The CMS Transforming Maternal Health (TMaH) Model

TMaH Value-Based Payment Design Session II

February 11, 2026

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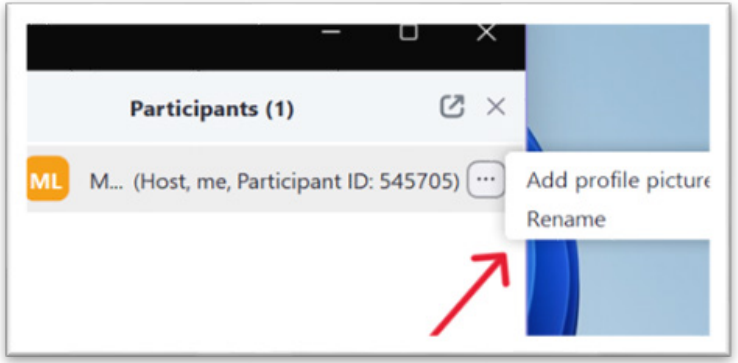

Closed captioning is available at the bottom of the screen

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Agenda

1. Introduction and Overview
2. Value-Based Payment (VBP) Design
   - Accountable Entity
   - Safety Net Providers
   - Inclusion / Exclusion Criteria
   - Risk Adjustment
   - Quality Measures
3. Questions and Breakout Sessions
4. Closing

Meeting Objectives

State Medicaid agencies (SMAs) will learn more about:

- The **Accountable Entity** structure within the TMaH VBP Model
- Potential pathways for **Safety Net Providers**, like Federally Qualified Health Centers (FQHCs) and Tribal Health Providers, to participate in the TMaH VBP Model
- **Inclusion and exclusion criteria** for the prospective and retrospective payments
- Preliminary concept for **risk adjustment**
- **Quality measure concepts** that may be used in the TMaH VBP Model for accountability

Disclaimer

The information provided in workshops is subject to change based on SMA feedback and additional testing/analysis.

