# Transforming Maternal Health (TMaH) Value-Based Payment (VBP) Model Webinar for Providers

***September 3, 2026***

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

# Acknowledgement of Support

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***Note:*** *As CMS continues to refine the TMaH Model, the information provided on these slides is subject to change, in accordance with forthcoming CMS guidance*.

# Agenda

- Meeting Objectives
- TMaH Background
- Provider Infrastructure Payments
- Retrospective Shared Savings
  - Quality Measures
  - Quality and Risk Adjustment
  - Attribution Methodology
  - Included/Excluded Services
- Provider Next Steps
- Discussion

# Meeting Objectives

- Share the most up-to-date information from CMS on the TMaH Value-Based Payment (VBP) Model and answer questions
- Highlight upcoming milestones and provider next steps, including how providers can prepare to apply for Provider Infrastructure Payments and to participate in the TMaH Model as an Accountable Entity

# TMaH Model Background

# Recap: TMaH Model Overview

In January 2025, the federal Centers for Medicare & Medicaid Services (CMS) announced California as one of 15 states selected to implement **TMaH Model**.

- **10-year delivery and payment model** designed to test whether evidence-informed interventions, sustained by a **VBP model**, can improve maternal outcomes and reduce Medicaid and Children's Health Insurance Program (CHIP) program expenditures.
- Implementation in **Fresno, Kern, Kings, Madera, and Tulare** counties.
- **$17 million total in federal funding** over 10 years.
- **Provider participation** in the TMaH Model **is voluntary.**

# Key Goals of the TMaH Model

- By aligning incentives around shared outcomes rather than individual services, the TMaH Model encourages care team collaboration and recognizes that coordinated, team-based care is essential to improving maternal and infant health outcomes

- **The key goals of the TMaH Model are:**
  - Improve maternal and infant health outcomes
  - Reduce avoidable complications
  - Support high-quality care for Medi-Cal populations
  - Strengthen team-based care and care coordination across providers and settings
  - Build sustainable value-based payment (VBP) infrastructure among participating providers

# Providers Participate in the TMaH VBP Model through an Accountable Entity (AE)

- AEs are entities (which may consist of **one** provider organization or **multiple** provider organizations in a contractual arrangement) that deliver prenatal, delivery, and postpartum care to Medi-Cal members and agree to be accountable for cost and quality outcomes under the TMaH VBP Model

# TMaH Model-Qualifying Maternity Care Providers

**The following types of providers are eligible to participate in the TMaH VBP Model as part of an AE:**

- Obstetrics and Gynecology physicians (OB/GYN)
- Maternal-Fetal Medicine physicians (MFM)
- Midwives, including Certified Nurse Midwife (CNM), Licensed Midwife (LM)
- Obstetric Nurse Practitioners
- Women's Health Nurse Practitioners
- Family Medicine physicians
- Family and Adult Nurse Practitioners (NP)

**Providers must be:**

- Enrolled as a Medi-Cal provider;
- Contracted with at least one MCP in Fresno, Kern, Kings, Madera, or Tulare counties
- Deliver clinical perinatal services to Medi-Cal Managed Care Members in least one of the TMaH counties; and
- Be willing to strengthen data collection/reporting and quality improvement capabilities to enable payment in the TMaH VBP Model

# AE Eligibility Requirements

**To qualify as an AE, an organization or group of organizations collectively must:**

- **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 Medi-Cal-enrolled** with an active Taxpayer Identification Number (TIN) and organizational Medi-Cal Billing ID
- **Provide the full range of perinatal care**—prenatal, delivery, and postpartum care—which could be provided among different organizations within the same AE
- Employ or contract with providers who bill for **prenatal, postpartum, and delivery services**
- **Bill under qualifying maternity care provider types**
- **Meet a minimum volume of 30 Medi-Cal-covered deliveries annually** for Medi-Cal Managed Care Members in the TMaH counties
- Comply with **applicable TMaH Model requirements**, such as data and reporting requirements, and participate in performance measurement and financial reconciliation

# How Can an AE Be Structured?

- An AE is identified based on the **taxpayer identification number (TIN) of a Primary Participant Organization**, which serves as the single legal entity that forms a business relationship with a MCP for purposes of participation in the TMaH VBP Model

  - **Single AE**: A single organization under one TIN—such as an 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
  - **Joint AE**: Multiple organizations that formally join together under a Primary Participant Organization's TIN to meet Model requirements—for example, one practice providing prenatal and postpartum care and another providing delivery services.

