Transforming Maternal Health (TMaH) Model Value-Based Payment Frequently Asked Questions

Overview

CMS will be regularly releasing Frequently Asked Questions (FAQ) based on questions received on the Transforming Maternal Health (TMaH) Value-Based Payment (VBP) Model. The FAQ below is related to material presented during the **TMaH Value-Based Payment Design Session II Workshop** on February 11, 2026 – please see the workshop materials for additional details.

Question	Answer
What is an Accountable Entity (AE) and which providers can participate in the TMaH VBP Model?	TMaH Model Accountable Entities (AEs) are provider organizations that deliver prenatal, labor and delivery, and postpartum ("perinatal") care and agree to be accountable for cost and quality outcomes under the TMaH VBP Model. AEs are intended to be the providers with a direct impact on patient care. These providers have the greatest ability to manage care continuity and influence outcomes across the perinatal period. For this reason, the model prioritizes practice-level accountability, where performance tracking and financial incentives can most directly support care improvement. An AE may be structured as: 1. A single organization under one tax identification number (TIN)—such as an obstetrics and gynecology (OB/GYN) practice, hospital-based OB/GYN practice, family medicine practice, federally qualified health center (FQHC), midwifery practice, or birth center—where the organization provides all perinatal professional services; OR 2. Multiple organizations ("Participant Organizations") that formally join together to meet program requirements—for example, one practice providing prenatal and postpartum care and another providing delivery services. Participating organizations contract with the state or managed care plan through a single primary TIN, while maintaining their individual operations.
Do state Medicaid agencies (SMAs) have the flexibility to reimburse a variety of maternal health services such as non-nurse midwives (nurse midwives already must be reimbursed), lactation consultants, doulas and perinatal community health workers (P-CHWs) as part of their TMaH VBP Model?	Yes, in fact we encourage the inclusion of the full array of maternal health services to be included in care teams.

Question	Answer
Who contracts with providers under the TMaH Model in managed care states?	Managed Care Plans will contract with participating AEs and administer the prospective monthly payment and retrospective payments consistent with model requirements. The TMaH Model team is working with the Center for Medicaid & CHIP Services (CMCS), which sets national policies and manages operations for the Medicaid and Children's Health Insurance Program (CHIP), to ensure that shared savings are distributed in a manner that aligns with Medicaid managed care regulations.
For FQHCs that provide only prenatal and postpartum care and work with OB/GYNs who deliver at the hospital, will the FQHC have to join with the OB/GYN delivery group to become an AE?	Yes, an AE must include either one practice that performs all perinatal care services including labor/delivery, or multiple entities that collectively provide all perinatal care services. In this case, since the FQHC providers do not provide patients with labor/delivery services, the FQHC would need to join with the OB/GYN delivery group to form an AE.
Who are the ideal candidates to become an Accountable Entity (AE)?	The ideal candidate for an AE in the TMaH Model is a practice that provides all perinatal care services, or that provides prenatal and postpartum care and then has a partnership with practice that performs labor and delivery care. This type of entity could be, for example, a standalone OB/GYN practice, a hospital-based OB/GYN practice, or other practices that deliver prenatal care (e.g. birth centers, family medicine practices, FQHCs, rural health clinics). Practices that do not provide all perinatal care would be required to partner with a practice that offers the missing service in order to form an AE for the TMAH VBP Model. Additional information and details on AEs and attribution scenarios are included in the February 11, 2026 workshop materials.
If a practice providing prenatal/postpartum care and a practice performing labor/delivery services do NOT want to form an AE, can they split the retrospective shared savings payment?	No. The retrospective shared savings payment is only available to AEs. The two practices would be required to form an AE to be eligible for the retrospective shared savings payment.
If a prenatal provider and a delivery provider want to come together to form an AE, can they split the retrospective shared savings payment?	Yes. If a practice providing prenatal and postpartum care (midwifery practice, FQHC, family medicine practices etc.) and a labor/delivery practice (e.g. hospital-based OB/GYN practice) join together to form an AE, both the prenatal/postpartum practice and hospital-based OB/GYN practice together can decide how to split the retrospective shared savings payment. However, the model will require that hospitals serving within or as the AE provide contractual assurances that shared savings will be reinvested in preventive perinatal services (including clinical staffing, community health workers, care coordination programs, or other maternal health service enhancements).
What will make a patient eligible for the TMaH Model?	All Medicaid and CHIP enrolled pregnant women between the ages of 12 and 55 are eligible to be enrolled in the TMaH Model.

