Centers for Medicare & Medicaid Services (CMS) Transforming Maternal Health (TMaH) Model

Notice of Funding Opportunity (NOFO) Summary

July 17, 2024

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The views expressed here do not necessarily reflect the views of the Foundation.

Agenda

- TMaH Model Overview
- TMaH Care Delivery Model
- TMaH Medicaid Payment Model
- TMaH Technical Assistance (TA)
- TMaH Funding, Cost Restrictions, and CMS Model Overlap Policies
- TMaH Application Requirements
- General TMaH Reporting Requirements
- TMaH Evaluation
- Key Steps for Interested States

TMaH Model Overview

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TMaH Goals

On June 26, CMS released the NOFO for the TMaH model, which is a 10-year delivery and payment model designed to test whether effective implementation of evidence-informed interventions, sustained by a value-based payment (VBP) model, can improve maternal outcomes and reduce Medicaid and Children's Health Insurance Program (CHIP) program expenditures. TMaH goals include:

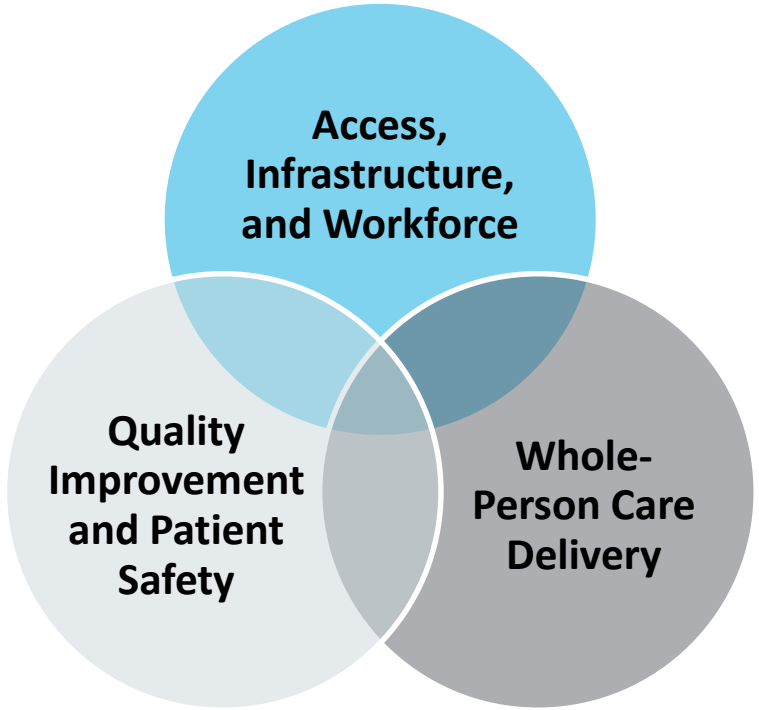
- Reduced rates of low-risk C-sections.
- Reduced incidence of severe maternal morbidity.
- Reduced rates of low-birthweight infants.
- Improved experience of perinatal care.
- Reduced Medicaid and CHIP program expenditures for maternity and infant care.

TMaH Overview

Overview of TMaH Model

- CMS will issue cooperative agreements to **up to 15 state Medicaid agencies (SMAs);** states, D.C., and territories are all eligible to apply.
- Each SMA selected to participate will be eligible to receive **up to $17 million** over the course of the model**:**
  - **3-year pre-implementation period (2025 to 2027, up to $8 million):** States will receive TA and infrastructure funding to help achieve required milestones.
  - **7-year implementation period (2028 to 2034, up to $9 million):** States will execute the model, including implementing a VBP model.

TMaH Care Delivery Transformation Pillars



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TMaH Implementation Region

SMAs must propose either to implement TMaH statewide or in a sub-state region specified by counties or ZIP codes.

Sub-State Implementation

- CMS **strongly prefers sub-state implementation** for evaluation purposes. SMAs are encouraged to include **rural, underserved, and Tribal** areas in proposed test regions.
- For **sub-state implementation**, SMAs must propose a model test and a comparison region. The sub-state and comparison regions do not need to be contiguous.
- Model Test Region Selection:
  - Has **overall poor birth outcomes or high levels of disparities in outcomes; and**
  - Includes **more than one managed care plan (MCP)** (if a managed care state) and **mirrors the MCP catchment areas** to the extent possible.
- Comparison Region Selection:
  - Similar to model test region in **demographic composition, resource availability, population size and density**, and where there is **no service overlap**.

Statewide Implementation

- For **statewide implementation**, SMAs must propose at least three comparable states for patient-level comparison, based on demographic composition, resource availability, population size and density, birth outcomes and disparities, and Medicaid policy.

Regardless of whether an SMA proposes statewide or sub-state implementation, the average number of Medicaid- and CHIP-covered births in the model test region between calendar year (CY) 2015 and 2020 must be **no less than 1,000 per year**.