# Why Should Providers Participate in the TMaH VBP Model?

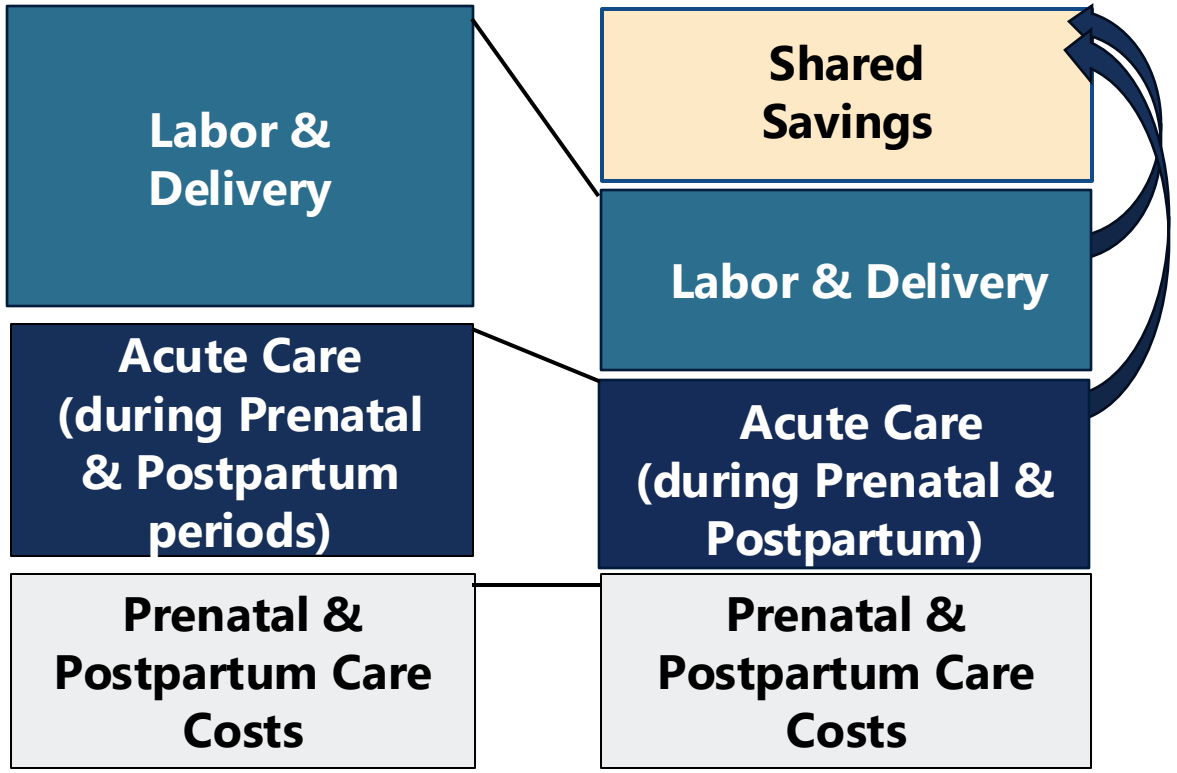
- The TMaH Model offers maternity care providers a meaningful opportunity to **strengthen their practices while improving outcomes for Medi-Cal Members**
  - AEs will **earn a share of any savings** resulting from improving outcomes for Medi-Cal patients
  - AEs may receive upfront **Provider Infrastructure Payments** to support collaborative, team-based, and data-driven practice
  - The TMaH Model includes **built-in financial protections** to reduce provider risk, including risk adjustment, exclusions for certain patients and high-cost cases, and minimum delivery thresholds
  - AEs will **strengthen their referral network** by building stronger relationships with other providers and community organizations

# Why Should Providers Participate in the TMaH VBP Model? (cont.)

- The TMaH VBP model rewards quality care, expands flexibility in how services are delivered, and supports **better outcomes and more coordinated, prevention-focused care for Medi-Cal Members**