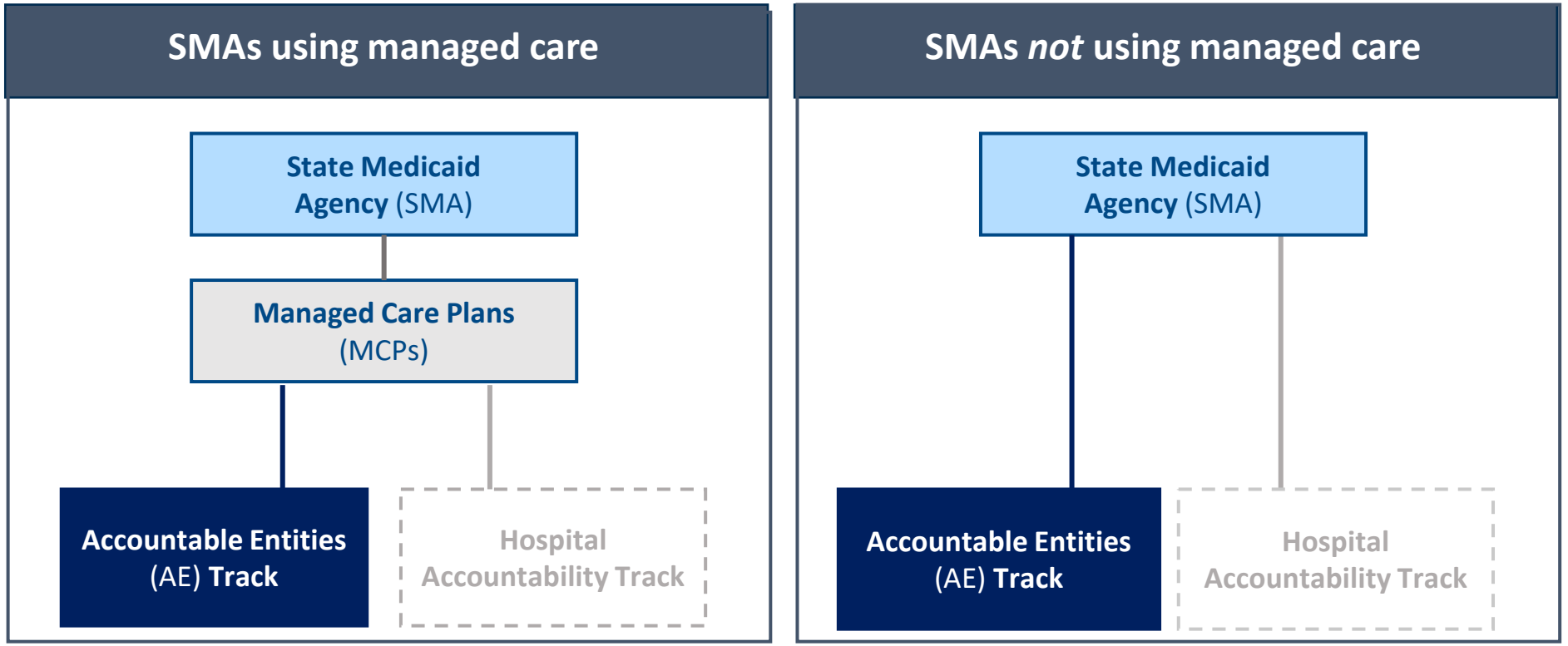
Opening Remarks from CMS

Overview of TMaH Model VBP Strategy

TMaH VBP Model includes two tracks with implementation varying based on the role of managed care in each state.

AE Track refers to the payment mechanisms by which the SMA holds the AEs accountable for their attributed patients' perinatal journey.

Hospital Accountability Track refers to the mechanism by which the SMA holds the sites of delivery accountable for outcomes.



Today, we will focus on the Accountable Entity Track.

VBP Design: Review from October 2025 VBP Workshop

Why Providers Will Benefit from Participating in the TMaH VBP Model

The TMaH VBP Model is designed to:

- **Provide maternal health providers with upfront funds** and predictable revenue to invest in prevention
- **Improve patient outcomes by incenting screening, identifying of, and providing continuous care for high-risk** patients across the spectrum of physical and behavioral health
- **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

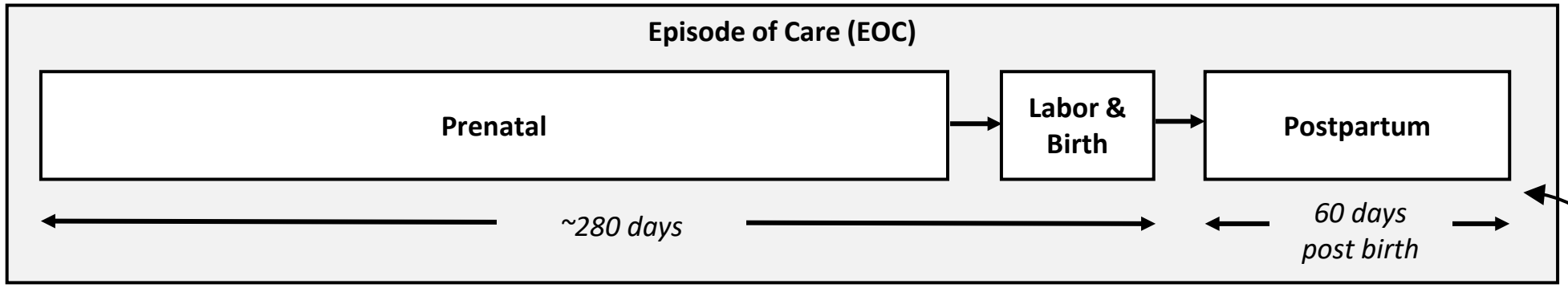
Reduced rates of low-birth weight infants

Improved experience of care for pregnant women

Accountable Entity (AE): Definition and Requirements

- Accountable Entities are the entities accountable for care in the TMaH Model, **primarily practices**, with some exceptions for hospitals, providing prenatal, labor/delivery, and/or postpartum care (perinatal)
  - Targeting obstetric and midwifery practices because these practices often focus on providing prenatal and postpartum care
  - Participating AEs must be identified by a tax identification number (TIN)
  - The AE may be one practice, or multiple practices that join together
- AEs are **accountable** through upside and downside risk (shared savings and losses) for:
  - **Cost** and **quality outcomes**
  - Ensuring all practices (if the AE comprises more than one practice) adhere to the **terms and conditions** of participation
  - **Distributing** shared savings **or recouping** phased in shared losses

Prospective Monthly Payments



Newborn costs are excluded from the EOC given neonatal and pediatric influence out of AE's control

