LOGISTICS

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- To **submit comments or questions**, click the Chat icon at the bottom of your screen.
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- For help with **technical issues**, send a message through the Chat feature.
- The **slides and a recording** of the webinar will be emailed to registered participants and available soon on the Integrated Care DC website.
- Right-click on your name in Zoom, select “Rename,” and **add your organization to your name**.

Transforming Maternal Health (TMaH) Webinar:

Understanding the TMaH Payment Model for Physician Groups and Federally Qualified Health Centers (FQHCs)

INTEGRATED CARE DC
A learning community for District of Columbia Medicaid providers

PRESENTED BY:
Kelli Stannard, BSN, RN
Olivia Reding, MPH
Alisa Bannerjee
Joe Weissfeld

Tuesday, August 11, 2026
11:30 AM–12:30 PM ET

Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF). This project is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS). A total of $1,527,057.67, or 57 percent, of the project is financed with federal funds, and $1,147,478.36, or 43 percent, is funded by non-federal sources. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, CMS/HHS or the U.S. Government.

DHCF
Department of Health Care Finance

HMA

TODAY'S AGENDA

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- Welcome and Session Orientation
- July Webinar Recap
- Breakout Sessions: Payment Model Deep Dives
- Conclusion and Next Steps

Image Source: Microsoft 365 Stock Photos

LEARNING OBJECTIVES

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Identify implications of the TMaH payment model on billing operations, care integration approaches, and overarching maternal health care provision.

Recognize current organizational culture regarding value versus volume-focused care.

Develop one or two practical next steps that can be implemented now to prepare for implementation of the TMaH payment model.

PRESENTERS

INTEGRATED CARE DC
A learning community for District of Columbia Medicaid providers

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Faculty	**Kelli Stannard, BSN, RN Presenter**	**Olivia Reding, MPH, PMP Presenter**	**Alisa Bannerjee Presenter**	**Joe Weissfeld Presenter**	**Jeanene Smith, MD, MPH CME Reviewer**	**Reina Hudson, LCSW CE Reviewer**
Company	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures
Nature of relationship	N/A	N/A	N/A	N/A	N/A	N/A

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- Health Management Associates (HMA), #1780, is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved as ACE providers. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. HMA maintains responsibility for this course. ACE provider approval period: 09/22/2025–09/22/2028. Social workers completing this course receive 1 continuing education credit.
  - *To earn CE credit, social workers must log in at the scheduled time, attend the entire course and complete an online course evaluation. To verify your attendance, please be sure to log in from an individual account and link your participant ID to your audio.*
- The American Academy of Family Physicians (AAFP) has reviewed Integrated Care DC Webinar Series and deemed it acceptable for AAFP credit. Term of approval is from 05/12/2026 to 05/11/2027. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This session is approved for 1 Online Only, Live AAFP Prescribed credit.
  - **<u>If you would like to receive CME credit, the online evaluation will need to be completed</u>.**
  - You will receive a link to the evaluation shortly after this webinar.
- Certificates of completion will be emailed within 12 business days of course completion.

JULY WEBINAR RECAP

TMAH PAYMENT MODEL

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The TMaH Value-Based Payment (VBP) Model is designed to:

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

Outcomes of interest

Reduced rates of low-risk caesarean deliveries

Reduced incidence of severe maternal morbidity

Reduced rates of low-birth weight infants

Improved experience of care for pregnant women

TMAH PAYMENT MODEL

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Overall Approach	**Maternal Health Episode of Care** • 280 days prior to delivery through….60 days postpartum
Accountable Providers	• OB-GYNs, Federally Qualified Health Centers, Birth Centers • Held accountable for their attributed beneficiaries' perinatal journey
Considerations	• Encourages services to improve overall quality of care and cost • Required service delivery elements include prenatal care, labor and delivery (L&D), postpartum care, and community supports such as integration of doulas, community health workers (CHWs), community-based organizations (CBOs), and referral pathways • TMaH will include telehealth and home monitoring services where appropriate • Accountable providers are encouraged to establish formal partnerships with doulas
Payment	• Monthly Case Rate Payment + Shared Savings/Shared Risk Incentive Payment • Centers for Medicare & Medicaid Services (CMS)-directed Infrastructure Payments

IMPORTANT! The TMaH payment model is **not** final.

KEY TAKEAWAYS FROM JULY SESSION

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1

One key takeaway about team-based maternal care:

- Models/relationships with doulas vary across sites and referral partnerships vary in formality.
- Relationship building is key to “growing” these networks/partnerships.

2

Planning for a new payment model:

- At least one team prefers separating the hospital payment and the doula payment.
- More understanding around the differences between the physician group model vs the FQHC model is needed to understand operational realities and opportunities with a new payment model.

3

Changes to be planned for in preparation for new payment model:

- Doulas need support on how to enroll with Medicaid managed care plans.