TMaH Model Partners

SMAs are expected to partner with providers, care delivery locations, MCPs, and state public health departments, among other partner organizations, to implement various TMaH elements, including: a VBP model; data infrastructure; and risk assessments, screenings, and referrals.

Partner Providers[1]

Obstetrician-gynecologists (OB/GYNs), midwives, physicians, fetal medicine specialists, nurses, and other clinical and support staff—such as doulas, lactation consultants, and perinatal community health workers (CHWs).

Partner Care Delivery Locations

Hospitals, OB/GYN practices, safety net providers [Federally Qualified Health Centers (FQHCs) and rural health clinics],* Tribal sites,* birth centers,* and other sites of care.

Partner Organizations

MCPs,[2] state public health departments, perinatal quality collaboratives (PQCs), maternal mortality review committees, universities, community-based organizations (CBOs),* and other non-clinical partners.

If the applicant is a managed care state, all Medicaid contracted payors within the model test area must participate.

1. In the TMaH application, SMAs are required to state whether provider participation will be voluntary or mandatory in the model test region.

(*) Asterisk indicates an optional TMaH model partner. CMS may consider and give preference to SMAs that partner with them.

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TMaH Application and Model Timeline

Dates	Key Activity
August 8, 2024	Optional Letter of Intent Due to CMS[1]
September 20, 2024 by 11:59 pm ET	Application Due[2]
December 15, 2024	Anticipated Award
January 13, 2025	Anticipated Issuance Notice of Award
January 20, 2025	Period of Performance Start
January 19, 2035	Period of Performance End

1. The letter of intent should include the proposed regions of participation.
2. CMS recommends submitting the application at least three to five before the due date. Grants.gov can take up to 48 hours to notify an applicant of a successful submission.

TMaH Care Delivery Model

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Overview of Pillars and Elements

TMaH is organized into three pillars, with 10 required and eight optional elements for SMAs to implement.

Pillars	Required Elements	Optional Elements
1. Access, Infrastructure, and Workforce	• Increase access to the midwifery workforce. • Increase access to birth centers. • Cover doula services. • Improve data infrastructure. • Develop payment model.	• Cover certified midwives (CMs) and certified professional midwives (CPMs). • Cover perinatal CHWs. • Create regional partnerships in rural areas. • Extend Medicaid eligibility to 12 months postpartum.
2. Quality Improvement and Safety	• Support implementation of the Alliance for Innovation on Maternal Health (AIM) patient safety bundles. • Support "Birthing-Friendly" hospital designation.	• Promote shared decision making between birthing individuals and providers.
3. Whole-Person Care Delivery	• Increase risk assessments, screenings, referrals and follow-up for perinatal depression, anxiety, tobacco use, substance use disorder (SUD), and Health Related Social Needs (HRSNs). • Increase home monitoring of diabetes and hypertension. • Develop Health Equity Plan.	• Expand group perinatal care. • Increase use of home visits, mobile clinics, and telehealth. • Expand oral healthcare.

Optional elements must be identified in application and cannot be added after award.
Funding remains the same regardless of optional elements.

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TMaH Pre-Implementation Milestones: *Pillar 1 Access, Infrastructure, and Workforce*

SMAs will need to complete pre-implementation milestones no later than the end of model year 3. CMS will develop state-specific milestones for model years 4 through 10.

Required Model Elements	Pre-Implementation Milestones
Increase Access to the Midwifery Workforce	• Assessment of **workforce capacity**; established **billing pathway** for interprofessional consultations; completed **payment analysis** of midwife reimbursement rate as a proportion of a benchmark (and annual analysis thereafter).
Increase Access to Birth Centers	• Completed **payment analysis** of birth center facility fee as a proportion of a benchmark rate (and annual analysis thereafter); plan for providing **birth center info to enrollees**; implementation plan for reimbursement **sustainability.**
Cover Doula Services	• Completed **workplan and payment analysis** of doula reimbursement rate as a proportion of a benchmark rate (and annual analysis thereafter); submission/implementation process for a **state plan amendment (SPA)/waiver** to cover doula services (if not already covered); convened a **State Doula Support Council.**
Improve Data Infrastructure	• Established timeline and plan for **linking Medicaid data and vital records**; completed **data needs assessment and challenge resolution process** for stratifying demographic data with partner providers and care delivery locations; collection/reporting of **stratified enrollee demographic data** across social service and benefit programs.
Develop Payment Model	• Submitted **payment model implementation plan** to CMS, including MCP engagement plan and contracting timeline; establish payment model **cost and quality benchmarks** in partnership with CMS.

