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

May 12, 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
- Transforming Maternal Health (TMaH) Background
- TMaH Value-Based Payment (VBP) Model: Designed to Reward Maternal Health Providers for Improved Outcomes
  - Helping Providers Prepare for VBP: Provider Infrastructure Payments (PIPs)
  - How are Providers Paid in the TMaH VBP Model?
  - How do Providers Participate in the TMaH VBP Model?
- Discussion
- Upcoming Milestones and Provider Next Steps

Meeting Objectives

- To share the most up-to-date information from CMS on the TMaH VBP Model
- To answer questions and obtain information on provider technical assistance needs
- To highlight upcoming milestones and provider next steps, including how providers can express interest in participation

Transforming Maternal Health (TMaH) Background

DHCS

TMaH Overview

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

- **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 TMaH **is voluntary**.

TMaH Model Year (MY) Timeline*

CMS-designed VBP model components will be phased-in (the same model across all 15 TMaH states)

Pre-Implementation Period				Implementation Period					
MY 1 2025	★ MY 2 2026	MY 3 2027	MY 4 2028	MY 5 2029	MY 6 2030	MY 7 2031	MY 8 2032	MY 9 2033	MY 10 2034

*Approximate timing, still to be finalized by CMS

★ Current Model Year

TMaH Partners

Partner Providers

- Obstetricians/Gynecologists (Ob-Gyn)
- Midwives
- Family physicians
- Maternal-fetal medicine specialists/Perinatologists
- Nurses
- Doulas
- Lactation consultants
- Community Perinatal Health Workers (CPHWs)

Partner Care Delivery Locations

- Hospitals
- Ob-Gyn, family medicine, and midwifery practices
- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Tribal sites
- Birth centers
- Other sites of clinical care

Partner Organizations

- Managed Care Plans (MCPs)
- California Department of Public Health (CDPH)
- Local Health Jurisdictions (LHJs)
- California Maternal Quality Care Collaborative (CMQCC)
- California Perinatal Quality Care Collaborative (CPQCC)
- Pregnancy-Associated Review Committee (PARC)
- Universities/Educational Sites
- Community-Based Organizations (CBOs)
- Other non-clinical Partners

Intersection of TMaH with the Birthing Care Pathway

TMaH

- Aligned and **complementary** to the Birthing Care Pathway.
- Sub-state region, including **Fresno, Kern, Kings, Madera, and Tulare** counties.
- Required elements to **improve access, infrastructure and workforce; quality improvement and safety; and whole-person care.**
- Lessons learned and evidence-based practices from the TMaH implementation region may be **scaled statewide** through the Birthing Care Pathway.

Birthing Care Pathway

- **Comprehensive Medi-Cal policy and care model roadmap** to cover the journey of all pregnant and postpartum Medi-Cal members from conception through 12 months postpartum.
- **Strategic roadmap** for state entities, MCPs, counties, providers, social service entities, philanthropy, and other key partners serving pregnant and postpartum Medi-Cal members throughout the state.
- Includes a series of policy solutions that address the **physical, behavioral, and health-related social needs** of pregnant and postpartum members.

TMaH VBP Model: Designed to Reward Maternal Health Providers for Improved Outcomes

DHCS

Why a VBP Model for Maternal Health Care?

Maternal Mortality
84% of maternal deaths are considered preventable[1]
Over 50% of deaths are caused by behavioral health, cardiac and coronary conditions, and hypertension[2]

Maternal Morbidity
Severe Maternal Morbidity (SMM) affects 3.6% of the Medicaid population[3] **and is associated with a high rate of preventability**[4]
SMM can increase delivery costs by 20-50%[5] **and impact a woman's health in the short- and long-term**

