national partnership for women & families

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Making the Most of Medicaid's Transforming Maternal Health (TMaH) Model

A Guide for Birth Justice and Community Leaders

Transforming maternity care has never been more urgent. The United States is the most dangerous place to give birth among high-income countries. This status quo is unacceptable. Business as usual results in hundreds of people dying annually due to pregnancy-related conditions and thousands more having major – even life-threatening – complications with serious short- and long-term health consequences.[1] Yet four of every five maternal deaths are preventable.[2]

Birthing people need a health care system that pays for what works and what they want and need. Innovative care delivery and alternative payment models (APMs) are key pathways to achieving care that is equitable, accessible, respectful, safe, effective, and affordable. The Centers for Medicare & Medicaid Services' (CMS) new Transforming Maternal Health (TMaH) model is a crucial opportunity to drive change. But for TMaH to succeed in improving outcomes for birthing people, especially those most affected by the maternal health crisis, it must incentivize and support the practices, policies, and providers that will most likely result in concrete improvements in health outcomes, experiences, and equity.

Advocates have a critical role working with State Medicaid Agencies (SMAs) to ensure that their proposed models prioritize and support the concrete changes that birthing people and their families need.

What is TMaH?

CMS's TMaH initiative is a voluntary, 10-year payment and care-delivery model that aims to transform how maternity care is provided, who provides it, and how to pay for care that results in improved outcomes. The model will test whether payment and delivery system reforms, coupled with targeted technical assistance, can drive a whole-person care-delivery approach to pregnancy, childbirth, and postpartum care, while reducing costs to the Medicaid and CHIP program. In January 2025, CMS will identify up to 15 SMA awardees, and will provide each with technical assistance and up to $17 million over 10 years.

Why changing how we pay for maternity care matters

Our maternity care system is failing birthing people. People from communities of color, especially Black and Indigenous families, bear the brunt of this crisis, along with rural and low-income families.[3] How we pay for health care is a key driver of this disaster. The financial underpinnings of our health care system are not designed to support high-quality, equitable health care, and limit what even the most well-meaning providers can do. The financial incentives are grossly misaligned and cannot support consistently treating each individual with genuine care, as a whole person rather than as a series of symptoms, aligned with their preferences and values, in the time and place they need.[4]

For example, our health care system fails to incentivize team-based care that includes midwives and doulas, support care coordination with community-based services, or deliver care tailored to the unique needs of birthing people.

TMaH provides a powerful, unprecedented opportunity for SMAs to ensure childbearing families get the services and supports they need to thrive by transforming what care is provided and how, when, where, and by whom. It aims to reduce inequities in access and treatment and improve outcomes and experiences. TMaH will test value-based care delivery and payment reforms that, if proven to be effective, could be scaled nationally.

However, the ultimate success of the model will require centering leaders of the birth justice movement and others from the most affected communities throughout the entire process – from planning, to implementation, to evaluation.

Your opportunity: Help your state get it right

As advocates for better maternal and infant health, you have a critical role to play in influencing your state's Medicaid program so that their TMaH initiative focuses on equity and is designed for success. It must support the practices, policies, and providers most likely to produce concrete improvements in health outcomes, experiences, and equity – especially for those most affected by the maternal health crisis. We recommend advocating in your state on the following five issues:

Prioritize Meaningful Community Collaboration

One reason our health care system has been profoundly failing birthing people is that it was designed with minimal input from those giving birth and their families. Developing models and programs without deep collaboration with the most affected communities will usually miss the mark and even further erode people's trust in the health care system. Prioritizing meaningful, authentic collaboration with communities will not only improve the chances of success, but can also serve to build trust. SMAs should prioritize birth justice and other community leaders across the model's full 10-year cycle to co-develop and co-lead solutions, implementation, and evaluation efforts. True collaboration requires early, consistent, ongoing, and robust engagement and co-leadership with community-based organizations. Let decision-makers know what they can do to ensure TMaH advances quality and equity:

- **Build trust by being trustworthy over the long haul.**

  Building trust is indispensable to ensuring that each program has a positive impact on the communities most affected by health inequities. In general, medical institutions in the United States do not have a positive track record of acting in a trustworthy way with communities of color, dating from before the founding of the nation. Our nation's reproductive health history in particular has included forced sterilization, abusive gynecological practices, and longstanding and ongoing racism, discrimination, and mistreatment – a lot of which continues to this day.

  Repairing these relationships must start with acknowledging community concerns as valid, and valuing and respecting their lived experience, on-the-ground expertise, leadership, and the existing community assets. This requires, among other things, ongoing, proactive, and non-transactional collaboration. Health care provider institutions can practice trustworthiness through clear, transparent, and respectful communication, by explicitly incorporating people's input, and honoring agreements with the community.