TMaH Pre-Implementation Milestones: *Pillar 2 Quality Improvement and Safety*

Required Model Elements	Pre-Implementation Milestones
Support Implementation of AIM Patient Safety Bundles	• Established **partnerships with Perinatal Quality Council** to support selection and rollout of AIM patient safety bundles in facilities. • **Implementation plan** for capacity building to participate in AIM patient safety bundles. • **Data collection and monitoring plan.** • **Expanded database** to collect relevant quality, process, structure and outcomes data.
Support "Birthing-Friendly" Hospital Designation	• **Completed analysis of challenges and actions needed** in attaining "Birthing-Friendly" designation for hospitals and Critical Access Hospitals. • Attest "Birthing Friendly" hospital designation is displayed in **provider directories**.

TMaH Pre-Implementation Milestones: *Pillar 3 Whole-Person Care Delivery*

Required Model Elements	Pre-Implementation Milestones
Increase Risk Assessments, Screenings, Referrals, and Follow-Up for Perinatal Depression, Anxiety, Tobacco Use, SUD, and HRSNs	• <u>Risk Assessment:</u> — Selection of **risk assessment tools and** plan to implement medical and social risk assessments for **risk-appropriate care.** • <u>Screening/Referral for Behavioral Health Needs (including SUD and Tobacco) and HRSN:</u> — **Journey map** of existing screening and referral processes and identified areas of improvement; identified **workflows and data collection** processes; hospital and provider **staff training on screening tools**; established **follow-up protocol** for positive screens and identified needs; established **bi-directional referral pathways** with CBOs (HRSN only).
Increase Home Monitoring of Diabetes and Hypertension	• Completed SPA/waiver for **Medicaid coverage** of home monitoring if needed; **partnership plan and meetings** with public health department, MCPs, and others on the design and implementation of home monitoring; **draft implementation plan.**
Develop Health Equity Plan	• **Health Equity Plan completed and approved by CMS** that includes which health disparities will be addressed and how entities will be held accountable for equitable outcomes. • **Established process for measuring stratified outcomes** for conditions with identified disparities. • Submitted plan to CMS to comply with **non-emergency medical transportation and translation** requirements, if needed.

**Milestones for optional elements are to be established in model year 1.*

TMaH Medicaid Payment Model

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Overview

Implementation of a VBP model is a required Model element and will occur in three phases as outlined below. SMAs must transition to a VBP approach by end of model year 5.

TMaH's Roadmap to Value-Based Care

Provider Infrastructure Payments (no later than model year 3): Payments to providers to support care delivery and infrastructure changes.

Quality and Cost Performance Incentive Payments (PIPs) (model year 4): Upside-only PIPs to providers based on quality performance and cost benchmarks.

VBP Model (by the end of model year 5): Transition from current maternal care payment methodologies to a VBP approach. CMS will lead the design of the VBP model, and SMAs and other key stakeholders will provide input.

SMA Infrastructure Funding in Model Years 1 and 2:

SMAs will receive up to $3 million in funding for infrastructure needs, including to hire and retain staff, perform data analytics, and build skills and capacity to implement the payment model.

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Provider Infrastructure Payments (No Later Than Model Year 3)

Overview

- Up to $5 million Provider Infrastructure Payment will be available based on the **number of attributed TMaH model-eligible Medicaid enrollees** and will be risk adjusted.
- CMS will work with each SMA to conduct data analyses to **determine the risk-adjusted payment amount**.
- SMAs will disburse payments to partner providers and partner care delivery locations to support **care delivery and infrastructure changes permitted** by CMS.
- SMAs must execute **legal agreement with subrecipients**, including MCPs, foundations, or others to disburse payments to providers.

Permitted Activities Under Provider Infrastructure Payments

Patient Safety Initiatives and Maternal Care Assessment, including AIM patient safety bundles, Birthing-Friendly hospital designation, or medical and social risk assessments.

Quality Measure Reporting, including data reporting on required quality measures.

Data integration and other activities to support data-driven maternity care, including EHR/data infrastructure improvements, connection to health information exchanges, or screening and referral info sharing with CBOs.

Team-Based Care, including regular care team meetings and quality improvement.

Enhanced Access to Care, including alternatives to office visits, e.g., home monitoring or other telehealth activities.

Connection to CBOs to Address HSRNs and Behavioral Health Needs, including collaboration with local entities on screening, referral and follow up activities.