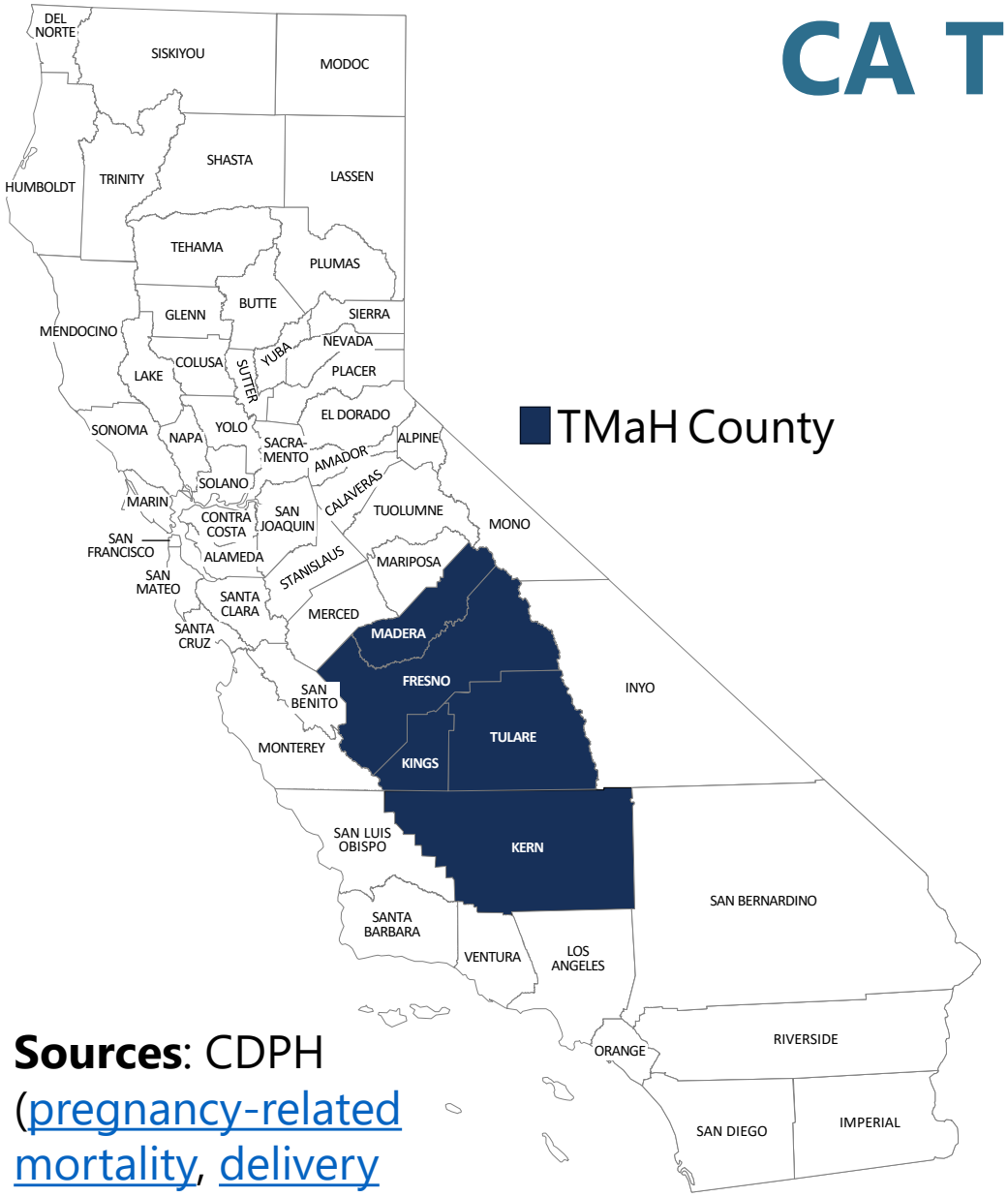
Percentage of Pregnancy-Related Deaths by Underlying Cause, 2017-2019[2]

Behavioral Health Condition	22.7%
Hemorrhage	13.7%
Cardiac and coronary conditions	12.8%
Infection	9.2%
Thrombotic embolism	8.7%
Cardiomyopathy	8.5%
Hypertensive disorders of pregnancy	6.5%
Amniotic fluid embolism	3.8%
Injury	3.6%
Cerebrovascular accident	2.5%

Improving maternal and infant health outcomes requires preventive continuous care starting in the prenatal phase and into postpartum