BREAKOUT SESSIONS

BREAKOUT ROOM LOGISTICS

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Breakout Group Composition

- Participants will be placed into the following working groups with a facilitator:
  - Physician Groups
  - FQHCs

Breakout Focus

- Review key design elements from the TMaH payment model
- Discuss implications on your practice, your questions, and what your practice can do today

PHYSICIAN GROUPS

ACCOUNTABLE ENTITY (AE) REQUIREMENTS

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AE is a single organization that provides ALL* perinatal services

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

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

*The AE must provide the prenatal, labor and delivery, and postpartum care

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

ATTRIBUTION METHODOLOGY: DEFINITIONS

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Concept	Definition
Trigger	Live birth
Delivery Setting	The site of care where a patient delivers a baby (hospital, birth center, etc.)
Switch	When a patient receives care from more than one accountable entity, primarily during the prenatal or postpartum period
Transfer	When a patient is transferred to a higher level of care, typically across care settings, due to medical need (for example, from a birth center to a hospital)

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

ATTRIBUTION METHODOLOGY: PATIENT ELIGIBILITY

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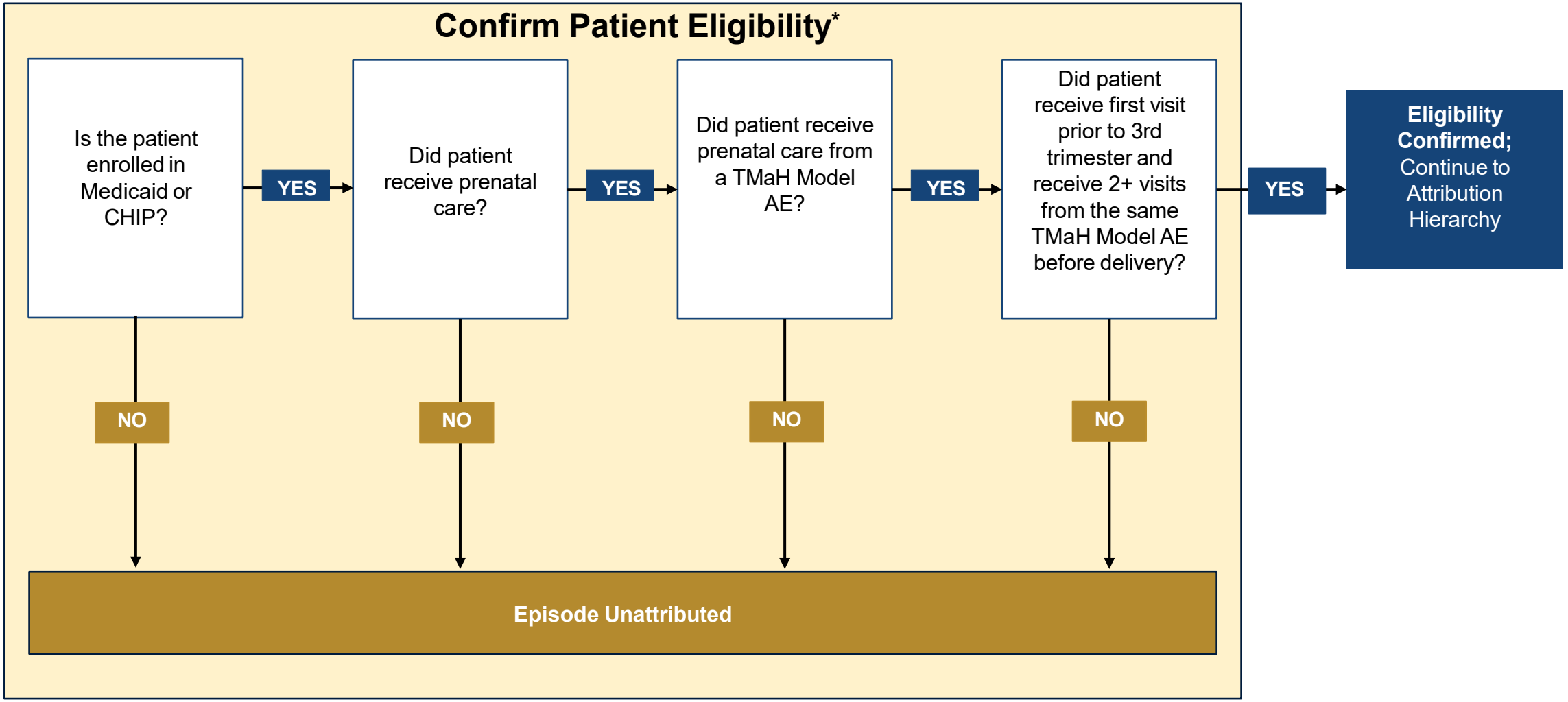

* Additionally, the TMaH VBP Model excludes certain patients and events from accountability, such as dual eligible patients, out of age range (<12 and >55), miscarriages, stillbirth, left care against medical advice, and high- and low-cost outliers and conditions.