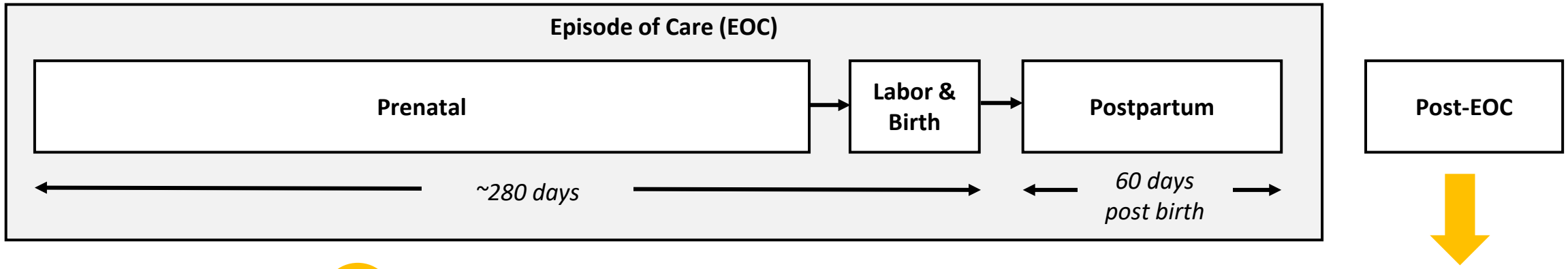
Prospective monthly payments triggered by prenatal appointment in the second trimester

1

SMA/Managed Care Plan (MCP) will pay AEs a <u>prospective monthly payment (the case rate)</u> starting in the second trimester until 60 days postpartum that provide consistent and steady funding to support professional services and care coordination.

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

Retrospective Shared Savings



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Retrospective shared savings (or phased-in losses)

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

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

VBP Support Available to Practices: Provider Infrastructure Payments (PIPs)

- VBP participation is an opportunity for practices to participate in care delivery transformation activities and readiness for the TMaH VBP Model
- The model included the PIP to aid practice transformation activities and build readiness to implement the TMaH VBP Model
- All SMAs will be making PIP payments in 2027 to ready practices to participate in the TMaH VBP Model in 2028 and beyond*
- CMS will share additional guidance in the spring of 2026 and hold the PIP Workshop Session II in Q3 2026
- State coaching teams will support SMAs in understanding guidance and planning efforts