1. CDC Preventability, 2017–2019; 2.CDC, Clinical Characteristics, 2017-2019 ;3. CMS; 4. ACOG; 5. Women's Health Report, Commonwealth Fund

CA TMaH Counties



Sources: CDPH ([pregnancy-related mortality](), [delivery method](), [birth weight](), [SUD at delivery](), [NAS]()), [HRSA](), [HPI]()

DHCS chose to implement TMaH in Fresno, Kern, Kings, Madera and Tulare due to challenging maternal heath outcomes and provider need:

- **Pregnancy-related mortality,** Fresno (24.0), Kern (26.6), and Tulare (32.1) compared to statewide rate of 21.6 in 2017 – 2021
- **C-section births,** Fresno (34.2%), Kings (33.6%), Madera (32.8%), and Tulare (34.5%) compared to statewide rate of 31.0% in 2020 – 2022
- **Low infant birthweight,** Fresno (7.6%), Kern (7.5%), and Tulare (7.2%) compared to statewide rate of 7.2% in 2020 – 2022
- **Maternal substance use disorder,** Kern (2.6%), Kings (1.9%), and Tulare (1.8%) compared to statewide rate of 1.7% in 2020 – 2022
- **Neonatal abstinence syndrome (NAS) at delivery**, Kern (3.3%) compared to statewide rate of 2.6% in 2020 – 2022
- High HRSA Maternity Care Target Area scores and low Healthy Places Index scores, indicating a greater need for maternity care providers and health-related social services compared to other counties

How Providers and Patients May Benefit from the TMaH VBP Model

The TMaH VBP Model is designed to:

- **Provide maternal health providers with upfront funds** 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 cesarean deliveries