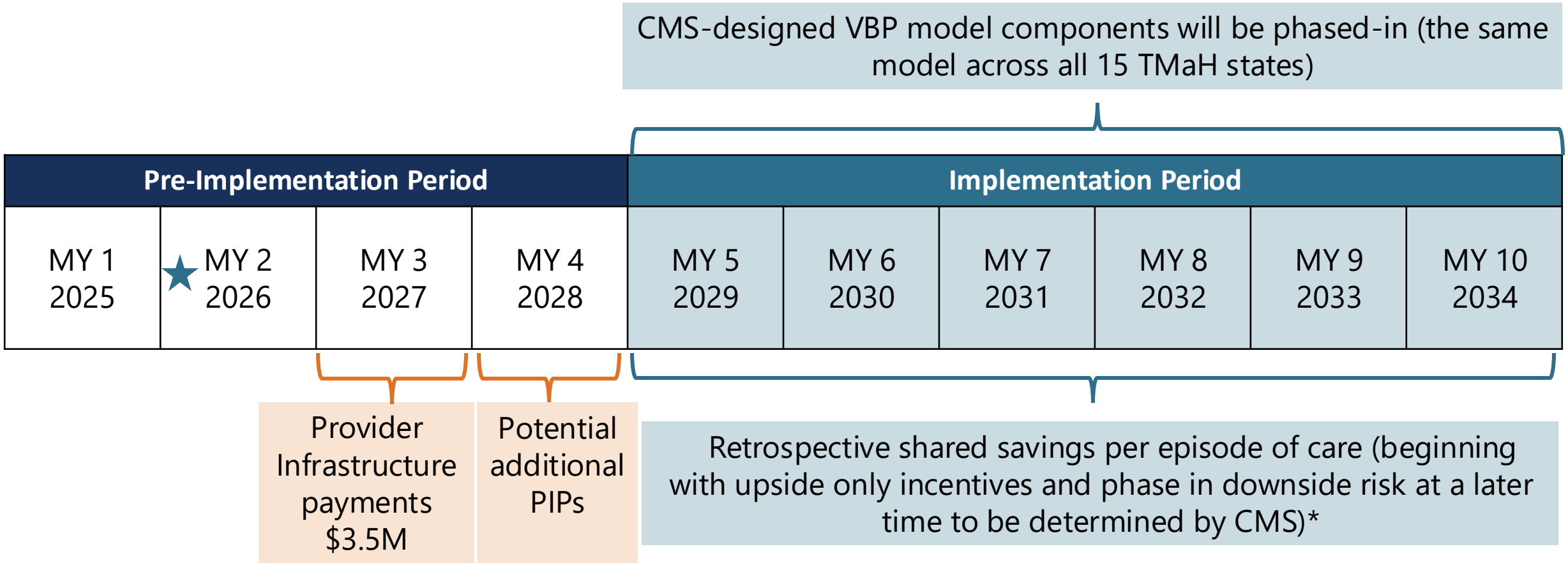
- Providers will **receive support through TMaH to develop their operational and clinical capabilities to successfully manage greater accountability for cost and performance,** which is essential in the broader context of the DHCS Value Strategy and ongoing federal and state advancement of VBP models

# How Are Reduced Costs Re-Allocated as Shared Savings in TMaH VBP Model?




**In TMaH, when an AE reduces avoidable costs (such as during labor and delivery or related to acute care during the prenatal and postpartum period), it can earn shared savings.**

# TMaH Model Year (MY) Timeline*




*Approximate timing, still to be finalized by CMS ★ Current Model Year

# Helping Providers Prepare for VBP: Provider Infrastructure Payments

# Provider Infrastructure Payments (PIPs) to Build Capacity for the TMaH Model (Starting in 2027)

- PIPs are **time-limited payments to address key gaps needed to accomplish the TMaH Model's goals**, including, but not limited to:
  - Care delivery improvements
  - Data infrastructure improvement
  - Expanded practice capacity, and
  - Capabilities needed to participate in the TMaH VBP Model
- PIPs are intended to **build the infrastructure** of providers and organizations directly responsible for delivering and coordinating care for TMaH-attributed patients
- **$3.5 million in PIPs will be disbursed via MCPs to TMaH-participating providers in 2027**, at a minimum, with likely additional future year payments pending CMS approval

*DHCS must submit a list of providers interested in participating in the TMaH Model to CMS by **October 1, 2026**. Providers must be included on this list to be eligible to receive provider infrastructure payments starting in 2027.*

# PIP Domains

**PIPs may be used to support health care transformation in the following six domains:**

- Patient safety initiatives and maternal care assessments
- Quality measure reporting for VBP
- Data integration/Electronic Health Record (EHR) upgrade
- Team-based care
- Enhanced access to care
- Connections to community-based organizations (CBOs) to address upstream drivers of health

*See the Appendix for examples of allowable uses within these six domains.*

**PIP funding cannot be used for:**

- Activities or expenses covered by Medi-Cal

# AEs and PIP-Collaborating Entities (PCEs) Are Eligible to Receive PIP Funds

- **A PIP-Collaborating Entity (PCE)** is a non-AE that collaborates with an AE to support the implementation of the TMaH Model. PCEs are eligible to receive PIPs based on CMS guidelines and approval.
- **Examples of eligible PCEs:**
  - Doula group supporting AE patients; has a formal relationship with AE and communicates with AE providers
  - Community-Based Organization providing care navigation for AE patients; receives referrals from AE and works directly with patients on housing, nutrition, or transportation needs, with closed-loop communication back to care team
  - Behavioral health provider that is integrated with the AE care team; accepts referrals from AE, shares care plans, and coordinates treatment with OB/GYNs or midwives
- **Examples of entities not eligible to be a PCE or receive PIP Funds:**
  - Consulting firm that advises on VBP strategy
  - Administrative services organization (ASO) providing billing/contracting services
  - MCPs