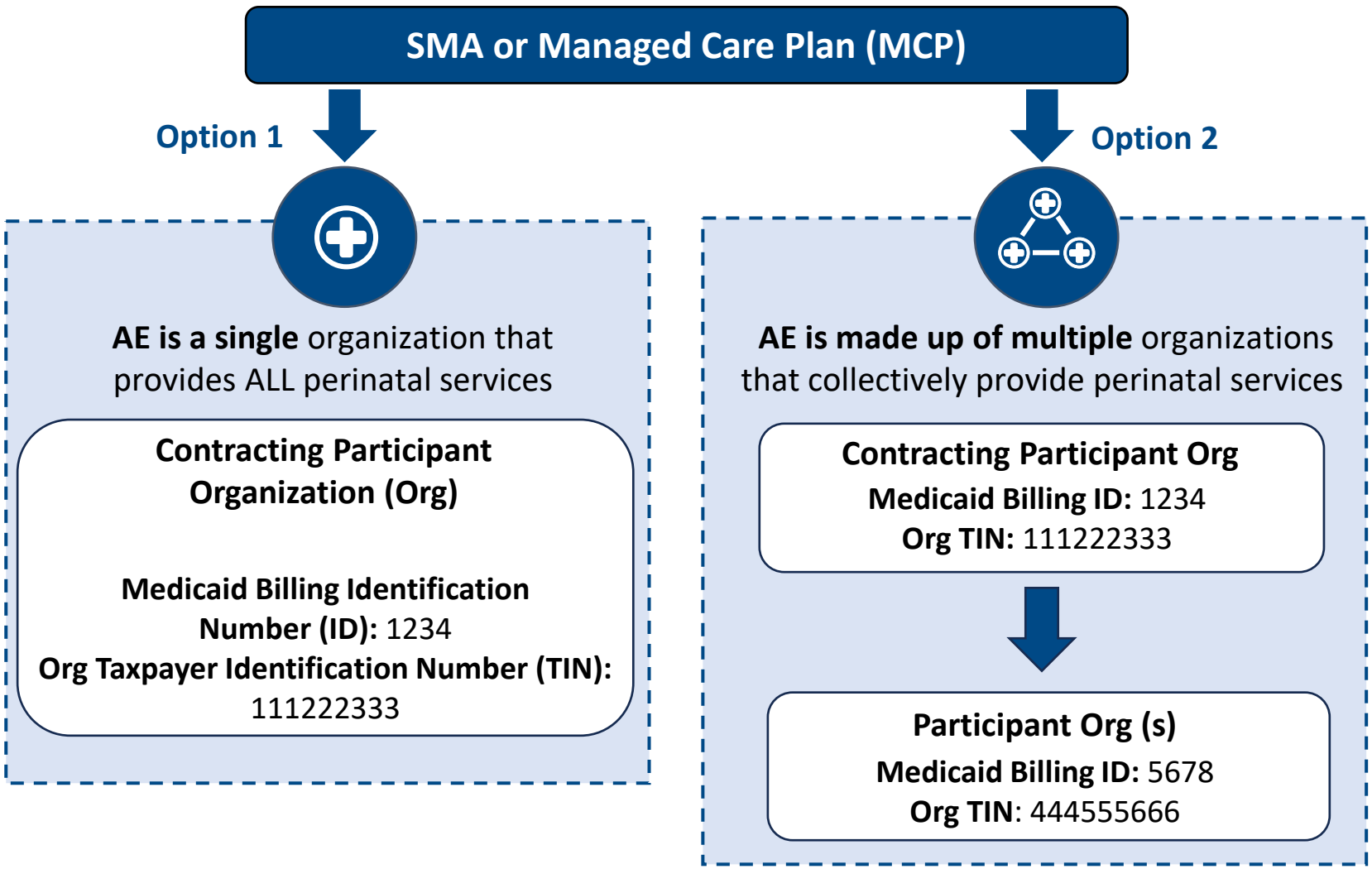
PIP Payments Can Be Used For:

- ☐ 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)

*Three SMAs will implement PIPs in 2026.

VBP Design: Accountable Entity (AE)

Accountable Entity (AE) Structure



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

AE may enter **downstream contractual arrangements** with Participant Organizations to meet delivery requirements.

AE Eligibility Criteria

Legal Requirements	❑ **Be a legal entity** formed under applicable state, federal, or Tribal law and authorized to conduct business in the state in which it operates ❑ **Be Medicaid-enrolled** with an active TIN and organizational Medicaid Billing ID (and appropriate CHIP enrollment and billing identifier, if required by the state)
Service Provision Requirements	❑ Provides the **full range of perinatal care** - prenatal, delivery, and postpartum care - which could be provided among different organizations within the AE ❑ Employ or contract with providers who bill for **prenatal, postpartum, and delivery services** (demonstrated by submitting claims with the appropriate codes*) ❑ **Bill under qualifying maternity care specialty types*** ❑ Collectively perform a **minimum number of deliveries** (between 30-50 births per year, further details forthcoming) annually for Medicaid patients
Contractual Requirements Between AEs and Other Participant Organizations	❑ Comply with **applicable model requirements**, such as data and reporting requirements, and participate in performance measurement and financial reconciliation ❑ **Agree to directly receive a case rate for perinatal services** provided to attributed patients in lieu of certain Medicaid FFS payments

*Examples of codes that are used to identify prenatal visits to start the case rate payments and/or show administration of those services, as well as provider types who qualify to receive case rate payments are provided in Appendix A.

Hospital Participation in AEs

- While hospitals may serve as Participant Organizations, they are restricted from serving as the AE ***unless*** they provide:
  - The **full range of perinatal care** (prenatal, delivery, and postpartum)
  - Provide **contractual assurances** that at least 80% of the AE's portion of the shared savings payment will be dispersed to the individuals who provided a majority of the prenatal and postpartum care
- The TMaH Model allows hospital participation subject to these requirements to ensure increased accountability for all primary actors involved with perinatal care

Example of a hospital AE: A hospital in a rural or underserved area that provides perinatal care services but does not have an OB-GYN practice

Note: This slide is about hospitals participation in AEs. It is not about the separate Hospital Accountability Track for which there will be more information in the future.

What Can an AE Look Like?

