planned for today. Linda?

>>Linda Streitfeld, CMS: Thank you Jennifer, and hello everyone. My name is Linda Streitfeld and I am the Project Lead for the TMaH Model. It’s really exciting to see so many great questions coming in about the model, and we really hope that this event today is going to help states prepare their applications. I am joined by Djene Sylla, she is the Grants Management Specialist with Office of Acquisition and Grants Management.

The first question we have prepared is: Are state Medicaid agencies required to adopt birth center licensure? This answer to this is, no. States have different licensing entities and processes, and state Medicaid agencies are not typically responsible for licensing birth centers. If birth centers are licensed, or if a state would like to begin licensing, then technical assistance would be provided to the state Medicaid agency to understand Medicaid coverage of birth centers, potential reimbursement rates and processes, and other relevant activities that are spelled out in more detail in the Notice of Funding Opportunity.

And we have a related question: If the Medicaid agency or another state agency does not license birth centers, do the birth center requirements still apply? This answer here is, yes. The birth center requirements would still apply even if a state does not license birth centers. The aim of the model is for birth centers in the state to receive payment, commensurate with their services. As part of technical assistance, CMS would help a state explore possible pathways for Medicaid reimbursement.

Next question: What about a state that doesn't have birth centers, may they still apply? This too is a yes. CMS will require that the state Medicaid agency examine potential Medicaid coverage requirements, reimbursement rates and processes, and undertake other relevant activities included in the TMaH Notice of Funding Opportunity to determine feasibility of establishing birth centers. These studies would then be applied if birth centers were to open in the state at some point during the TMaH Model.

We received another question: What options exist for state Medicaid agencies to cover doula services through the TMaH Model? States can cover doula services using their Medicaid authority, typically through a State Plan Amendment. As a part of participation in the model, states will receive guidance on covering doula services, including how to define doula services, how to develop doula rate benchmarks, how to establish a state doula support council, which would advise the state on best practices for expanding access to doula services, and guidance on connecting with local and state resources that may already be in place.

We received this very important question: May a state Medicaid agency propose to implement some TMaH Model pillars statewide, and others regionally? So, as we have already heard, state Medicaid agencies must identify the test area for the Model, which can encompass the entire state or a sub-state region. All elements of each pillar in the model must be implemented within the test region. That said, we understand that some model elements may already exist statewide and will continue to exist statewide even if the test is limited to a sub-state region. In a sub-state implementation, any enhancement or expansion of elements that is funded by the Cooperative Agreement, rather than as a Medicaid-covered service, must be exclusive to the test area. Cooperative Agreement funding may not be used to add, enhance, or expand a TMaH intervention or service outside the test area. On the other hand, the requirement to establish Medicaid payment for doula services or optional establishment of payment for other Medicaid-covered services, would be implemented statewide using the appropriate Medicaid authorities, regardless of the proposed test area configuration.

The next question we received is: Do professional midwife requirements only apply if there is state licensure? And the follow on: What if a state does not have current licensure requirements for Certified Professional Midwives? So, coverage for Certified Nurse Midwives is required by Medicaid. With the assistance of the TMaH Model, each state Medicaid agency will be required to assess their current levels of coverage with a goal to improve overall access to midwifery care. Possible strategies for improved access may include revising how midwives are paid or reducing the administrative burden for timely payment. CMS is not requiring that SMAs add new midwife certification categories. However, if a SMA is interested in covering other licensed midwives, like certified midwives and Certified Professional Midwives, the model will offer technical expertise to assist them with that process.

Next question: What is the plan for providing technical assistance to states regarding expansion of midwifery workforce? CMS will provide a multidisciplinary technical assistance team for our awardees. During the first quarter of the Pre-Implementation Period, CMS and each awardee will collaborate to draft a technical assistance plan, workstreams, goals, participants, and team leads. That plan will estimate the time required by each participant, specify topics, and create a timeline of milestone activities to be accomplished during Pre-Implementation Period. The technical assistance plan will be revised as needed throughout the Pre-Implementation Period.