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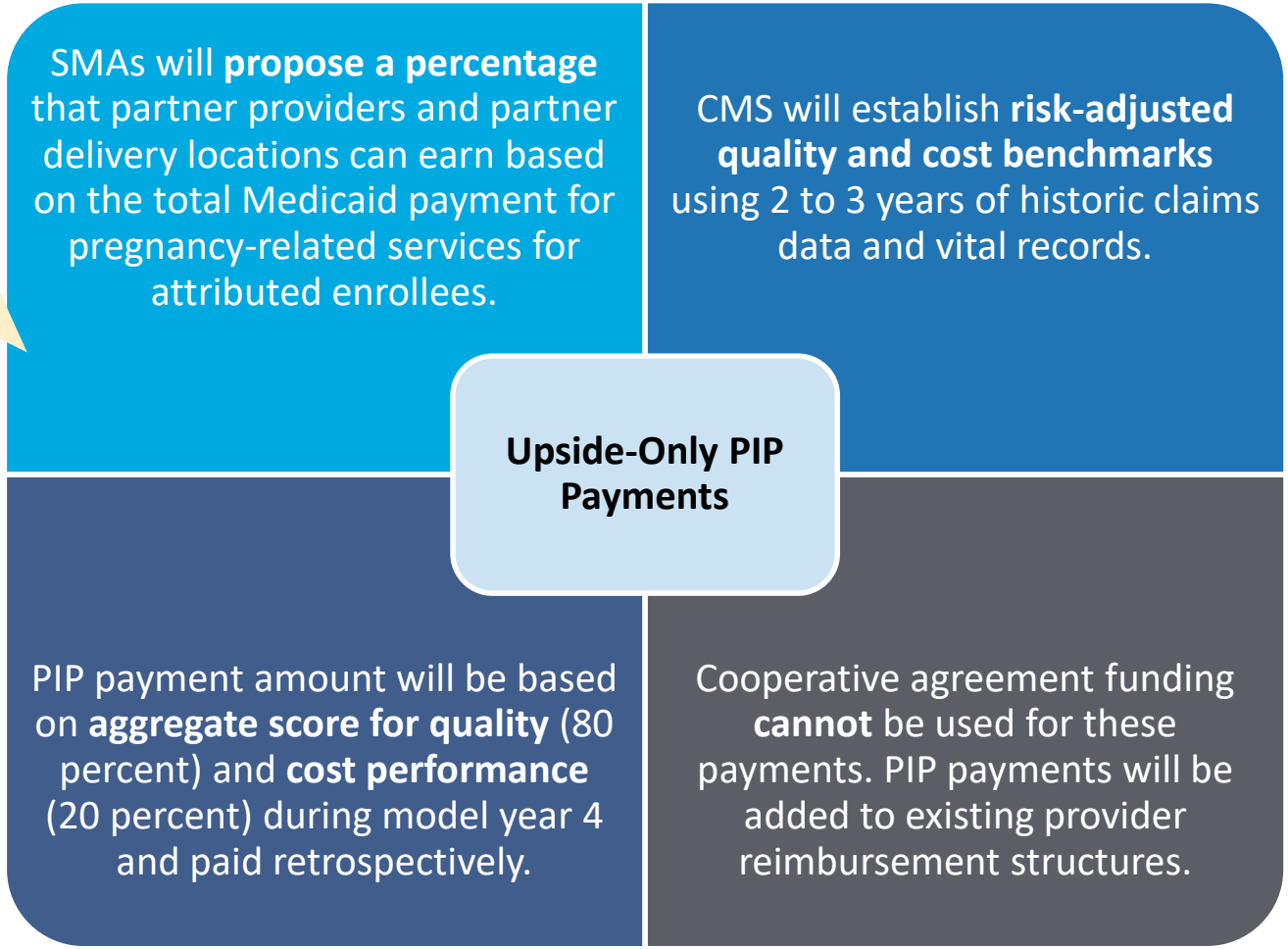
Quality and Cost PIP (Model Year 4)

Quality Measure Concepts Used to Determine PIP:

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



CMS will finalize PIP methodology and implementation plan during the pre-implementation period (model years 1 to 3).

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VBP Model (End of Model Year 5)

VBP Model

- By end of model year 5, SMAs will transition from the current payment approaches, including the Provider Infrastructure Payments and PIP, to implementing a **VBP model**.
- CMS will lead the design of the VBP model and **stakeholders, including SMAs, will provide input** on key features of the model.

Topics for Stakeholder Feedback

- Aligning the payment model design with key maternal health outcome goals.
- Analysis of different payment approaches, including performance benchmarks and risk adjustment methodology.
- Identification of quality measures.
- Data sharing, collection, and processing considerations.
- Partner provider, partner care delivery location, and enrollee inclusion and exclusion criteria.
- Attribution methodology.
- Implementation considerations for managed care and fee-for-service (FFS) environments.

It is uncertain how much flexibility SMAs will have in tailoring the VBP model.