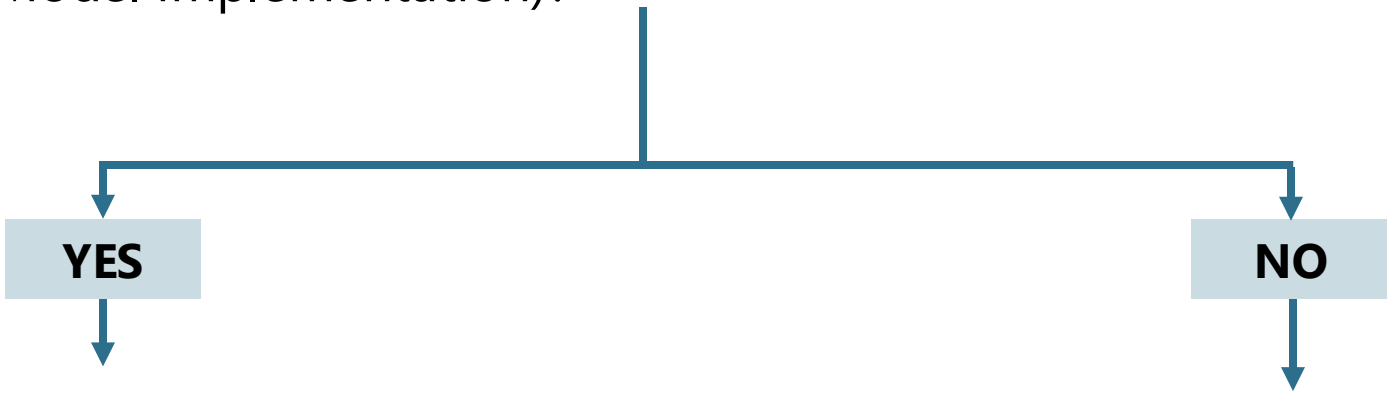
# PCE Eligibility Determination

**Does the organization:**

Serve TMaH Model-attributed patients?

**AND**

Coordinate directly with the AE and its care team to deliver or support care (or commit to coordinating directly during TMaH Model implementation)?




**Organization can serve as a PCE eligible for PIP funds**

**Organization cannot serve as a PCE and is ineligible for PIP funds**

# How PIPs May Be Distributed

**DHCS will gather input from AEs and PCEs to understand funding needs and key infrastructure gaps.**

**Then, DHCS will develop methodology consistent with CMS guidance to:**

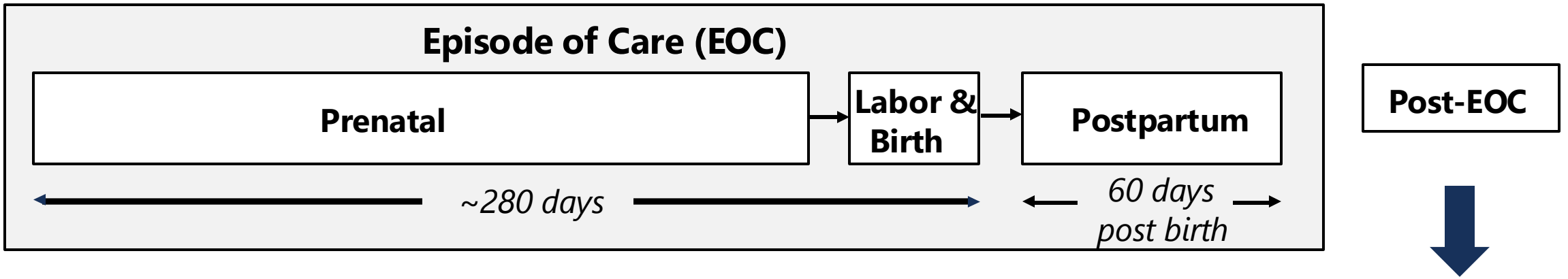
- Determine which AEs and PCEs receive PIPs
  - DHCS will prioritize PIP investments that can be sustained through future reimbursement, shared savings, or other long-term funding sources
- Determine the specific disbursement amounts and schedules
  - PIP disbursements may start as early as Q1 2027
- Establish accountability structure and appropriate expectations for use of funds (milestones)

# Retrospective Shared Savings

# TMaH Model Episode of Care and Performance Period

- The TMaH VBP Model will **launch in 2029**
- The **TMaH Model episode** measures Medi-Cal payments for a defined set of perinatal services from 280 days before delivery through 60 days postpartum
- The **performance period** is the defined period of time during which CMS evaluates all eligible TMaH Model episodes attributed to the AE
- AEs are eligible for **shared savings** – a share of the Medi-Cal savings the AE helps generate across all the episodes included in that performance period

# Retrospective Shared Savings




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

# Retrospective Shared Savings: How Shared Savings Are Calculated

**Shared savings are calculated as follows:**

- Before each performance period, CMS sets a **risk-adjusted target price** for each AE using historical data
- During each performance period, **AEs bill Medi-Cal MCPs as usual**
- After each performance period, CMS **compares the AE's actual average spending per attributed episode to its risk-adjusted target price** to determine whether the AE generated savings
- CMS reviews the AE's **quality performance** for the performance period
- AEs that meet quality goals and generate savings **receive a share of the savings**