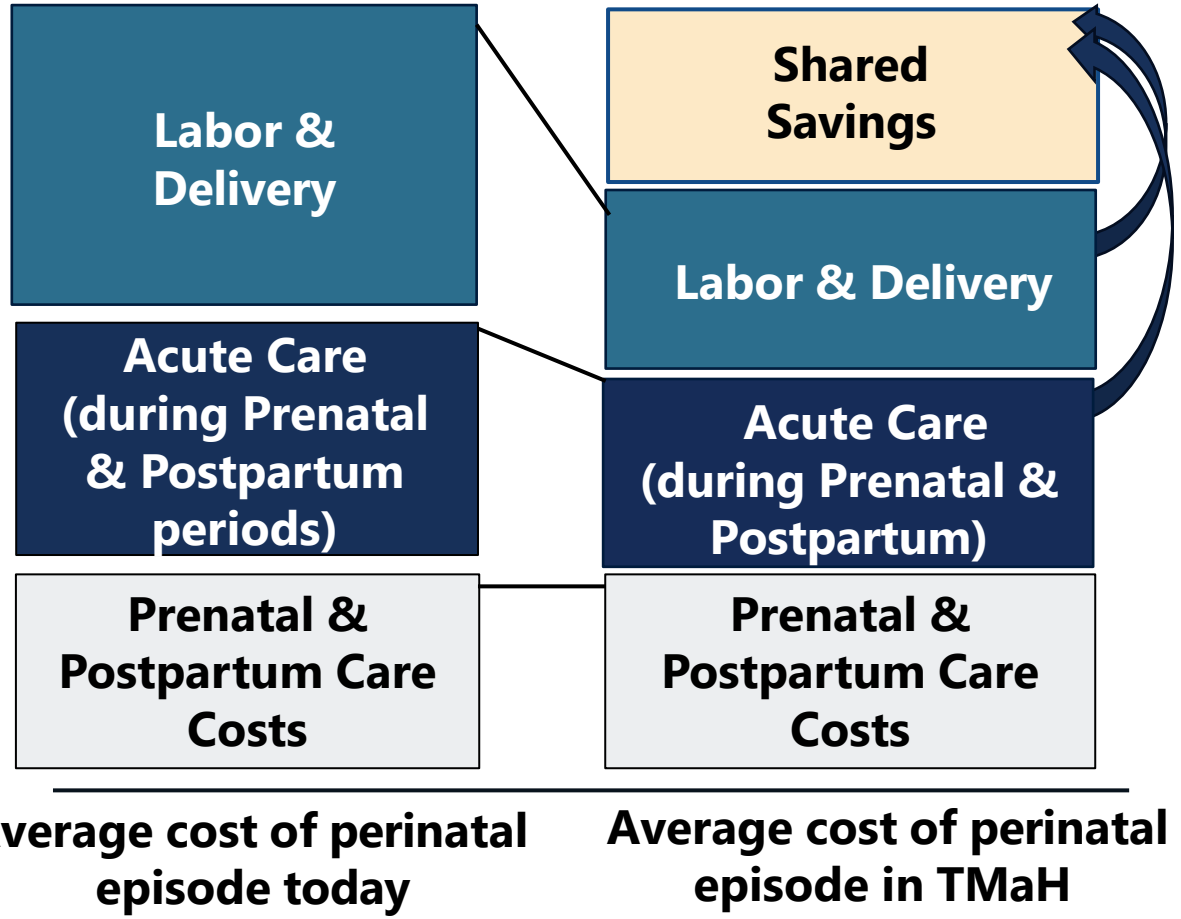
Reduced incidence of SMM

Reduced rates of low-birth weight infants

Improved experience of care for pregnant women

How Reduced Costs are Re-Allocated as Shared Savings in TMaH VBP

How Perinatal Episode Costs Evolve and Are Allocated in TMaH



TMaH VBP shifts costs from complications during delivery and the perinatal period to shared savings and overall cost savings to the system

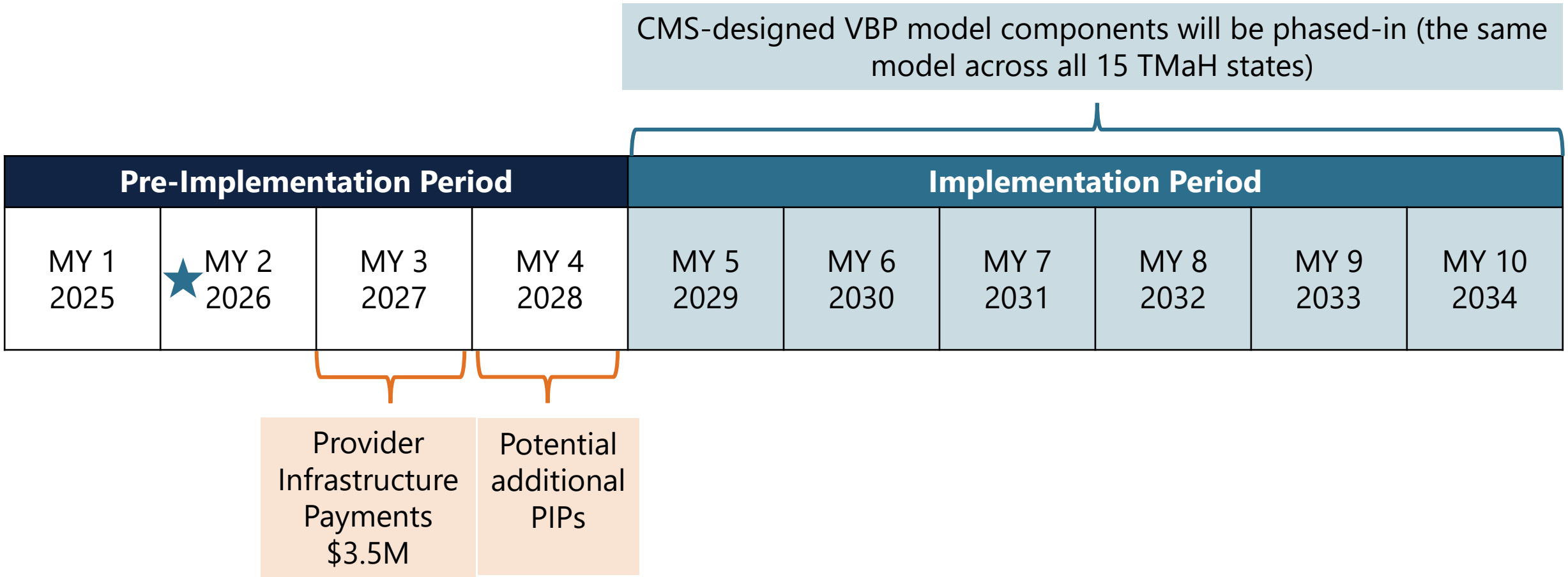
Providers can use shared savings for enhanced prenatal and postpartum care