TMaH TA

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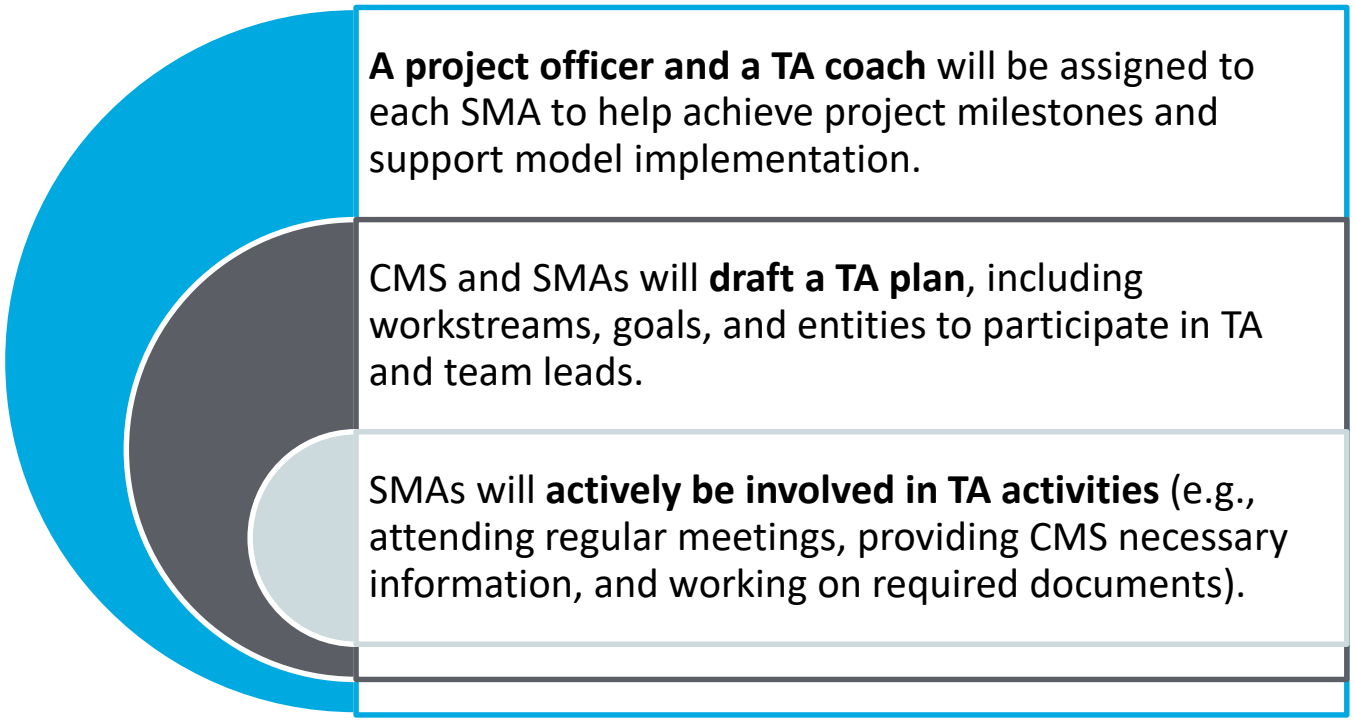
TMaH TA

CMS will provide targeted TA to SMAs for TMaH implementation, including Medicaid data analysis and guidance on payment analysis. CMS will also provide peer-to-peer learning opportunities and one-on-one assistance.



Areas for CMS TA

- Maternal healthcare and maternal health policy.
- Identifying and addressing health disparities.
- Developing partnerships among and between MCPs, providers, and CBOs.
- Designing and implementing VBP models.
- Healthcare quality improvement.
- Medicaid data linkage and data sharing.
- Medicaid claims data analytics and financial modeling.

TMaH Funding, Cost Restrictions, and CMS Model Overlap Policies

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Cooperative Agreement Funding Per SMA

Yearly funding after model year 1 will be issued via **non-competing continuation awards, contingent on each SMA's progress** in meeting project goals, timely submission of required data and reports, and compliance with model requirements.

Model Year	Maximum Amount Cooperative Agreement Funding (Amounts Not Guaranteed)
Pre-Implementation Period	
1	$1M
2	$2M
3	$5M
Subtotal	**$8M**
Implementation Period	
4	$3.5M
5	$2.5M
6	$1.25M
7	$1.0M
8	$0.25M
9	$0.25M
10	$0.25M
Subtotal	**$9M**
Total	**$17M**

TMaH Cost Restrictions

Direct Costs

- Funding under TMaH can only be used for **supportive functions necessary** to build capacity and implement the TMaH payment model.
- Cooperative agreement funding **cannot** be used to duplicate or supplant other funding sources, including state Medicaid and CHIP coverage of care delivery services.

Indirect Costs

- Indirect activities/costs are **not allowable unless an exception is specifically authorized** by statute or stated otherwise in the TMaH NOFO.

Examples of Cooperative Agreement Funding Use

Examples of Cooperative Agreement Funding Use	
Category	**Eligible Activity**
Recruitment and Partnerships	• Engage MCPs on the TMaH model. • Recruit TMaH model providers. • Convene PQCs, CBOs, and other partners.
Model Development	• Participate in discussions and activities related to advancing model elements. • Complete draft SPA/waiver documents, as needed, and apply for federal waivers to implement TMaH model elements as necessary and appropriate. • Participate in discussions and provide feedback to CMS on development of the payment model. • Design and implement any necessary claims processing procedures to support the VBP approach. • Collect cost and quality data for monitoring and evaluation purposes and to meet model requirements. • Complete quarterly reporting requirements.
Health IT, Data, and Infrastructure	• Data sharing between payers, providers and CBOs, as appropriate and needed to support model operations. • Data warehousing, extraction, and management to support model operations. • Data linkage and analytic activities to support model operations.
Personnel	• Salaries for key personnel to support model implementation.
Partner Providers	• In model year 3, recipients will provide partner providers with a portion of cooperative agreement funding to complete required activities.