# TMaH VBP Model Quality Measures

| | PRENATAL | LABOR & BIRTH | POSTPARTUM |
|---|---|---|---|
| **Model Goals** | • Increase engagement in prenatal care<br>• Increase screening, follow up, and management of comorbidities | • Decrease rates of low-risk c-section<br>• Decrease maternal morbidity<br>• Decrease rates of low birth-weight infants | • Increase engagement in postpartum care<br>• Increase screening, follow up, and management comorbidities |
| **Measures** | • Timeliness of prenatal care*<br>• Depression screening and follow-up*<br>• Maternal hypertension control | • Low-risk c-section*<br>• Low birth weight<br>• Maternal morbidity (e.g., obstetric complications) | • Timeliness of postpartum* depression screening and follow-up*<br>• Maternal hypertension control |

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

# Retrospective Shared Savings: Quality Adjustment

Quality measures will be used in the TMaH VBP Model to determine AEs' quality adjustment, which will impact the amount of retrospective shared savings they may earn.

| Performance Tier Calculation | Improvement Tier Calculation |
|---|---|
| » Based on all quality measures<br>» Compared to historical benchmarks | » Based on selected measures<br>» 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.

*Additional details on the TMaH quality adjustment calculation are forthcoming from CMS.*

# Retrospective Shared Savings: Risk Adjustment

- Risk adjustment is a process to **ensure fair comparison of episode costs across providers** during reconciliation by **accounting for differences in clinical complexity and social risk** of pregnant individuals.

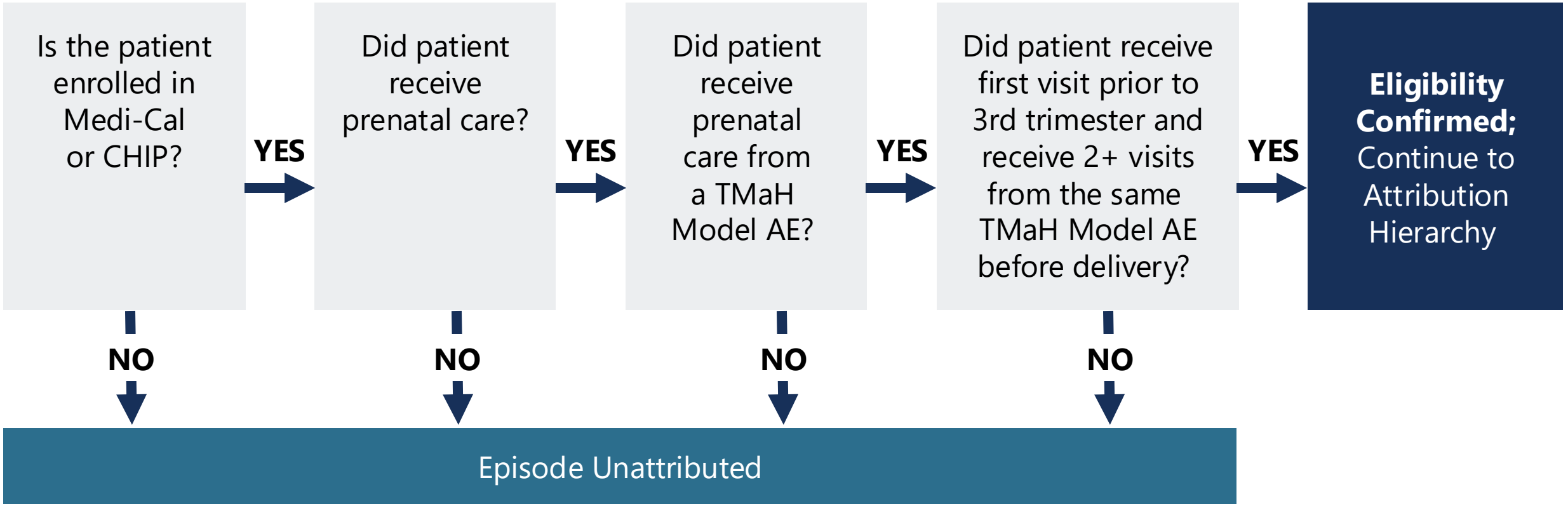
- **Why is risk adjustment necessary?**
  - Ensures the TMaH VBP Model target price fairly reflects the underlying health risk of the pregnant population attributed to each AE and therefore does not unfairly penalize providers serving sicker populations
  - It helps compare spending across patients with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

# Attribution Methodology: Guiding Principles

- **Assign patients and their maternal health outcomes to a single AE based on where patients receive the majority of their prenatal and postpartum care,** ensuring providers are accountable and rewarded for preventative care
- **Maximize attributable patients** by creating flexible attribution pathways that capture as many eligible births as possible within the TMaH VBP Model
- **Ensure FQHCs, Indian Health Care Providers, and Rural Health Clinics can meaningfully participate** in attribution where they play a central role in maternal care delivery
- **Create clear decision rules** for patients connected to multiple providers or AEs, including tie-breaking and reconciliation processes

# Attribution Methodology: Patient Eligibility

## Confirm Patient Eligibility*




*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.