- **Ask the community what their priorities are and the solutions they need, and then work with community leaders to incorporate them into their TMaH strategy.**

  Communities and their leaders have a clearer understanding of on-the-ground priorities, barriers to health, and potential concrete solutions. SMAs should work intentionally with communities and birthing people to co-develop solutions for people's top priorities and continue to collaborate to implement and evaluate them. This is especially important to address inequities in communities that have been structurally marginalized and contend with the worst outcomes, including Black, Indigenous, and other communities of color, people who identify as LGBTQIA+, people with disabilities, and those who live in rural areas.

- **Share power and resources to enable equitable collaboration.**

  The communities most affected by the maternal health crisis are often the most under-resourced, while also being routinely excluded from decision-making processes. Effective, equitable collaboration that results in concrete improvements for birthing people in these communities requires a different approach to policy and program development and implementation. Respectful collaboration must take into account the deep imbalances in power and resources between these communities on one side, and health care provider institutions and government agencies on the other. Successful collaboration demands proactive efforts to level these hierarchies by sharing power and resources, truly valuing the community's deep expertise, lived experiences, and existing assets. This can require providing logistical, technical, and financial assistance to enable community members and the community-based organizations that work with them to fully participate and contribute. Asking them to come sit at the table one time is insufficient, and can sometimes lead to tokenism and further erosion of trust. Collaboration should extend through every step of the process, from setting priorities and co-developing solutions, to program implementation, evaluation, and sharing with the community the outcomes, impact, and lessons learned.

Work with your state Medicaid agency to build in community engagement by creating a **community advisory council** that is well supported and representative of the communities that most urgently need improved care, for the entire length of the 10-year model.

Authentic, respectful collaboration requires these elements:

- Ensuring that solutions be based on the expressed priorities of those most affected, and built on their knowledge, expertise, and skills.
- Inclusion in decision-making processes for program development, implementation, and evaluation.
- Compensating people and organizations for their time and expertise and provide other supports needed for robust participation from the community.

Include the Kinds of Care that Show Proven Results

Medicaid needs to do much more to financially and logistically support maternity care approaches and practices that make a difference for birthing people and their families, especially for those who need better care the most – specifically, midwifery care, doula support, giving birth in birth centers or in one's home, and working with community-led perinatal health and support organizations. These have all been shown to improve experiences, outcomes, and equity. They reduce preterm birth, cesarean deliveries, unwarranted neonatal intensive care unit admissions, perinatal anxiety and depression, and unmet social needs. They also increase vaginal birth after cesarean, breastfeeding, and overall improve people's care experiences. They should be included in TMaH programs. To achieve this, Medicaid programs should:

- **Pay for what works.**

  Many Medicaid programs have started to reorient their reimbursement policies and managed care contracts to better cover some of these types of care – especially doula support. Much more can be done to ensure more Medicaid members have access to high-value, high-quality modes of care. Too often, highly effective, disparity-reducing care is either not covered by Medicaid, or their reimbursement rates are too low to be sustainable. Programs should be designed to provide sufficient payment to strengthen and diversify workforces serving historically harmed and underserved groups.

- **Work to remove regulatory roadblocks.**

  Health care provider regulations are critical to ensure patient safety and community well-being, and accountability. However, excessive or inappropriate regulation of services most likely to improve maternal and infant health outcomes, especially in communities struggling with structural inequities, is an unnecessary obstacle that Medicaid programs should work with state decisionmakers to remove. For example, removing overly restrictive licensure requirements for birth centers (e.g., certificates of need) and midwives (e.g., physician supervision and written practice agreements) would set the stage for better quality and access to care.

  Regulatory rightsizing is critical, especially in the context of clinical provider shortages, maternity care deserts, and the lack of the diversity and cultural centeredness that are foundational to transforming maternity care.

TMaH is an unprecedented opportunity for SMAs to ensure childbearing families get the services and supports they need to thrive.

Work with your state Medicaid agency to support proven approaches and practices[5] by:

- Implementing a payment system that rewards high-value care.
  - Reimbursement rates for maternity care should be the same, regardless of provider type (midwives and physicians) and location (office, birth center, or home), and be sufficient to cover the cost of providing high-quality care.
  - Cover community-based **perinatal support workers**, (including doulas, peer counselors, care navigators, and lactation counselors) during the prenatal, birth, and postpartum periods.
  - Use **prospective payments – the payment of a set amount** covering the entire pregnancy, birth, postpartum, and newborn periods to cover valuable support services that do not have specific billing codes (e.g., doula support and other community-based support services).
  - Equalize reimbursement rates for vaginal and cesarean births using **blended case and facility rates** to eliminate perverse incentives for medically unnecessary surgeries.
  - Pay birth centers sustainable facility fees and community midwives modified facility fees to cover the costs of preparing for birth at the family's home.
- Incentivizing and facilitating hospitals and physicians to collaborate with high-performing care providers.
- Working with state-level decisionmakers to:
  - Eliminate overly restrictive midwifery and birth center licensure requirements, such as removing physician supervision and written practice agreements for midwives.
  - Establish state licensure for all three nationally recognized midwifery credentials.
  - Remove certificates-of-need requirements for birth centers.