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ATTRIBUTION METHODOLOGY: ATTRIBUTION HIERARCHY

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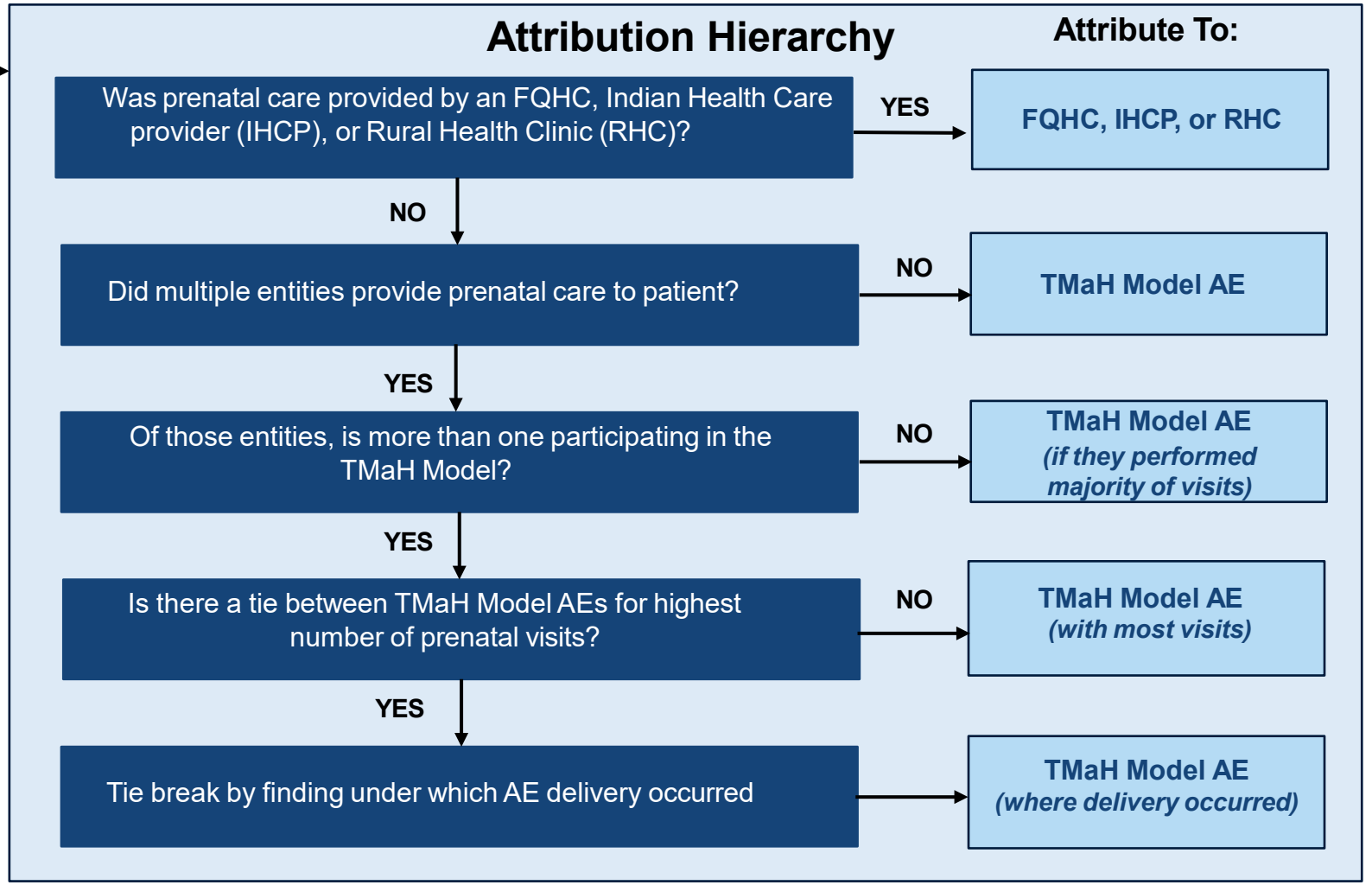
Patient Eligibility Confirmed



CMS recognizes that unique attribution scenarios may arise during model testing and implementation and will refine the attribution methodology as needed to address these cases.

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

PROSPECTIVE RATE

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- AEs will be paid a prospective monthly payment ("case rate") that provides consistent and steady funding to support professional services and care coordination, **starting in the second trimester until 60 days postpartum**
  - Case rate will be calculated individually for each AE based on historic professional claims costs and re-calculated annually based on costs from the prior year
  - **Hospital professional fees** are part of the case rate
- CMS has delayed the TMaH Model prospective payment implementation for at least the first two years of implementation (2029 to 2030)

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

IMPLICATIONS OF AMA CODE CHANGES

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- The American Medical Association (AMA), in collaboration with the American College of Obstetricians and Gynecologists (ACOG), is establishing a new set of maternity care CPT service codes effective January 1, 2027*
- Expected impacts on maternity care include:
  - Billing systems changes
  - Provider payment
  - Patient utilization of preventive services
  - Capacity to track services and referrals

Image Source: Microsoft 365 Stock Photos

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

IMPLICATIONS OF AMA CPT 2027 MATERNITY CARE CODE CHANGES ON THE TMAH VBP MODEL

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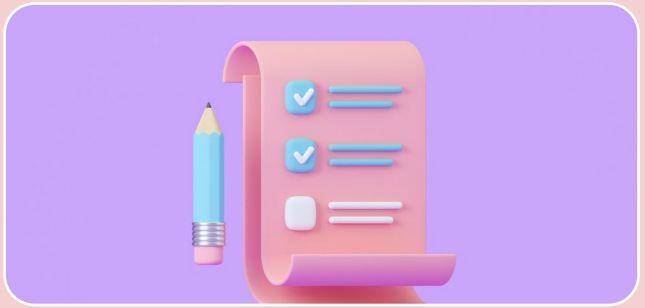
Delay retrospective reconciliation to 2029 to establish a more stable historical baseline using the new billing codes and acknowledge uncertainty during the coding transition period

Delay monthly prospective payment to establish a more accurate baseline and acknowledge the burden on providers to **update payment systems**