# Attribution Methodology: Attribution Hierarchy

**Patient Eligibility Confirmed**

| Attribution Hierarchy | | Attribute To: |
|---|---|---|
| Was prenatal care provided by an FQHC, Indian Health Care provider (IHCP), or Rural Health Clinic (RHC)? | **YES** | FQHC, IHCP, or RHC |
| **NO** | | |
| Did multiple entities provide prenatal care to patient? | **NO** | TMaH Model AE |
| **YES** | | |
| Of those entities, is more than one participating in the TMaH Model? | **NO** | TMaH Model AE *(if they performed majority of visits)* |
| **YES** | | |
| Is there a tie between TMaH Model AEs for highest number of prenatal visits? | **NO** | TMaH Model AE *(with most visits)* |
| **YES** | | |
| Tie break by finding under which AE delivery occurred | | TMaH Model AE *(where delivery occurred)* |

**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.**

# What Services are Included in Calculations for Determining Retrospective Payments?

- The retrospective payment methodology includes a defined set of services (see Appendix) intended to **incentivize use of high-value, evidence-based care while discouraging overutilization of unnecessary services**. Services are excluded for two primary reasons:
  - **To avoid creating a disincentive for providing high-value services** – Services such as behavioral health, SUD, home monitoring, doula, dental and lactation care are excluded because they are cost-effective services that improve maternal health outcomes.
  - **They are outside the scope or control of the participating provider –** Services such as pediatric and neonatal care are excluded because they are not directly attributable to the maternal care provider's performance.

# Phased-In Losses

- After several years of participation in shared savings, AEs will also assume **limited financial risk** if costs across all attributed episodes during the performance period exceed the risk-adjusted target, subject to upper limit protections to limit financial exposure

- This risk will be **phased in gradually** over several years to allow providers time to build capabilities

# Provider Next Steps

# Provider Next Steps

**Providers interested in applying for Provider Infrastructure Payments and participating in the TMaH Model as an AE should:**

- ❑ Complete the **TMaH Model Provider Interest Survey** by **September 15th** if your practice/organization has not done so already
  - DHCS will use the results of the survey to develop a list of interested TMaH Providers for submission to CMS October 1st; providers must be on this list to be eligible to receive provider infrastructure payments starting in 2027
  - DHCS may follow up with providers needing technical assistance on AE formation
- ❑ Complete the AE Application, which DHCS will release later this Fall, to apply for Provider Infrastructure Payments and to participate in the TMaH Model as an AE
- ❑ Contact the DHCS TMaH Program team with any questions at **tmah@dhcs.ca.gov**