Another question is: Are states able to use Cooperative Agreement funding to support existing staff who would spend part of their time working on the TMaH Model? This answer is, yes. But we'll ask you to please review our NOFO, particularly *Section D.3.2* and *Appendix I* for the specific details and justification you will need to include in your Budget Narrative in order to use Cooperative Agreement funding for existing and new staff. Please note that if the staff person has duties unrelated to the TMaH Model, the recipient must ensure the staff person properly accounts for his or her time and effort for model activity

and non-model activity. Please take care not to use TMaH Model Cooperative Agreement funding for non-model duties. The recipient may not use TMaH Cooperative Agreement funds to cover the portion of a staff person's time spent fulfilling other duties as an employee of a SMA nor may the recipient receive Medicaid reimbursement for the portion of time the staff member is working on model activities and is being reimbursed through Cooperative Agreement funds.

We've received a couple of other questions that are pretty specific to the Office of Acquisition and Grants Management so I'm going to hand-off for now to Djene Sylla to take those questions. Djene?

>>Djene Sylla, OAGM: Hi Everyone, and thank you Linda for that introduction. So, the first question, I'm on my phone, because my Zoom is not working right now, so I apologize.

So, the first question that was asked is: Is the annual budget amount inclusive for both direct and indirect costs? So the answer to that is, yes. The annual amount is inclusive of both direct and indirect costs. For example, in y? 1, the one million is inclusive of direct costs and indirect costs, that should be in there.

The follow-up question which is: May our sub-awardees claim indirect costs? The answer to that is also, yes. Our sub-awardees can claim indirect costs.

Yeah, those were the two questions. I'm going to pass it back to Linda. Thank you, Linda.

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

So, we have another question here: Are all of the milestones to complete by the end of Model Year 3 required? The answer is yes. *TMaH Notice of Funding Opportunity in Table 3* summarizes each model element, and the Pre-Implementation Period milestones that recipients need to complete by the end of Model Year 3, as well as the supporting technical assistance activities that will be provided by CMS. Most of the technical assistance will be provided to the recipients. However, depending on the model element, and at the direction of the recipient, the technical assistance may be provided to Partner Providers, Partner Care Delivery Locations, and Partner Organizations to reach these Pre-Implementation Period milestones. Recipients are required to ensure that they, or their collaborating managed care plans or Partner Providers and Partner Care Delivery Locations, as appropriate, reach all Pre-Implementation Period milestones no later than the end of the Pre-Implementation Period, which ends at the end of Model Year 3. CMS will collaborate with each awardee to conduct a needs assessment and to create the detailed technical assistance plan, as I had discussed previously.

The next question we received is: Which doula care services will be covered in the TMaH Model? So, doula services are defined as emotional, physical, and informational support provided by a non-clinical, trained professional during pregnancy, delivery, and after childbirth. The doula services established under the TMaH Model must include, but are not limited to, the following. And this is a long list, and I'll also note that this is, they are listed in *Appendix 7* of the Notice of Funding Opportunity, which is the Glossary, and that lists all of these required doula services.

So, prenatally, we want to ensure that they are: promoting health literacy and understanding 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.

And then, during labor and delivery: providing physical support comfort, sorry, physical comfort measures, information and emotional support, advocating for beneficiary needs, and being an active member of the birth team.

And then postpartum: education, requiring newborn care, nutrition and safety, supporting breastfeeding, providing emotional support, and encouraging self-care, supporting individuals in attending their recommended medical appointments, and coordinating referrals or linkages to community-based support services to address health-related social needs.

We have a few other questions that have come in during the webinar, and I'm going to try to grab these. So, one question is: As a hospital group interested in the program, can they participate if their state isn't enrolled? And sadly, the answer to this is, no. Only the providers in accepted states are allowed to participate in the model. During this open application period, we encourage any key audiences interested in the model to send letters of support to their state Medicaid agency.