TMaH Indirect Cost Restrictions

- Use of cooperative agreement funding for model year 4 upside-only payments.
- Pre-award costs.
- Matching requirements to any other federal funds or local entities.
- Services, equipment, or supports that are the legal responsibility of another party under federal, state, or Tribal law (e.g., workplace modifications).
- Goods or services not allocable to the approved project.
- Supplanting existing state, local, Tribal, or private funding of infrastructure or services, such as staff salaries.
- Construction.
- Capital expenditures for improvements to land, buildings, or equipment which materially increase their value or useful life as a direct cost, except with prior written approval of federal awarding agency.

- Cost of independent research and development, including their proportionate share of indirect costs.
- Funds related to any activity influencing the enactment of legislation, appropriations, regulation, administrative action, or an Executive Order proposed or pending before any government.
- Certain telecommunications and video surveillance equipment.
- Meals, unless in limited circumstances.
- Provider payments for services covered under Medicaid/CHIP, including any newly covered services under this model.
- Cost of any Medicaid-covered service at any time during the model or supplantation/duplication of existing resources covering costs of Medicaid-covered services or administrative expenses.
- Other services provided after, or because of, TMaH model (e.g., transportation, travel, construction).

TMaH Model Overlap Policy

CMS allows overlaps between TMaH and other ongoing CMS models.

CMS Models	TMaH Model Intersections
States Advancing All-Payer Health Equity Approaches and Development (AHEAD)	A state can apply for both models if there is **no geographic overlap and no providers or enrollees are participating in both models**.
Cell and Gene Therapy (CGT)	A state can apply for both models; and **geographic, provider, and enrollee overlaps are permitted**.
Innovation in Behavioral Health (IBH)	A state can apply for both models; and **geographic and enrollee overlaps are permitted**, but **providers may not participate in both models**.
Making Care Primary	A state can apply for both models; and **geographic, provider, and enrollee overlaps are permitted**.

TMaH Application Requirements

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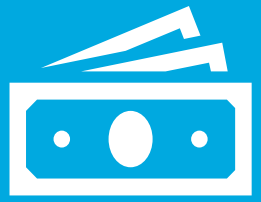
Program Requirements and Expectations

Applicants for the TMaH model must submit the following documents to CMS for review. Specific details for each required document[1] are outlined in subsequent slides.

Project Narrative
(Required – Maximum 60 Pages, Double Spaced)



Budget Narrative[2]
(Required – Maximum 10 Pages, Single Spaced)

Other Documents Required

- Project Abstract Summary (Required – One Page, Single Spaced)
- Business Assessment of Applicant Organization (Required – Maximum 12 Pages, Single Spaced)
- Program Duplication Assessment (Required – Maximum 10 Pages, Single Spaced)
- Appendices (Required – No More than 20 pages)

1. The list of other required documents is not exhaustive. The NOFO requires submission of other forms, such as Form SF-LLL, Project/Performance Site Location Form, etc.
2. Budget Forms (SF-424, SF-424A) are also required.

Project Narrative (1/2)

Applicants must submit a project narrative that gives a clear and concise description of the project, articulating proposed goals, measurable objectives, and milestones based on requirements provided in the NOFO. The project narrative must be double-spaced and not exceed 60 pages.

Project Narrative Elements		
Element	**Inclusion Status**	**Description**
1. Maternal Health Policy Priorities	Required	• Articulate how participation in the model will **advance and align with the state's maternal health policy priorities**.
2. Organization, Administration, and Capacity	Required	• Demonstrate **capacity to implement the model** and **work collaboratively** with other interested parties (e.g., organizational chart, project director assignment, staff capacity, and partnerships with other state agencies).
3. Payment Environment	Required	• Describe existing statewide VBP models and **how existing payment efforts will be incorporated** into the TMaH payment model; and **enabling factors and/or potential barriers**. • Indicate whether the model will be implemented in **FFS, managed care, or both**. • Provide **existing maternal health-related language in procurement materials and MCP contracts** in the proposed test region and substate comparison region, if applicable.
4. Regional Plan	Required	• Indicate whether the model will be implemented **statewide or in substate region**; propose a **test and comparison region** along with **rationale**; and provide a list of **counties or ZIP codes where the model will be tested**. • Provide (a) the **number of Medicaid/CHIP enrollees in the proposed model test region** between the ages of 15 and 45 years by gender, and by race/ethnicity if possible, (b) **lists of partner provider and partner care delivery locations** contracted to care for Medicaid/CHIP enrollees in the test region, and (c) **needs for the test region** (e.g., health disparities, outcome trends, unmet population-specific needs). • Provide **health outcomes** by race/ethnicity (if possible) in the test region (e.g., ICU admission rate, C-section delivery rate, rate of live births weighing < 2,500 grams) for the most recent year available.