VBP allows Medi-Cal to pay for the enhanced prenatal and postpartum care with savings from reduction in acute care, specifically savings in:

- Reduced low-risk c-sections
- Reduced SMM and associated acute care costs
- Reduced low-birth weight and associated infant costs

Helping Providers Prepare for VBP: Provider Infrastructure Payments (PIPs)

TMaH Model Year (MY) Timeline*



*Approximate timing, still to be finalized by CMS

★ Current Model Year

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

- To support practice transformation activities and build readiness to implement the TMaH VBP Model, **$3.5 million in PIPs** will be disbursed via MCPs to participating providers in 2027
- Providers will have reporting requirements with the MCP disbursing the payment
- CMS will share **additional guidance on PIPs in Q2 and Q3 of 2026**

PIP Uses Approved by CMS:

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

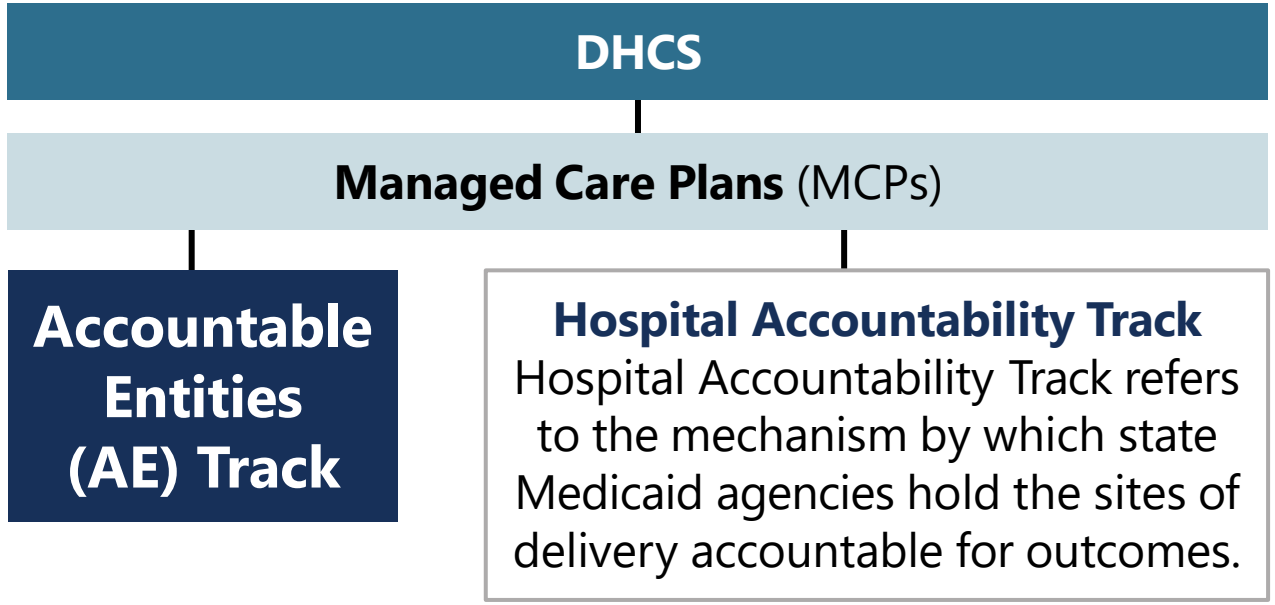
How are Providers Paid in the TMaH VBP Model?

Overview of TMaH VBP Model Strategy

The TMaH VBP Model includes two tracks. The Accountable Entity (AE) Track refers to the payment mechanisms by which state Medicaid agencies hold the AEs (primarily OB-GYN and/or midwifery practices and FQHCs) accountable for their patients' perinatal journey.