Another question, which I think I'm going to hand off to Kevin, if he is able to respond at this point is: How will CMS determine the amount of the Provider Infrastructure Payments? Kevin, are you able to pick up that question?

>>Kevin Koenig, CMS: Sure. And the answer is that we will be using historic administrative data in each state, and a methodology that we'll develop. And we will work with states to set a floor for that. So, it will be based on historic claims data on the cost of providing certain types of care, prenatal care, other types of delivery or postpartum care. And then states will have some discretion to increase that amount, at CMS, and CMS will then approve that for each state, on a case-by-case basis. So, the answer is that we'll have a few years of working with states to develop the methodology and then work with states to set those amounts.

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

We also have a question about specific examples of care transformation activities that can be paid for using our Cooperative Agreement funding. So, the Provider Infrastructure Payments can be used for activities, such as supporting regular and ongoing interprofessional care team meetings, and planned quality assurance and improvement activities. In addition to obstetricians and other physicians and registered nurses, the maternal care team might include doulas, perinatal CHWs, midwives, physician assistants and behavioral health providers, as appropriate. And also, offering one or more alternatives to traditional office visits to increase access to care in ways that best meet the needs of the population. So, this could include home monitoring for diabetes and hypertension or other telehealth initiatives, group perinatal visits, home visits, alternate location visits, or expanded early morning, evening, or weekend hours. There's a longer list of acceptable uses of funds in the *Notice of Funding Opportunity*, on pages 25 and 26.

We've also been asked: Could CMS confirm that states have the flexibility to disperse Quality and Cost Incentive Payments directly to providers, or leverage managed care plans, or another entity, to disperse these payments? So, state Medicaid agencies must execute a legal agreement, a sub-award, with a sub-recipient for the purpose of administering those Provider Infrastructure Payments. Such sub-recipients may include a managed care entity, a foundation, or some other entity that is capable of dispersing payments to Providers and Partner Care Delivery Locations. And for more information on the Provider Infrastructure Payments, again, we can refer you to the *Notice of Funding Opportunity* in *Section A.4.3.1*.

I'm not seeing additional questions coming in that we're able to answer at this point. So, unless I hear something else from our team, I believe that it's time to thank all of you for your attention and for the work that I know you're doing already, to try to prepare for these applications. Really look forward to

reading those applications as well. And now I'm going to hand it back to Arbre'ya to close us out. Next slide.

>>Arbre'ya Lewis, SEA: Thank you all. So, to close out today's event, we've got some information to keep in mind as the TMaH application deadline is approaching. Next slide, please.

The TMaH Model Cooperative Agreement funding application deadline is September 20th, 2024, at 11:59 PM Eastern Time. Application materials are available on Grants.gov, and there are resources to begin the registration process if needed. The model is anticipated to begin with the Pre-Implementation Period, which will start in January 2025, and will continue through December 2027, followed by the Implementation Period in January 2028, which will last to January 2035. Next slide, please.

On this slide, we have some additional resources for those interested in the TMaH Model. As a reminder, if we didn't get to your question today, there's an email address that you can reach out to, displayed on the slide. There's more information about the TMaH Model requirements and opportunities in the Notice of Funding Opportunity, which has just been included in the chat. There's a TMaH Model listserv that you can sign up for to learn more about upcoming events and resources.

Also, the TMaH Model team will host another office hour on September 12th, 2024, to review some new areas of focus in the questions that were submitted. The link to register for this event is on the slide and will be shared in the coming days through the TMaH Model listserv. We have linked some additional resources, such as the TMaH Model Payment Design Fact Sheet, Technical Assistance Fact Sheet, and Model Overlaps Policies Fact Sheet to this slide for interested stakeholders to learn more about specific areas related to the model. Next slide, please.

Thanks again to everyone for joining today's webinar. We're really proud to share information on the TMaH Model and appreciate your participation. Please let us know how we did today by participating in a three-to-five-minute survey that's posted in the chat, and it'll pop up after you close this webinar. We would love to hear from you.

Lastly, thanks for attending today's webinar. This concludes today's event.

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