The following slides contain examples of what it might look like when an AE is comprised of:

- A **single organization** provides all perinatal care
- **More than one practice** that collectively provides all perinatal care

Example 1: Single Organization as the AE

SMA or MCP

SMA or MCP contracts with AE

Contracting Participant Org: OB/GYN Practice or Midwifery Practice

Employs clinicians providing delivery, prenatal, and postpartum*

Patient Perspective

Patients receive prenatal, postpartum, and delivery care from **one organization**

*Minimum delivery volume threshold between 30-50 births per year, further details forthcoming

Why this is an AE

An organization operating under a single TIN that:

- Provides the full continuum of perinatal care (prenatal, delivery, and postpartum care) and
- Contracts with the SMA or MCP to be accountable for cost and quality under the TMaH VBP Model

How it Operates

The practice:

- Employs all clinicians needed to deliver comprehensive perinatal care
- May operate at multiple sites of care
- Receives PIP funding to prepare for the TMaH VBP Model, including, for example: hiring a staff member to support VBP administration, financial oversight and claims submissions

Example 2: Two or More Organizations as the AE

SMA or Subrecipient (MCP)

SMA or MCP contracts with AE

Contracting Participant Org: FQHC

Employs clinicians providing prenatal and postpartum care

AE contracts with Participant Organization

Participant Org: Hospital or Hospital Owned OB/GYN Practice

Employs clinicians providing delivery and postpartum care

Patient Perspective

Patients receive prenatal, postpartum, and delivery care from **multiple organizations**

Why this is an AE

Two Participant Organizations coordinate to collectively provide the full continuum of perinatal services.

One organization contracts with the SMA or MCP as the AE which contracts downstream with a Participant Organization to meet eligibility requirements.

How it Operates

- The two organizations collectively employ all clinicians needed for the full perinatal episode
- AE receives PIP funding to, for example: formalize patient and provider workflows between both organizations and hire a staff member to support VBP administrative and financial oversight

Who Cannot be an AE

Entities that do not alone meet the eligibility criteria include:

- ✖ Individual clinicians without organizational infrastructure
- ✖ Hospitals that do not provide prenatal or postpartum services
- ✖ AEs below minimum delivery volume threshold*
- ✖ Practices/FQHCs where providers do not perform labor/delivery cannot be AEs on their own

*Minimum delivery volume threshold between 30-50 births per year, further details forthcoming

VBP Design: Safety Net Providers

Safety Net Provider Participation

- Safety net providers* (SNPs) provide critical maternal health care services
- Unique SNP reimbursement structures require flexibility related to phased-in downside risk and potentially the case rate payment
  - **FQHCs:** The Medicaid Prospective Payment System (PPS) is the single required rate that states must pay FQHCs in a single visit. Many SMAs pay an alternative rate either equal to or greater than the PPS rate, known as an Alternative Payment Methodology (APM) rate
  - **Tribal Health Providers**: The Indian Health Service (IHS) All-Inclusive Rate (AIR) is the U.S. Office of Personnel Management-determined payment methodology for Medicaid or Medicare services furnished in IHS-operated or Tribally operated (Section 638) facilities
- The TMaH VBP Model will phase in downside risk over time
- SNP dynamics in your state will be discussed in follow-up TA calls

*This workshop focuses on FQHC and Tribal Health providers, we will discuss other types of SNPs providing perinatal care services in your state.

Optional Pathways for FQHC Participation

1. ACO Approach

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

2. AE Umbrella Model

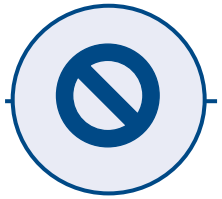
FQHCs join a larger AE—such as a health system or integrated OB group—that holds the financial risk and redistributes incentives.

3. Limited Risk/Reward

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

SMAs with an 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.

*Payments above PPS are designed to ensure cost coverage, rather than incentive payments.

Optional Pathways for Tribal Health Participation

1. AE Umbrella Model

Tribal providers join an AE that takes on downside risk on behalf of the Tribal provider(s).

2. No Risk

Tribal providers are eligible for shared savings if they reduce costs and improve quality, but downside risk is not required.