Question	Answer
What conditions/characteristics will exclude otherwise eligible patients?	The following types of beneficiaries or events will be excluded from the TMaH VBP Model (additional technical specifications are forthcoming): • Dual eligible beneficiaries • Individuals who are out of age range (younger than 12 or older than 55 years old) • Individuals who have experienced a miscarriage or stillbirth • Individuals who left care against medical advice • High-cost outliers or conditions • Individuals who switched or transferred providers in third trimester
In states that deliver Medicaid services using both managed care and fee-for-service (FFS) payment, do SMAs need to include FFS patients in the TMaH VBP Model?	No. SMAs can elect to implement the TMaH VBP Model in either their managed care or FFS programs, or both.
How does the TMaH VBP Model integrate other providers who also play a role in improving perinatal and birth outcomes, such as perinatal providers of specialty care and pediatricians?	CMS acknowledges that other providers, such as perinatal providers of specialty care and pediatricians, may also play a critical role in supporting improved perinatal and birth outcomes. Please also note that multiple entity types may join together as one AE. For example, a specialty provider practice that provides services to a high proportion of pregnant mothers could be included as a Participant Organization within the AE. Importantly, the AE must deliver all perinatal care services, including labor/delivery services to be included in the perinatal episode of care. We are not expecting that pediatric practices would be included as a Participant Organization within the AE, since they do not typically provide perinatal care services.
Does the TMaH VBP Model assume that FQHCs, multiple practice groups, and larger healthcare systems will contractually connect as Accountable Care Organizations (ACO)?	There is no official designation of "ACO" in Medicaid, but multiple organizations (“Participant Organizations”) can formally join together to meet program requirements to become an Accountable Entity (AE).
Can a birth center be an AE on its own?	Yes, so long as it meets the AE requirements.
Will CMS provide any more guidance about the Provider Infrastructure Payments (PIP)?	Yes, CMS plans to release additional guidance for SMAs on the use of Provider Infrastructure Payments in Q2 CY 2026. Please also send any specific questions you may have to your Project Officer. CMS will address state-specific questions as appropriate.
Are there thresholds or tiers for performance-based payments in the TMaH VBP Model?	In the retrospective component of the TMaH VBP Model, quality measures will include performance thresholds for determining shared savings, and the distribution of incentive payments will be adjusted based on each AE's quality performance. Higher quality performance may result in a greater percentage of shared savings being awarded. This approach ensures that incentive payments reward high-value care rather than cost reductions alone.

Question	Answer
What is the difference between the prospective monthly payment and shared savings payments and why does the TMaH VBP Model have two types of payments?	Prospective payments are monthly payments, also called a case rate, triggered during the second trimester and based on each Accountable Entity's historical professional claims; these payments replace fee-for-service or global payments for covered services and provide predictable, upfront funding to support care coordination, prevention, and comprehensive prenatal and postpartum care. Retrospective performance-based payments are calculated at the end of the episode, and AE's are eligible for shared savings contingent on meeting defined quality thresholds and performing below a risk-adjusted cost benchmark. The cost benchmark includes professional and facility fees. Together, these two payment types reflect common VBP design: prospective monthly payments stabilize revenue and enable practice-level change, while shared savings align financial rewards with improved outcomes and cost effectiveness over the full episode of care.
Are the TMaH VBP Model prospective monthly payments launched when a patient enters the system or universal based on the estimated number of patients?	Within TMaH VBP Model, the prospective monthly payment, is triggered by a prenatal visit in the second trimester at which time the pregnant person is "attributed" to the AE. Once triggered, the case rate continues to the second month postpartum unless perinatal care services are transferred to a provider outside of the AE. Patients are attributed beginning in the second trimester to avoid high rates of provider switching in the first trimester and to support appropriate referrals without incentivizing premature retention or offloading of patients. Attribution does not begin in the third trimester to ensure providers have sufficient time to influence outcomes and are not discouraged from referring patients who require higher levels of care.
How does the TMaH VBP Model affect a practice's revenue compared to historical Medicaid payments?	Participating in the TMaH VBP Model will provide practices with upfront support, predictable monthly revenue, and the opportunity to earn additional performance-based payments. Practices that join TMaH may be eligible for Provider Infrastructure Payments, which can help fund care delivery improvements, expand capacity, and build the capabilities needed for value-based care—without requiring practices to finance these investments on their own. Practices can also apply these new VBP capabilities beyond TMaH to other value-based arrangements. In addition, practices will receive a monthly prospective monthly payment (case rate) that is based on their historical professional claims, providing a predictable revenue stream that generally reflects what they have earned in the past. This steady monthly payment supports day-to-day care delivery and care coordination throughout the perinatal period. At the end of the episode, practices may also earn shared savings when they meet quality targets and reduce avoidable costs compared to a risk-adjusted benchmark. Retrospective shared savings is designed to reward high-quality, efficient care and can increase overall practice revenue. CMS will also provide technical assistance to support clear communication about expected revenue impacts and help practices understand how TMaH payments compare to historical Medicaid payments.