# Questions?

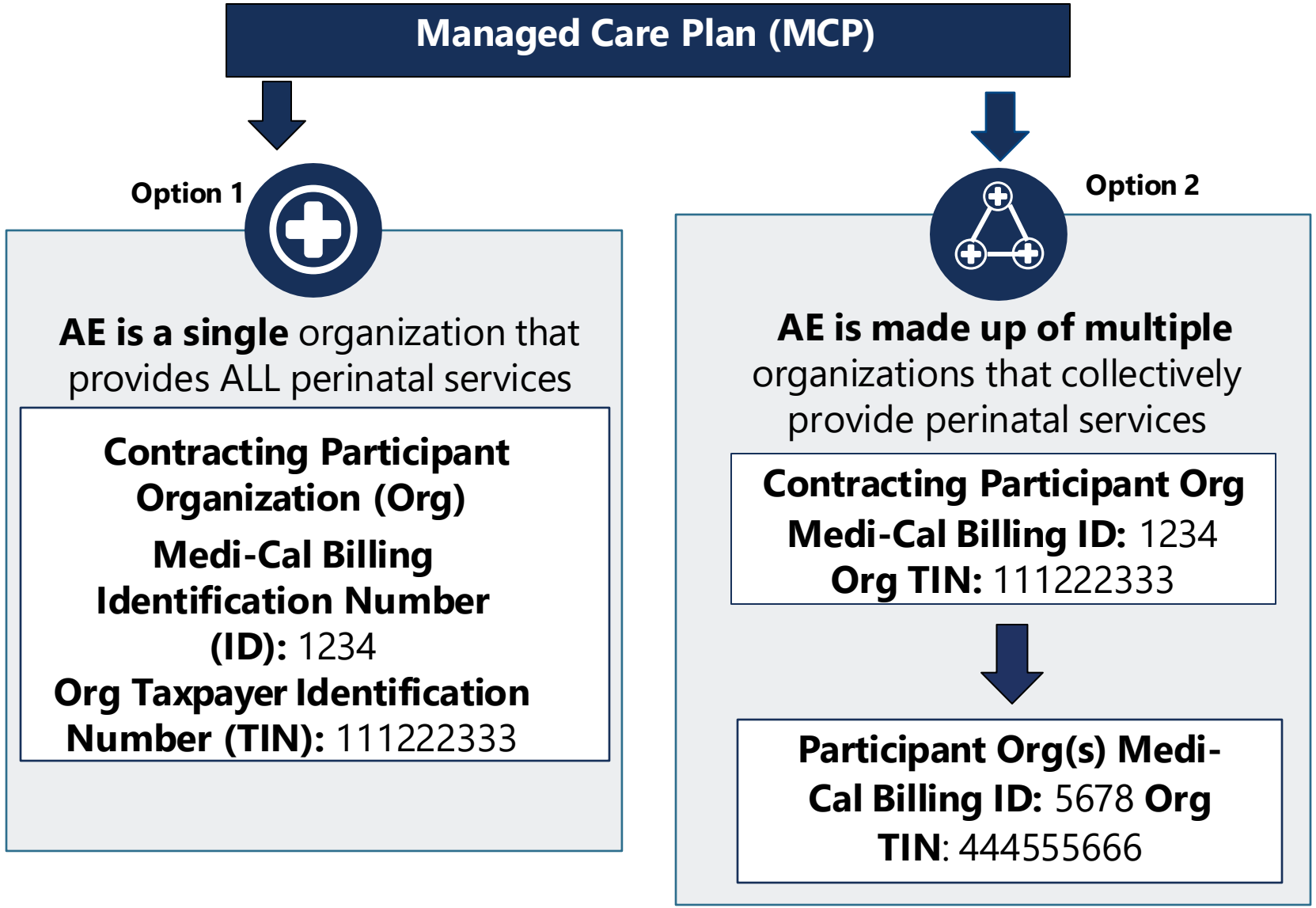


**We welcome your ongoing feedback and questions.**

Please submit feedback or questions to: tmah@dhcs.ca.gov

# Appendix

# Accountable Entity (AE) Structure




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

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

# Allowable Uses for Provider Infrastructure Payments (1/6)

**1. Patient Safety Initiatives and Maternal Care Assessment**

- Implementation of Alliance for Innovation on Maternal Health (AIM) patient safety bundles
- Planning, workflow changes, documentation and direct recruitment of needed clinical personnel or clinical support services to achieve Birthing-Friendly hospital designation (for hospitals only)
- Planning, patient-flow revision, acquisition of EHR systems, coding changes, or other activities required to effectively use clinical and non-clinical risk screens and assessments to drive risk-appropriate care

# Allowable Uses for Provider Infrastructure Payments (2/6)

**2. Quality Measure Reporting and Value-Based Payment**

- Data reporting on mandatory quality measures consistent with federal and state privacy laws
- Infrastructure, reporting, and analytics needed to support payment under the TMaH VBP Model

# Allowable Uses for Provider Infrastructure Payments (3/6)

**3. Data Integration and Other Activities to Support Data-Driven Maternity Care**

- EHR upgrades and data infrastructure improvement and interoperability, as needed, to meet model data collection and reporting requirements
- Connections that enable providers' EHRs to exchange data with regional or national networks that facilitate health information exchange (HIE)
- If basic data integration functions are already met, the creation of dashboards to support QI activities
- Integration with CBOs to share screening and referral information (and for CBOs to share notifications back to the referring provider) to meet patient non-clinical and behavioral health needs in compliance with state and federal data privacy laws

# Allowable Uses for Provider Infrastructure Payments (4/6)

**4. Team-Based Care**

- Support regular and ongoing interprofessional care team meetings and planned quality assurance and improvement activities. In addition to obstetricians and other physicians and registered nurses, the maternal care team may include, but are not limited to, doulas, perinatal community health workers (CHWs), CHWs, midwives, physician assistants, and behavioral health providers, as appropriate

# Allowable Uses for Provider Infrastructure Payments (5/6)

**5. Enhanced Access to Care**

- Offer one or more alternatives to traditional office visits to increase access to care in ways that best meet the needs of the population. This may include, but is not limited to, home monitoring for diabetes and hypertension or other telehealth initiatives; group perinatal visits; home visits; alternate location visits; or expanded early morning, evening, and/or weekend hours

# Allowable Uses for Provider Infrastructure Payments (6/6)

**6. Connections to CBOs to Address Factors that Affect Health and Behavioral Health Needs**

- Identification of local entities that can help address social and mental health (e.g., depression and anxiety) or substance use disorder-related needs of patients and integrate them into screening, referral, and follow-up activities, where legally permissible and appropriate to do so