Recruiting for the TMaH VBP Model

- The TMaH VBP Model is focused on practice-led maternity care to maximize the benefits of the VBP model and improve outcomes
- State and regional maternal health care delivery structures vary in:
  - Use of integrated health systems
  - Experience with independent hospital-based outpatient obstetric practices
  - Types of care provided by safety net providers
- **CMS will work with each SMA** to help identify and recruit AEs for the TMaH VBP Model

VBP Design: Payment Rate Inclusion/Exclusion Criteria

Included Services for Prospective and Retrospective Payment

	Service
Professional Services	• Labor & Delivery (L&D) Professional* • Outpatient Professional* • Inpatient Professional (codes unrelated to L&D Professional)
Facility & Diagnostic Services	• Ultrasounds • Inpatient Facility • Outpatient Facility • Outpatient Laboratory • Outpatient Radiology
Other	• Certain Durable Medical Equipment (DME) • Pharmacy • Emergency Department & Observation Stay • Other Services (uncategorized claims that are determined to be included services)

Rationale

Included services are intended to incent use of standard services and disincentivize overutilization of unnecessary services.

Except for L&D and outpatient professional services, other services are included in the retrospective episode but excluded from the prospective monthly payment to ensure that providers are not discouraged from ordering clinically appropriate services.

*Services in blue font with * are included in basis for prospective and retrospective payment

All services in black font are included in the basis for retrospective payment but not in the prospective monthly payment

Excluded Services for Prospective and Retrospective Payment

	Service
Professional Services	• Pediatric professional services • Behavioral Health and Substance Use Disorder (SUD) services*
Facility & Care Services	• Neonatal care/NICU • Hospital costs and non-pregnancy related care
Medications & Devices	• Pharmacy claims with excluded medications/high-cost drugs • Durable Medical Equipment (DME)**, including home monitoring equipment
Other	• Non-emergency transportation • 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 claims with excluded services (e.g., appendectomy, hip replacement, hernia procedure) • Contraceptive services and procedures

Rationale

Certain services such as behavioral health, SUD, home monitoring, doula, dental and lactation care are intentionally excluded to incent providers to use them.

Other services such as pediatric and neonatal care are excluded because they are beyond the control of the provider.

*Services related to screenings for behavioral health and substance use disorder 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. Services related to treatment would subsequently be excluded.

**Certain DME is excluded from both the prospective and retrospective payments

Non-Attributable Patients or Events

The following patients or events will be excluded from reconciliation

- Dual eligible patients
- Out of age range (<12 and >55)
- Miscarriages
- Stillbirth
- Left care against medical advice
- High-cost outliers and conditions
- Switched or transferred providers in third trimester

VBP Design: Risk Adjustment

Risk Adjustment

A process used to account for differences in the health status and expected medical costs of patients when comparing outcomes, setting payments, or evaluating performance.

Why is risk adjustment necessary?

- Ensures the TMaH Model target price fairly reflects the underlying health risk of the pregnant population attributed to each AE and therefore does not unfairly penalize providers serving sicker populations
- It helps compare spending across patients with different risk levels

How Will the TMaH Model Implement Risk Adjustment?

CMS is considering using the **Chronic Illness and Disability Payment System (CDPS), a risk adjustment system** that is widely used in Medicaid programs and can be applied to a maternal health population.

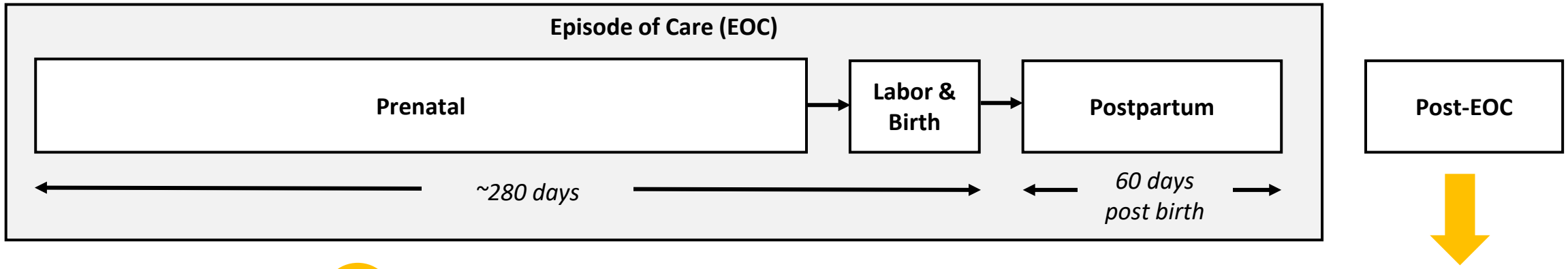
Risk-Adjusted Target Prices:

- Constructed using historic claims, encounters, and eligibility data from an established **historical baseline** period to create relative risk scores
- **Reassessed** after the performance period

CMS is continuing to test and refine risk adjustment methodology and additional details will be forthcoming. Additionally, TMaH will consider risk adjustment for relevant quality measures.