Support Whole-Person Care

Whole-person care approaches each individual within their family and community context to support physical and mental health, focus on prevention, and address unmet health-related social needs. A maternity care system that works for all birthing people must be built on the foundation of whole-person care, especially because unmet social and mental health needs are enormous drivers of poor maternal and infant health outcomes. Moreover, the maternity care system must support building

trusting relationships, ensure respectful care, and prioritize the individual's goals, shared decision-making, and agency.

- **Integrate maternal mental health (MMH).**

  MMH conditions affect one in five women and are a leading cause of maternal deaths. MMH issues may arise during pregnancy or during the year after giving birth, and can include depression, anxiety, and post-traumatic stress disorder (PTSD), as well as other diagnoses. Undiagnosed and untreated MMH conditions can lead to long-term health problems.[6] For example, women experiencing depression or anxiety during pregnancy are 40 percent more likely to develop hypertension during pregnancy. Pregnant women with untreated anxiety have a higher risk of preterm birth and lower birth weight, and their infants have a higher risk of being small for their gestational age.

  For people of color, preventing and treating MMH conditions is particularly challenging. People of color are more likely to experience mental and behavioral health issues, given the impacts of structural inequities, interpersonal racism, and toxic stress. At the same time, they are also less likely to have access to providers who they can trust, who understand their cultural context and can provide respectful care. Easy access to respectful, culturally centered maternal mental and behavioral health support and treatment is vital to good outcomes for both mother and baby.

- **Respect women's voices, choices, and agency.**

  Whole-person care requires people to be treated with dignity and respect, and accountability for any mistreatment, disrespectful care, or discriminatory treatment. Moreover, every person must be recognized as the expert on their own body, needs, and values. They should have the power to determine their individual birth experience. Care plans should be co-created with the person's care team, including its non-clinical members, from pregnancy through the full year postpartum. Plans must be dynamic, able to adapt to evolving circumstances and preferences. Effective, respectful communication must be the foundation for this co-creation, and all members of the care team should demonstrate their commitment to the person's agency and decisions. TMaH models should be designed to promote culturally congruent care and diverse teams to increase opportunities for trustworthy, respectful, high-quality care and support.

- **Respond to social needs.**

  Addressing social needs is a key component of better maternity outcomes. Whole-person health includes screening for, and then addressing, unmet health-related social needs that contribute to poor health (such as food insecurity), prevent people from seeking or getting care (such as lack of transportation or child care), or reduce the effectiveness of care (such as language barriers). A broad range of unmet social needs – from experiencing intimate-partner violence or homelessness to having a substance use disorder – have a negative effect on maternal and infant

health outcomes, but pregnancy and the postpartum period are also times when women may be most open to exploring and pursuing different options. Social-needs screening during pregnancy has identified high rates of unmet needs and strong support for addressing them.

Comprehensive person-centered care can only be achieved through multiple strategies that account for the wide spectrum of community members' needs. Community-based care and support models must be integrated to help to narrow the inequities in maternal health outcomes by expanding prenatal, childbirth, postpartum, lactation, and new parent support that is respectful and culturally congruent.

TMaH is an opportunity for SMAs to develop and promote comprehensive, whole-health, integrated models that can address physical and mental health and health-related social needs during pregnancy and postpartum period (ideally to 12 months). This includes early prenatal and postpartum screening, development and maintenance of co-created care plans, and proactive follow-up to meet physical, mental health, and social needs.

Work with your state Medicaid agency to prioritize whole-person care by:

- Adjusting payments to account for the resources needed to address social, physical, and mental health needs, including providing more services to birthing families with greater needs and increasing resources to providers caring for them.
- Developing programs to co-locate behavioral and mental health services, lactation support, laboratory and imaging services, and pediatric care with prenatal and postpartum care.
- Increasing accountability for promoting respectful maternity care, including by measuring birthing people's experiences of care and by using existing toolkits and frameworks to promote respectful maternity care.
- Making care more accessible, in terms of geography and availability outside of usual working hours. This means increasing resources to support telehealth, home visits, and mobile clinics, and requiring providers to offer more evening and weekend appointments.
- Prioritizing partnerships with community-based organizations to address social needs and ensure closed-loop referrals. In addition, ensure providers' staff have the skills, knowledge, and resources to reliably inform and connect families to necessary social supports (including WIC, information about family leave, legal protections, and workplace accommodations).