Project Narrative (2/2)

Project Narrative Elements		
Element	**Inclusion Status**	**Description**
5. Model Pillars (Required)	Required	• Provide the **status of required model elements under pillars 1 – 3**, steps to achieve milestones, and potential barriers.
6. Optional Model Elements: Model Pillars	Optional	• Provide the **status of optional elements selected**, as well as brief background, context, and goals for selecting each element and how it may improve maternal and child health outcomes.
7. Sustainability Plan	Required	• Describe plan to **sustain funding and activities beyond the model performance period** after the cooperative agreement ends.
8. Stakeholder Recruitment Plans	Required	• Provide **payor, provider, and CBO recruitment plans** for model participation. • Summarize stakeholder communications, ability to participate, and committed activities.
9. Tribal Engagement	Program Priority - Optional	• CMS **may consider and give preference** to applicants that partner with at least one Tribe to implement the model. • Describe Tribal partnerships and roles and provide a Tribal letter of support.
10. Safety Net, Provider, and CBO Partnership	Program Priority - Optional	• CMS **may consider and give preference** to applicants that include safety net providers, including FQHCs, birth centers, and CBOs, as TMaH model partners. • Provide letters of support from safety net providers.
11. Healthcare Disparity	Program Priority - Optional	• Identify **health disparities** and indicate how model participation can help to reduce those disparities. • If implementing statewide, identify health disparities with respect to national averages; if implementing the model in a sub-state region, use state averages.

Budget Narrative

Applicants must submit a budget narrative that includes a yearly breakdown and justification of costs for each line item outlined in the proposed budget (Form SF-424A), separates funding administered directly by the SMA from funding sub-awarded to model partners, and clearly links each activity to the TMaH goals and milestones. The budget narrative must be single spaced and may not exceed 10 pages.

Budget Components (as outlined in SF-242A)	
Category	**Description**
A. (Personnel) Salaries and Wages	• Provide title, name, salary, percentage of time, and months of salary budgeted, and justification and description of each role as it relates to program objectives. All individuals must be SMA employees.
B. Fringe Benefits	• Provide the rate of fringe benefits used as basis for calculation. If a fringe benefit rate is not used, itemize how the fringe benefit amount is computed for each position.
C. Travel	• Describe travel that staff members will perform, including a justification. Dollars requested in the tsravel category are for SMA staff travel only.
D. Equipment	• Provide total amount, unit cost, and justification for equipment charged to the award with an acquisition cost over $5,000 per unit.
E. Supplies	• Provide total amount, unit cost, and justification for supplies charged to the award with an acquisition cost of less than $5,000 per unit.
F. Consultant/ Subrecipient/ Contractual Costs	• For consultant hiring, provide: consultant name and affiliation; nature of services to be rendered; relevance of service to the project; number of days of consultation; expected rate of compensation and justification; method of accountability. • For subrecipients, provide: costs of project activities to be undertaken by a subrecipient. • For contractor approval, provide: contractor name; method of selection; period of performance; scope of work; method of accountability; itemized budget and justification.
G. Construction	• N/A.
H. Other	• Provide total amount, unit cost, and justification of items not included in previous categories (e.g., printing)s.

Other Documents Required

In addition to the project narrative and budget narrative, applicants must complete and submit the following to CMS:

- **Project Abstract Summary (Required – One Page).** Write a one-page summary of the proposed project, including the goals, total budget, and description of how funds will be used. CMS will use this document for information sharing and public information requests if the applicant receives an award.
- **Business Assessment of Applicant Organization (Required – Maximum 12 Pages).** Answer business assessment questions. CMS evaluates the risk posed by an applicant on items such as financial stability, quality of management systems, internal budgetary controls, and ability to meet management standards prescribed in 45 C.F.R. Part 75.
- **Program Duplication Assessment (Required – Maximum 10 Pages).** Provide CMS with sufficient information to prevent program and funding duplication, including whether (1) other programs funded by Medicaid, Title V agencies, or other federal, state, or local programs will provide direct care coordination or case management services to the TMaH model population; and (2) some or the entire model focus population, including partner providers, may also participate in a separate program, model, demonstration, or VBP model that is similar to TMaH.
- **Appendices.**
  - Resumes and/or curriculum vitae (**required** for identified managers, project director, and all other key personnel identified at time of application).
  - Job descriptions for key model personnel (**required** in project narrative or appendix).
  - Organization chart (**required** in project narrative or appendix).
  - Letters of support (**optional** – from governor or state legislators, hospitals, safety net providers, primary care providers, birth centers, Tribes, and/or CBOs.