VBP Design: Quality Measures

The Role of Quality in the TMaH VBP Model



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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 target price and adjusted for quality performance.** Total cost includes professional and facility claims.

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

TMaH VBP Model Quality Concepts

Inclusion	AE Track	Hospital Accountability Track
Likely	• Timeliness of prenatal and postpartum care • Depression screening and follow up • Substance use disorder screening • Maternal hypertension control • Maternal morbidity (e.g., complications) • Low-risk cesarean delivery	• Low-risk cesarean delivery • Maternal morbidity, including obstetrical complications
Under Discussion	• Low birthweight • Upstream drivers of health risk screening • Patient experience measure	• Early elective delivery (EED)

The timing of reporting or tying these measures to payment needs are to be determined. We do not expect that all measures will be used in the first phase of implementation.

Q&A

Breakout Discussions

Breakout Rooms

- Each of the 4 breakout rooms will share reflections from the list of questions on the next slide
- After the session, each group will share one key finding from their discussion
- Please designate a spokesperson to briefly summarize your group's insight
- We'll reconvene in the main session to hear from:
  - **Room 1**: AL, DC, MN, OK
  - **Room 2**: AR, LA, MS, NJ
  - **Room 3**: CA, IL, KS, WI
  - **Room 4**: ME, SC, WV

Breakout Room Questions

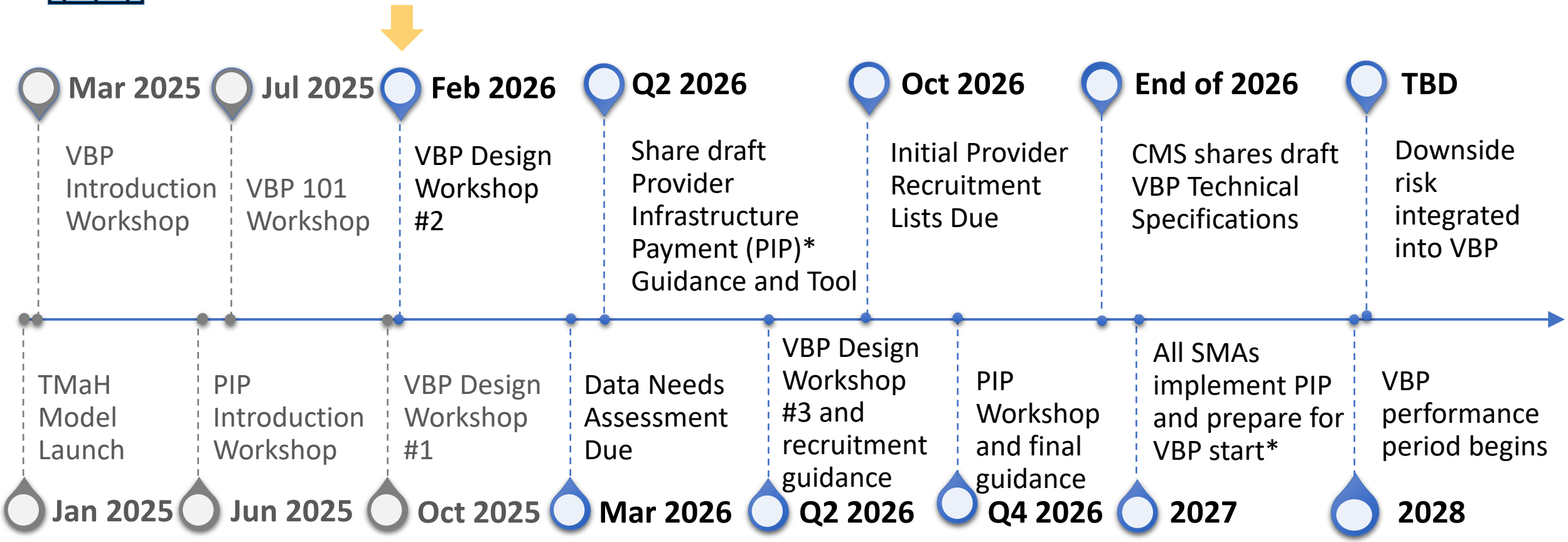
1. **Accountable Entities:** Which practice and/or hospital types do you want to recruit to participate in the TMaH VBP Model in your state?
   - Would they be a single or multiple organization AE?
   - What provider types will be most interested in the TMaH VBP Model?
   - What provider types will be more complex to recruit?
2. **Safety Net Providers (SNPs):** Which SNP (FQHC/RHC/Tribal) risk options would work best in your state?
   - What additional information does your state need to recruit SNP participants?
3. **Quality Measures for VBP:**
   - Are these the right measures for your state?
   - Any reactions on feasibility?