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# Included Services for Retrospective Payment

| Service Category | Included Services | Example Codes |
|---|---|---|
| **Professional Services** | Labor & Delivery (L&D) Profession | *Will be updated with 2027 codes from AMA* |
| **Professional Services** | Outpatient Professional | CMS 1500 claims with federal Service Category Code starting with '3' (e.g., '32 Laboratory') |
| **Professional Services** | Inpatient Professional (codes unrelated to L&D Professional) | CMS 1500 claims with place service code '21' |
| **Professional Services** | Initial and basic screening and assessments for Behavioral Health (BH) and Substance Use Disorder (SUD) | HCPCS: H0049, H1000 |
| **Facility & Diagnostic Services** | Inpatient Facility | Bill type codes: 019X, 020X, 021X, 11X, 12X, 18X, 41X, 86X |
| **Facility & Diagnostic Services** | Outpatient Facility | Bill type codes: 13X, 14X, 22X, 23X, 73X-77X, 79X, 83X-85X |
| **Facility & Diagnostic Services** | Outpatient Laboratory | Place of service code: 81<br>Revenue codes: 030X |
| **Facility & Diagnostic Services** | Outpatient Radiology (e.g., ultrasound) | HCPCS: C8903-C8908, S8042<br>Revenue codes: 032X, 035X, 040X, 061X |

*Disclaimer: The example codes listed in this slide reflect CMS guidance. These codes are illustrative and may be adjusted for the CA TMaH Model based on whether they are covered under Medi-Cal.*

# Included Services for Retrospective Payment

| Service Category | Included Services | Example Codes |
|---|---|---|
| **Other** | Telehealth and Remote Monitoring | *Place of Service Codes: 02, 10, 12*<br>Will be updated with 2027 codes from AMA |
| **Other** | Certain Durable Medical Equipment (DME) (e.g., insulin devices, glucose monitor) | HCPCS: A4220-A4223, A4233-A4236, S5560-S5561 |
| **Other** | Emergency Department & Observation Stay | Bill Types: 13X, 14X, 22X, 23X, 73X-77X, 79X, 83X-85X AND revenue codes 045x, 0760-0762, 0769 OR select CPT codes OR place of service = 23 |
| **Other** | Pharmacy | Any pharmacy claim that does not contain excluded medications |
| **Other** | Other Services* | HCPCS: A0427, A0429, S4005 |

** e.g., any remaining uncategorized claims including interim labor management, unlisted maternity care/delivery procedures, emergency transportation*

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# Excluded Services for Retrospective Payment

| Service Categoy | Excluded Services | Example Codes |
|---|---|---|
| **Professional Servies** | Pediatric professional services | HCPCS: B4034, B4036, T2101<br>ICD: Z381, Z382, Z3800, Z3801<br>Revenue codes: 170-174, 179 |
| **Professional Servies** | Comprehensive Assessments & services for BH/SUD* (e.g., treatment-related evals) | HCPCS: H0001-H0048, H1001-H1011, H2010-H2027 |
| **Facility & Diagnotic Services** | Neonatal care/NICU | HCPCS: B4034, B4036, T2101<br>ICD: Z381, Z382, Z3800, Z3801<br>Revenue codes: 170-174, 179 |
| **Facility & Diagnotic Services** | Hospital costs and non-pregnancy related care (e.g., fractures) | APR/DRG: 340-343<br>Revenue codes: 0116, 0126, 0136, 0146, 0156 |

**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; however, comprehensive services related to treatment are excluded.*

*Disclaimer: The example codes listed in this slide reflect CMS guidance. These codes are illustrative and may be adjusted for the CA TMaH Model based on whether they are covered under Medi-Cal.*

# Excluded Services for Retrospective Payment (cont.)

| Service Category | Excluded Services | Example Codes |
|---|---|---|
| **Rx & Devices** | Pharmacy claims with excluded medications and high-cost drugs | NDC/HIC3: 12496120801 (suboxone); V1(chemotherapy agent) |
| **Rx & Devices** | Breastfeeding supplies and other unspecified equipment | *Will be updated with 2027 codes from AMA* |
| **Other** | Non-emergency transportation | HCPCS: A0110, A0120, A0426 |
| **Other** | Contraceptive services and procedures | HCPCS: A4264, A4266, J7294-J7298<br>ICD: Z30011-Z30019 |
| **Other** | Flu and TdAP vaccines | *Will be updated with 2027 codes from AMA* |
| **Other** | Pregnancy-related care (e.g., doula, dental, lactation) that is cost-effective and important for improving health outcomes | HCPCS: S9443 (lactation classes)<br>*Will be updated with 2027 codes from AMA* |
| **Other** | Header-paid inpatient claim w/ an excluded service (e.g., appendectomy, hernia procedure) | *Will be updated with 2027 codes from AMA* |

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