Generate crosswalk to reflect changes to prenatal visits and labor and delivery related codes to ensure consistent application of **inclusion and exclusion criteria**

Image Source: Microsoft 365 Stock Photos

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

RETROSPECTIVE RATE: OVERVIEW

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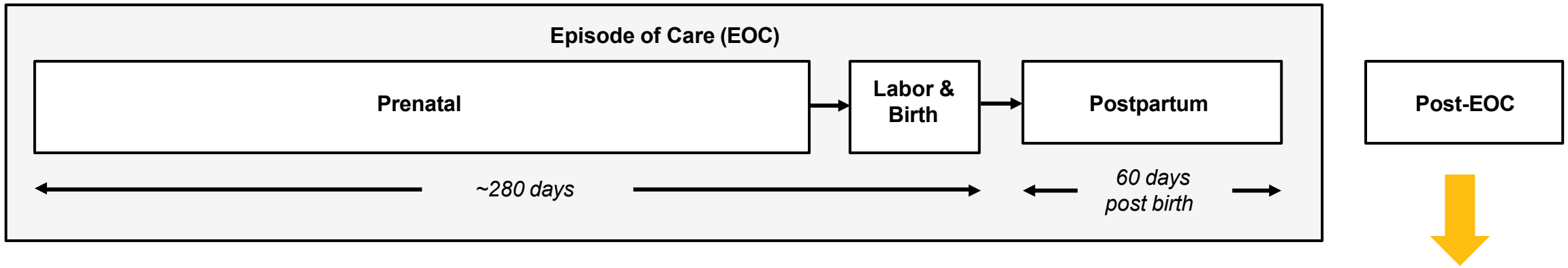

Retrospective shared savings (or phased-in losses)

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

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

CMS is considering requiring implementation of the retrospective episode of care payment model beginning January 1, 2029

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

INCLUDED/EXCLUDED CRITERIA RATIONALE

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Image Source: Microsoft 365 Stock Photos

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

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

INCLUDED RETROSPECTIVE SERVICES

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Professional Services

- Labor & Delivery (L&D) Professional
- Outpatient Professional
- Inpatient Professional (codes unrelated to L&D Professional)
- Initial and basic screenings and assessments for Behavioral Health (BH) and Substance Use Disorder (SUD)

Facility & Diagnostic Services

- Inpatient Facility
- Outpatient Facility
- Outpatient Laboratory
- Outpatient Radiology (e.g., ultrasounds)

Other

- Telehealth and Remote Monitoring
- Certain Durable Medical Equipment (DME) (e.g., insulin devices, glucose monitor)
- Emergency Department & Observation Stay
- Pharmacy
- Other Services (e.g., any remaining uncategorized claims including interim labor management, unlisted maternity care/delivery procedures, emergency transportation)

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

EXCLUDED RETROSPECTIVE SERVICES

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Professional Services	• Pediatric professional services • Comprehensive Assessments & services for BH/SUD* (e.g., treatment-related evals) • Services related to screenings for BH and SUD are included in the episode cost as part of pregnancy-related care that may occur during the perinatal window, and to incentivize providers to care for pregnant individuals with behavioral/SUD conditions; however, comprehensive services related to treatment are excluded.
Facility & Diagnostic Services	• Neonatal care/NICU • Hospital costs and non-pregnancy related care (e.g., fractures)
Rx and Devices	• Pharmacy claims with excluded medications and high-cost drugs • Breastfeeding supplies and other unspecified equipment
Other	• Non-emergency transportation • Contraceptive services and procedures • Flu and TdAP vaccines • Pregnancy-related care (e.g., doula, dental, lactation) that is cost-effective and important for improving health outcomes • Header-paid inpatient claim w/ an excluded service (e.g., appendectomy, hernia procedure)

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

RISK ADJUSTMENT METHODOLOGY

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Rationale: The core objective of risk adjustment is to ensure fair comparison of episode costs across providers by accounting for differences in clinical complexity and social risk of pregnant individuals. The TMaH VBP Model uses a **multi-dimensional approach to adequately capture the full range of complexity** affecting maternal health outcomes and costs.

1. Episode Construction

- Calculate baseline episode with valid maternity episodes, episode cost, standard exclusions

2. Clinical Risk (Chronic Conditions *and* Obstetric History)

- Identify chronic conditions
- Identify perinatal conditions (gestational diabetes, hypertensive disorders, prior obstetric history, etc.)

3. Community Deprivation Index (CDI)

- Apply area-level community deprivation index (CDI) to reflect non-clinical factors for episode resource needs

4. Develop Risk Score

- Create a score that allows weighting of cost relative to an average episode
- Conduct multivariable regression modeling