Report Out

- Please share:
  - Your group's main insights or recommendations in each of the three topic areas
  - Any emerging themes or questions?
- Report Out Order
  - **Room 1**: AL, DC, MN, OK
  - **Room 2**: AR, LA, MS, NJ
  - **Room 3**: CA, IL, KS, WI
  - **Room 4**: ME, SC, WV

Closing

TMaH VBP Timeline



Ongoing VBP Feedback from SMAs and VBP TA to SMAs

*Three SMAs will implement PIPs in 2026

Upcoming Workshops

Topic	Date	Description
Data Infrastructure	Q2 2026	• Overview of data needs assessment • Technical assistance for VBP data needs
VBP Design Workshop Session III	Q2 2026	• Additional TMaH VBP Model technical specifications: AE recruitment, attribution logic and quality measures
PIP Workshop Session II	Fall 2026	• Updated guidance on recruiting and executing contracts with AEs for PIP funding dispersal • Lessons learned from SMAs implementing PIPs in 2026 • PIP tool (questionnaire) • Operationalizing the tool and PIP payments

Additional Information and Resources

For more information and to stay up to date on upcoming TMaH Model events and resources:

- TMaH Model Website: www.cms.gov/priorities/innovation/innovation-models/transforming-maternal-health-tmah-model
- Overview Factsheet: www.cms.gov/files/document/tmah-fact-sheet.pdf
- Patient Journey Map: www.cms.gov/files/document/tmah-journey-map.pdf

Thank you for your time!

Please take the survey following this webinar so we can learn how to make our events better.

Questions? Please email your TMaH PO.

Appendix A: Prenatal Care and Delivery Services Code List and Qualifying Maternal Health Providers

Code List Under Consideration for TMaH Prenatal Care and Delivery Services Included in VBP Payments

Prenatal Care Codes	• Trigger diagnosis codes indicating pregnancy (ICD-10 codes to be specified in the technical specifications), **AND** • Qualifying Evaluation & Management (E&M) codes: 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

Delivery Procedure Codes or Delivery-Related Diagnosis Codes*	• Delivery procedure codes:
	  • Vaginal delivery: 59400, 59409, 59410
	  • Cesarean delivery: 59510, 59514, 59515
	  • VBAC and related delivery codes: 59610, 59612, 59614, 59618, 59620, 59622

Qualifying POS Codes	11 (Office), 19 (Off-campus outpatient hospital), 21 (Inpatient hospital; delivery only), 22 (On-campus outpatient hospital), 23 (Emergency room—hospital; delivery only), 50 (FQHC), 72 (RHC), Tribal POS codes

*This list of procedure codes does not represent the complete list that will be included in forthcoming technical specifications.

TMaH Qualifying Maternal Health Providers

The following types of providers/practices could participate in the TMaH Model as Accountable Entities if they meet other criteria*:

- Obstetrics and Gynecology (OB/GYN)
- Maternal-Fetal Medicine (MFM)
- Certified Nurse Midwife (CNM)
- Obstetric Nurse Practitioner
- Women's Health Nurse Practitioner
- Primary Care Providers (Family Medicine, Internal Medicine, General Practice)
- Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes providing perinatal services
- Tribal Health Centers and Indian Health Service (IHS) facilities providing perinatal services
- Hospitals are eligible to participate as Participant Organizations if they employ eligible clinicians who provide perinatal care services and bill under the hospital's TIN

*This list is subject to change.