Report Disaggregated Data from Start to Finish

The only way to know if any model or program is improving maternal health equity, outcomes, and experiences is requiring the reporting of disaggregated data and using stratified measures. Moreover, this is needed throughout the process, starting with the pre-implementation period to establish baselines, through implementation and evaluation, to capture and drive improvements, as well as identify where course correction is needed.

- **Disaggregated data should drive design.**

  Good data is essential to designing strong TMaH program solutions. Disaggregated data makes inequities visible. This information is needed to create plans and solutions to increase equity, and is the only way to ensure that changes are reaching the communities and populations with the greatest needs. Data should include information on self-identified race, ethnicity, Indigenous identity, economic status, and primary language. Ideally, disability status and sexual orientation and gender identity should be included.

  Early data collection during planning and pre-implementation should be used to identify where urgent action is most needed, how to design and implement effective solutions, and to develop state- or region-specific benchmarks and goals. This early data can inform program goals, set stratified benchmarks, and target improvement efforts that are explicitly designed to reduce disparities.

- **Measuring success requires disaggregated data.**

  Without disaggregated, stratified data, it is impossible to know whether any program actually advances equity. Indicators showing overall improvements can mask continuing, or even worsening, disparities. Especially in the maternal health context, where inequities are so deep, success must be defined by the extent to which outcomes in the communities bearing the brunt of the maternal health crisis improved.

Work with your state Medicaid agency to demonstrate their impact on equity by:

- Requiring all providers and Managed Care Organizations (MCOs) to implement systems to collect and report people's self-identified race, ethnicity, Indigenous identity, disability status, sexual orientation, and gender identity, in a respectful manner that prioritizes confidentiality.
- Requiring that quality and outcomes reporting be stratified by race, ethnicity, Indigenous identity, disability status, sexual orientation, and gender identity, or at a minimum, develop a plan to do so.
- Providing needed funding, training, and technical assistance to enable all providers of clinical and non-clinical care to capture and share disaggregated data to assess service utilization, outcomes, and change over time.

Measure What Matters

Being able to measure and track progress is critical for any alternative care delivery or payment model, and it is essential that what is measured actually makes a difference in people's outcomes and experiences. Strategically, it is also crucial that measurement helps lead to concrete improvements that can be scaled up. Models should use quality measures that are most likely to drive concrete, widespread improvements in care delivery and outcomes and promote accountability. Given provider concerns about measurement fatigue, it is critical that impactful measures are used.

- **Adopt measures most likely to drive improvements**

  SMA's should select and require measures that:

  - have a **widespread impact**
  - are already **well tested**
  - reflect a **high-enough bar** to make their impact significant
  - address **whole-person** care, such as mental health, social needs, and experience of care
  - are **valued by community** members

- **Avoid measures with limited reach and impact.**

  Some of the measures routinely used, while reflective of good clinical practice, are not likely to drive care transformation. Models intended to change care delivery should not include measures that are already in widespread use, affect a very low percentage of birthing people, or set too low a bar to spur improvement. For example, chlamydia screening is an essential clinical practice that is already widely used and has an impact on few people. SMAs could retire that measure to make space for one that will spur needed care delivery improvement.

Work with your state Medicaid agency to integrate high-impact measures[7] such as:

- Cesarean birth: Appropriate cesarean use is widely considered an essential indicator of maternity care quality. Measuring cesarean birth has the potential to meaningfully affect a wide segment of birthing people and has long-term impact on future births.
- Prenatal and postpartum depression screening and follow-up: Perinatal mood and anxiety disorders are the leading complication of pregnancy and a leading cause of maternal mortality. Screening, access to care and support, and follow-up are highly valued by birthing families.
- Social needs screening and intervention: To provide whole-person care, screening for and addressing social needs must be thoroughly incorporated into models.
- Experience of care: Improving the care experience is a top priority for birthing people, and a maternity-care-specific measure is currently under development.

Endnotes

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About the National Partnership: The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to achieving equity for all women. We work to create the conditions that will improve the lives of women and their families by focusing on achieving workplace and economic equity, and advancing health justice by ensuring access to high-quality, affordable, and equitable care, especially for reproductive and maternal health. We are committed to combatting white supremacy and promoting racial equity. We understand that this requires us to abandon race-neutral approaches and center the intersectional experiences of women of color to achieve our mission.

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