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

THE ROLE OF QUALITY MEASURES IN THE TMAH VBP MODEL

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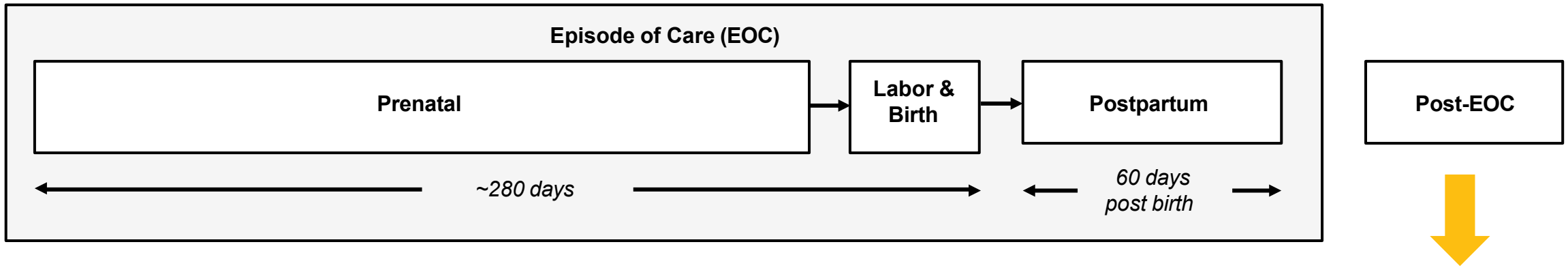

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Annually, the total cost of completed perinatal EOCs are **reconciled against the risk-adjusted target price and adjusted for quality performance.** Total cost includes professional and facility claims

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

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

THE ROLE OF QUALITY MEASURES IN THE TMAH VBP MODEL

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- Quality measures are a core part of VBP Model because they align provider incentives with better care and ensure that cost savings are achieved through improved outcomes
- The distribution of incentive payments will be adjusted based on the AE's quality performance

Performance Tier Calculation	Improvement Tier Calculation
• Based on all quality measures • Comparted to historical benchmarks	• Based on selected measures • Rewards year-over-year improvement
Performance Score	***OR*** **Improvement Score**

Final Score Calculation
Performance Score ***OR*** Improvement Score
Higher of the Two Options

AEs with low scores on both performance and improvement tiers can submit an **improvement plan to earn shared savings** in future years

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

TMAH VBP QUALITY MEASURES

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PRENATAL

Model Goals

- Engagement in prenatal care
- Screening, follow up, and management of comorbidities

Measures**

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

LABOR & BIRTH

Model Goals

- Rates of low-risk c-section
- Maternal morbidity
- Rates of low birth-weight infants

Measures**

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

POSTPARTUM

Model Goals

- Engagement in postpartum care
- Screening, follow up, and management of comorbidities

Measures**

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

**Measures confirmed by CMS to be used in the VBP Model initially*

These measures are tied to the TMaH VBP Model, but CMS will also monitor additional measures to support broader care management and outcome goals

****Prenatal and postpartum care**: Timeliness of Prenatal & Postpartum Care (CBE 0418e); **Depression:** Screening for Depression & Follow-Up Plan (NQF 0418); **Low-risk c-section:** PC-02 Cesarean Birth NTSV (CBE 0471); **Low birth weight:** Low Birth Weight (CT DSS 2025); **Maternal morbidity:** *Measure TBD;* **Hypertension:** Optimal Postpartum Blood Pressure Control (NQF – *in development*)

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

MY3 PROVIDER INFRASTRUCTURE PAYMENTS (PIP)

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What is a PIP?

During Model Year 3 (2027), participating providers will receive PIPs to develop infrastructure and capabilities needed for TMaH VBP Model participation in 2029 and beyond

PIPs Can Be Used For:

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

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

DISCUSSION

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- What stands out to you about the TMaH payment model? What elements excite you, and what concerns do you have?
- Based on what we know about the TMaH payment model today, what areas of your practice operations do you anticipate needing to adjust or enhance?
  - Care team roles/staffing models
  - Community partnerships/referral pathways
  - Quality measure reporting
  - Quality improvement
  - Data integration
- How could MY3 PIPs be used to address those needs?

Image Source: Microsoft 365 Stock Photos

FQHCS

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FQHC OPTIONS

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1. Accountable Care Organization (ACO) Approach

Multiple FQHCs form a joint entity to pool volume, coordinate quality efforts, and share accountability.

2. AE Umbrella Model

FQHCs join a larger AE—such as a health system or integrated OB group—that holds the financial risk and redistributes incentives.

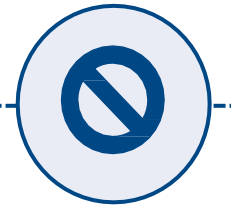
*Illinois plans to do this approach with a hospital, with an informal shared savings approach, when the FQHC does not do the delivery

3. Limited Risk/Reward

FQHCs participate as AEs but are exposed only to minimal shared risk/reward to a proportion of payments above Prospective Payment System (PPS).*

SMAs with an alternative payment model (APM) can put a portion of their existing APM at risk.

SMAs without an APM would need to create a new APM and put the amount above the PPS at risk.



4. No Risk/Reward

FQHCs participate without upside/downside risk through care delivery requirements, quality reporting, and access measures. Under this approach, FQHCs would not be eligible for provider infrastructure payments. Over time, FQHCs could participate in Options 1–3.