Question	Answer
What happens if an Accountable Entity (AE) does not meet the quality requirements?	If an AE does not meet the minimum quality performance requirements—including either established performance thresholds or defined improvement targets—it would not be eligible to receive shared savings for that performance period. In this case, the AE would continue to receive its prospective monthly payments, but no additional incentive payment would be awarded. This approach ensures that shared savings are only distributed when cost performance is accompanied by acceptable quality of care. CMS will provide additional details on the quality calculations in future workshops and technical specifications.
Do SMAs need to allocate specific funds towards the TMaH VBP Model payments in addition to FFS payments?	No. SMAs will not be required to pay providers anything additional outside of the prospective monthly payments, which are based on historic payment rates, and shared savings for AEs that meet quality benchmarks and reduce costs.
Can support for those providing wraparound services be a part of prospective monthly payments or retrospective payments?	Yes, AE's can use their prospective monthly payments or part of their shared savings to support a variety of services providing better care for their perinatal patients, including home visits.
Why are we only paying for services until 60 days postpartum when most states are now covering 12 months? What will happen after 60 days?	The TMaH VBP Model includes services through 60 days postpartum for two primary reasons. First, limiting the episode to 60 days allows for timely reconciliation and payment, ensuring that performance-based incentives are delivered close enough to the care period to meaningfully influence provider behavior and care delivery. Second, from a clinical perspective, the majority of pregnancy-related complications occur within the early postpartum period, particularly in the first six weeks, as noted by the American College of Obstetricians and Gynecologists (ACOG). Care beyond 60 days postpartum remains critical and continues to be covered under Medicaid, but will be paid for through fee-for-service and/or other state and managed care plans mechanisms.
How are prenatal and preventive care costs included in shared savings when Accountable Entities (AEs) receive a flat prospective monthly payment?	The prospective monthly payment is based on each AE's historical Medicaid payments, which already include the costs of prenatal and preventive care. During the episode, these services are generally paid through the prospective monthly payment instead of fee-for-service. Some services may be excluded from the prospective monthly payment—to ensure that they continue to be provided when clinically appropriate (for example, ultrasounds)—but will still be included in the cost benchmark for the retrospective payment.
Will SMAs be allowed to decide which type of VBP arrangement to implement, based on their state context?	No. In order to ensure robust evaluation of the model and it ultimate ability to be certified and expanded (per CMS statute), CMS intends for the TMaH VBP Model to be consistent across all participant SMAs, with some flexibility as needed for specific state context and implementation. As described in the "Roadmap to Value" section of the Notice of Funding Opportunity (NOFO), CMS will be leading the design of the maternal health VBP arrangements that all SMA participating in the TMaH Model are then expected to implement.

Question	Answer
How will the shift from receiving global payments to participating in TMaH value-based payment (VBP) Model benefit the provider and practice?	While global payments simplify billing, they are not tied to performance or outcomes. Participating in the TMaH VBP odel builds on that simplicity while adding accountability and upside potential by linking payment to quality and cost performance. Practices continue to receive predictable, upfront payments through the prospective monthly payment, and also gain the opportunity to earn shared savings when improved prenatal and postpartum care leads to better outcomes and lower avoidable costs.
How will TMaH VBP Model payments account for high-risk patients?	First, risk adjustment will be applied to retrospective cost benchmarks, so that AEs serving higher-risk patient populations are compared against appropriately adjusted spending targets. Additionally, TMaH will consider risk adjustment for relevant quality measures. In addition to risk adjustment, the TMaH VBP Model is designed to ensure that providers caring for higher-risk pregnant and postpartum individuals are not unfairly penalized for the additional costs necessary to provide perinatal care to this population. For example: • Understanding that practices will have different starting points on quality metric performance, practices will be eligible for shared savings for meeting the cost benchmark and making *improvements* towards the benchmark, even if the quality measure benchmark is not met.