Application Review Criteria and Scoring Methodology

CMS will consider geographic diversity, scale, program priorities, quality of applications, and participation in other CMS models when making award determinations. Merit review panelists will assess and score applicants' responses with the criteria below.

Project Narrative (80 Points)

Section	Topics	Points
1.	Maternal Health Policy Priorities	**5 Points**
2.	Organization, Administration, and Capacity	**7 Points** • (5 Points) Describes the entity that will perform the cooperative agreement activities under this funding opportunity. • (2 Points) Describes prior experience (CMS models, federal Medicaid maternal health programs, or state-led maternal health initiatives), as well as known challenges to improving maternal care.
3.	Payment Environment	**5 Points**
4.	Regional Plan	**15 Points** *SMAs may receive up to 2.5 points per application element.*
5.	Model Pillars (1 – 3)	**30 Points** *SMAs may receive up to 10 points per pillar.*
6.	Sustainability Plan	**9 Points**
7.	Stakeholder Recruitment Plans	**9 Points**

Budget Narrative (20 Points)

Section	Topics	Points

8.	Budget Narrative	**20 Points**
		• (10 Points) Detailed budget adhering to the format outline for the performance period, per the NOFO.
		• (10 Points) Reasonableness of requested funding based on:
		  ○ (4 Points) Total available funding, linkage to NOFO goals, and consistency with model requirements.
		  ○ (3 Points) Personnel costs.
		  ○ (3 Points) Project goals.

While the selection of optional elements will not be scored, CMS will consider the application's overall needs and implementation plan.

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General TMaH Reporting Requirements

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TMaH Federal Reporting Requirements

CMS will monitor programmatic progress and performance of each SMA through data collection and reporting. All SMAs participating in TMaH will be held to the following federal reporting requirements.

- **Programmatic Reporting with TMaH award,** including submission of **quarterly progress reports**, regular communications with CMS, participation in TA and learning system events.
- Submission of **Federal Financial Reports (FFRs)** via the Payment Management System (PMS) with real-time expense reporting along with semi-annual or annual expenditure FFRs.
- **Federal Funding Accountability and Transparency Act**-required reporting on recipients' or first-tier sub-recipients' subawards of $30,000 or greater. Some recipients may face additional reporting requirements.
- Disclosure of criminal, civil, and administrative proceedings that reached final disposition within the most recent five-year period and were connected with the award or performance, along with semi-annual disclosures regarding such proceedings. CMS will make this information publicly available in responsibility and qualification records.
- Reporting requirements associated with the **PMS** funds request process.
- **Audit requirements** outlined in 45 C.F.R. Part 75 (implementing 2 C.R.F. Part 200).
- **Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification** that neither recipients nor their principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency. Recipients who cannot make this attestation must submit an explanation.

TMaH Evaluation

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TMaH Evaluation and Measure Reporting

CMS will conduct a formal concurrent evaluation for the entire performance period to assess TMaH's impact on the experience and outcomes for pregnant and postpartum Medicaid members and their infants, health disparities, as well as changes in federal spending.

CMS will evaluate TMaH using quantitative and qualitative methods for the entire performance period:

- **State level analysis** on policy changes, implementation processes, and population-level service uptake changes.
- **Regional analysis** on TMaH impacts on population-level service use and outcomes relative to comparison region.
- **Patient-level analysis** on member outcomes and experience relative to comparison region.

SMAs will provide CMS administrative data for evaluation on an annual basis, including claims and encounter data, Medicaid dyad linkage, and vital records. Other data may need to be provided more frequently (e.g., EHR, screenings, site-level health, utilization and referral data, documentation, and survey data).

Measure Concepts

CMS will use the below measure concepts for monitoring and/or evaluation as proxies for healthcare quality and will announce specific measures[1] by end of model year 3.

- Low Birthweight
- Contraceptive Care for Postpartum Women
- Blood Pressure Control
- Pre-Term Birth < 37 Weeks Gestational Age
- Neonatal Intensive Care Unit Rate
- Emergency Department Utilization among Postpartum Enrollees
- Screening for Perinatal Anxiety
- Tobacco Use Screening
- Substance Use Screening
- Health-Related Social Needs Screening
- Patient-Reported Experience Measure

1. These measures will not affect quality and cost PIP payments in model year 4.

Key Considerations for Interested States

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Key Next Steps for States Interested in TMaH

1. **Assess where the state currently stands related to the required TMaH model elements** (e.g., what has the state already implemented, what's in progress, and what has not been started).
2. **Engage with key partners** that the state will need to collaborate with for TMaH implementation to assess interest (e.g., MCPs, providers, hospitals, state public health department).
3. **Decide whether to apply for TMaH** in advance of the letter of intent August 8th due date to be best positioned to prepare an application by the September 20th submission deadline.
4. **Identify resources** needed to prepare application and facilitate state participation in TMaH (e.g., programmatic and administrative).