PROSPECTIVE RATE

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- Non-FQHC AEs will be paid a prospective monthly payment ("case rate") that provides consistent and steady funding to support professional services and care coordination, **starting in the second trimester until 60 days postpartum**
  - FQHCs are not eligible for this payment, given FQHCs already receive a prospective payment via their APM
  - CMS has delayed the TMaH Model prospective payment implementation for at least the first two years of implementation (2029 to 2030)
- DHCF is exploring alternative opportunities to support FQHCs who become AEs
  - *2026 (Fall): Survey/Maternity-Focused Meetings to Explore a Maternity APM*
  - *2027: Collect Maternity-Specific Costs + CMS Measurement Year 3 (MY3) Provider Infrastructure Payments (PIPs)*
  - *2028: Review Cost Data*
  - *2029: TMaH VBP (Shared Savings) Launches*

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

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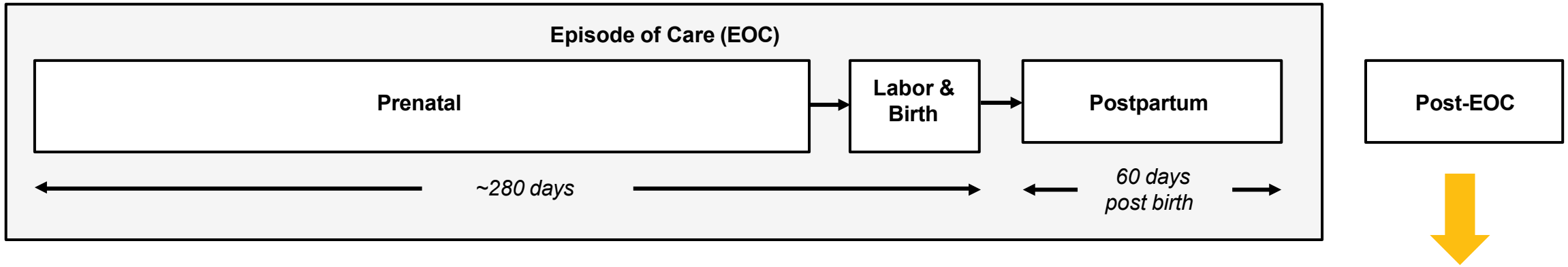

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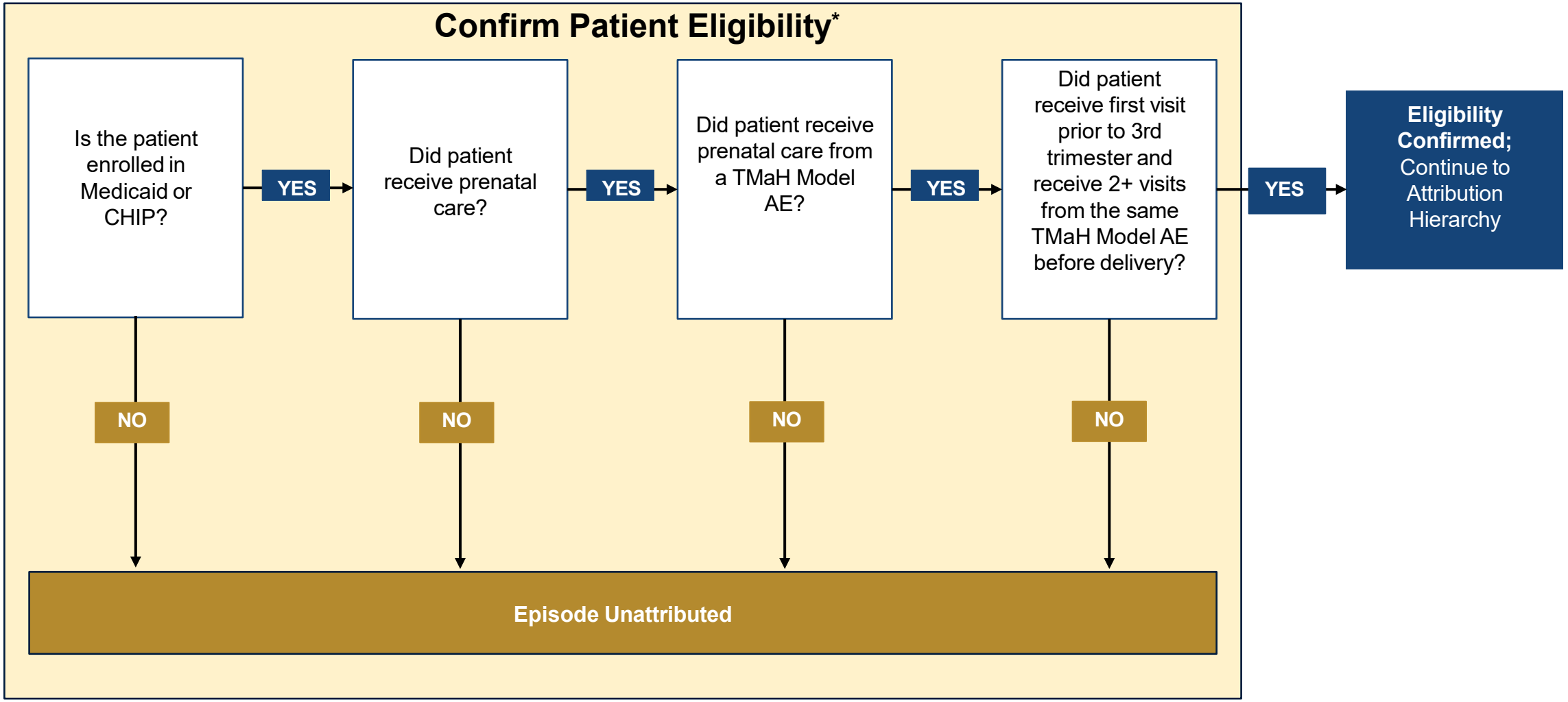

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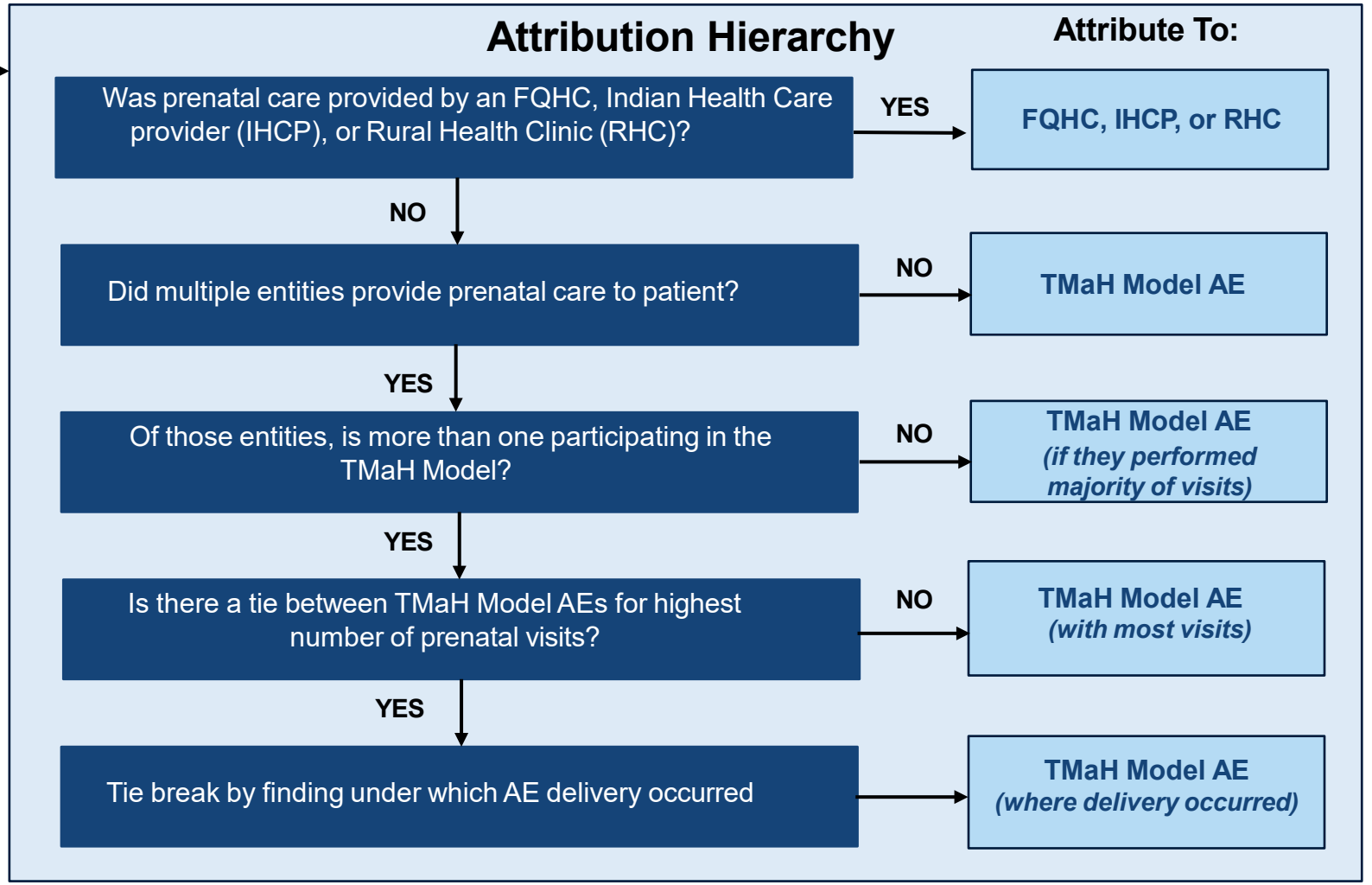

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- Identify chronic conditions
- Identify perinatal conditions (gestational diabetes, hypertensive disorders, prior obstetric history, etc.)

3. Community Deprivation Index (CDI)

- Apply area-level community deprivation index (CDI) to reflect non-clinical factors for episode resource needs

4. Develop Risk Score

- Create a score that allows weighting of cost relative to an average episode
- Conduct multivariable regression modeling

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

INCLUDED/EXCLUDED CRITERIA RATIONALE

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Image Source: Microsoft 365 Stock Photos

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

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

INCLUDED RETROSPECTIVE SERVICES

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Professional Services

- Labor & Delivery (L&D) Professional
- Outpatient Professional
- Inpatient Professional (codes unrelated to L&D Professional)
- Initial and basic screenings and assessments for Behavioral Health (BH) and Substance Use Disorder (SUD)

Facility & Diagnostic Services

- Inpatient Facility
- Outpatient Facility
- Outpatient Laboratory
- Outpatient Radiology (e.g., ultrasounds)

Other

- Telehealth and Remote Monitoring
- Certain Durable Medical Equipment (DME) (e.g., insulin devices, glucose monitor)
- Emergency Department & Observation Stay
- Pharmacy
- Other Services (e.g., any remaining uncategorized claims including interim labor management, unlisted maternity care/delivery procedures, emergency transportation)

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

EXCLUDED RETROSPECTIVE SERVICES

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Professional Services

- Pediatric professional services
- Comprehensive Assessments & services for BH/SUD* (e.g., treatment-related evals)
  - Services related to screenings for BH and SUD are included in the episode cost as part of pregnancy-related care that may occur during the perinatal window, and to incentivize providers to care for pregnant individuals with behavioral/SUD conditions; however, comprehensive services related to treatment are excluded.

Facility & Diagnostic Services

- Neonatal care/NICU
- Hospital costs and non-pregnancy related care (e.g., fractures)

Rx and Devices

- Pharmacy claims with excluded medications and high-cost drugs
- Breastfeeding supplies and other unspecified equipment

Other

- Non-emergency transportation
- Contraceptive services and procedures
- Flu and TdAP vaccines
- Pregnancy-related care (e.g., doula, dental, lactation) that is cost-effective and important for improving health outcomes
- Header-paid inpatient claim w/ an excluded service (e.g., appendectomy, hernia procedure)

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

THE ROLE OF QUALITY MEASURES IN THE TMAH VBP MODEL

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- Quality measures are a core part of VBP Model because they align provider incentives with better care and ensure that cost savings are achieved through improved outcomes
- The distribution of incentive payments will be adjusted based on the AE's quality performance

Performance Tier Calculation	Improvement Tier Calculation
• Based on all quality measures • Comparted to historical benchmarks	• Based on selected measures • Rewards year-over-year improvement
Performance Score	***OR*** **Improvement Score**

Final Score Calculation
Performance Score ***OR*** Improvement Score
Higher of the Two Options

AEs with low scores on both performance and improvement tiers can submit an **improvement plan to earn shared savings** in future years

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

TMAH VBP QUALITY MEASURES

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PRENATAL

Model Goals

- Engagement in prenatal care
- Screening, follow up, and management of comorbidities

Measures**

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

LABOR & BIRTH

Model Goals

- Rates of low-risk c-section
- Maternal morbidity
- Rates of low birth-weight infants

Measures**

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

POSTPARTUM

Model Goals

- Engagement in postpartum care
- Screening, follow up, and management of comorbidities

Measures**

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

**Measures confirmed by CMS to be used in the VBP Model initially*

These measures are tied to the TMaH VBP Model, but CMS will also monitor additional measures to support broader care management and outcome goals

****Prenatal and postpartum care**: Timeliness of Prenatal & Postpartum Care (CBE 0418e); **Depression:** Screening for Depression & Follow-Up Plan (NQF 0418); **Low-risk c-section:** PC-02 Cesarean Birth NTSV (CBE 0471); **Low birth weight:** Low Birth Weight (CT DSS 2025); **Maternal morbidity:** *Measure TBD;* **Hypertension:** Optimal Postpartum Blood Pressure Control (NQF – *in development*)

Source: CMS TMaH VBP Model Design Q2 2026 Update. June 17, 2026

DISCUSSION

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- What stands out to you about the TMaH payment model? What elements excite you, and what concerns do you have?
- What can FQHCs work on now to prepare for the TMaH payment model changes?

Image Source: Microsoft 365 Stock Photos

REMINDERS AND NEXT STEPS

TIMELINE FOR 2026

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May
Cross-Provider Journey Mapping (5/12/26)
1:1 TA

June
Improving Coordination Across Screening and Referral Workflows (6/9/26)
1:1 TA

July
Operational Sustainability for Maternal Health Services (7/14/26)
1:1 TA

August
Understanding the TMaH Payment Model for Physician Groups (8/11/26)
1:1 TA

We are here!

September
Building Referral Networks, Care Teams, and Clinical Partnerships (9/8/26)
1:1 TA

October
In-Person Workshop (10/20/26)
1:1 TA

November
Group Learning (11/10/26)
1:1 TA

December
Group Learning (12/8/26)
1:1 TA

MILESTONE 7 ACTIVITIES DUE DATE

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All Milestone 7 activities (Learning Collaborative participation) and required documentation must be completed and uploaded in D-TIPs by **December 15, 2026**, to receive the incentive payment of $15,000.

Image Source: Microsoft 365 Stock Photos

LOOKING AHEAD: NEXT STEPS

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Homework

- Consider at least one activity that you can start or enhance now for discussion in your individual coaching sessions.

Collaboration and Support

- **Goal**: Complete Learning Collaborative activities before **December 15, 2026**.

Coming Next!

- **Session 5**: Tuesday, September 8, 2026, 11:30 AM–12:30 PM
  - Focus: Building Referral Networks, Care Teams, and Clinical Partnerships
- **In-Person Workshop**: Tuesday, October 20, 2026 (***SAVE THE DATE!***)

WRAP UP AND NEXT STEPS

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- Please complete the online **evaluation by <u>August 21</u>!**
  - **<u>If you would like to receive CME and CE credit, the evaluation will need to be completed</u>.** You may use the link in the chat box or scan the QR code to access the evaluation.

- The slides and a recording of the webinar will be emailed to registered participants and available soon on the Integrated Care DC website.

- For more information about Integrated Care DC, please visit: www.integratedcare.dc.gov

CONTACT US

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REFERENCES

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INTEGRATED CARE DC
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- Centers for Medicare & Medicaid Services (CMS): *Transforming Maternal Health (TMaH) Value-Based Payment (VBP) Model Design Quarter 2 2026 Update*. June 17, 2026.