CMS' focus is on the **AE track** for 2029 implementation while continuing to assess a future hospital track to be implemented at a later date.

State Medicaid Agencies using Managed Care



TMaH VBP Model Accountable Entity (AE): Definition and Requirements

- Accountable Entities are the entities accountable for care in TMaH, **primarily practices**, with some exceptions for hospitals providing prenatal, labor/delivery, and/or postpartum care (perinatal)
- Focus on obstetric and midwifery practices because these practices often focus on providing prenatal and postpartum care
- AEs must provide the **full-spectrum of perinatal care**
- 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

TMaH VBP Model Quality Concepts*

Inclusion	AE Track
Likely	» Timeliness of prenatal and postpartum care » Depression screening and follow up » Maternal hypertension control » Maternal morbidity (e.g., complications) » Low-risk cesarean delivery
Under Discussion	» Low birthweight » Substance use disorder screening » Patient experience measure

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

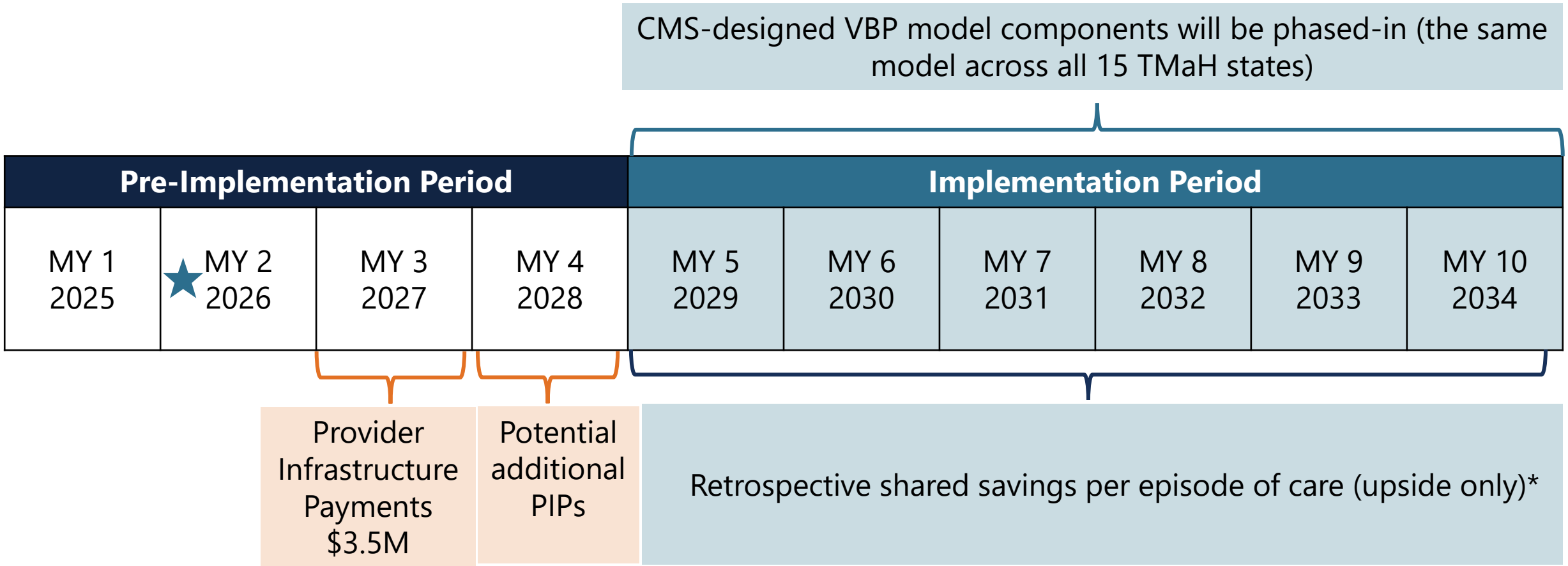
*This list is subject to change by CMS.

TMaH VBP Model Components

Provider Infrastructure Payments (PIPs) to Build Capacity (2027)

Retrospective Payment per Episode of Care to Reward Outcomes (2029)

TMaH Model Year (MY) Timeline*



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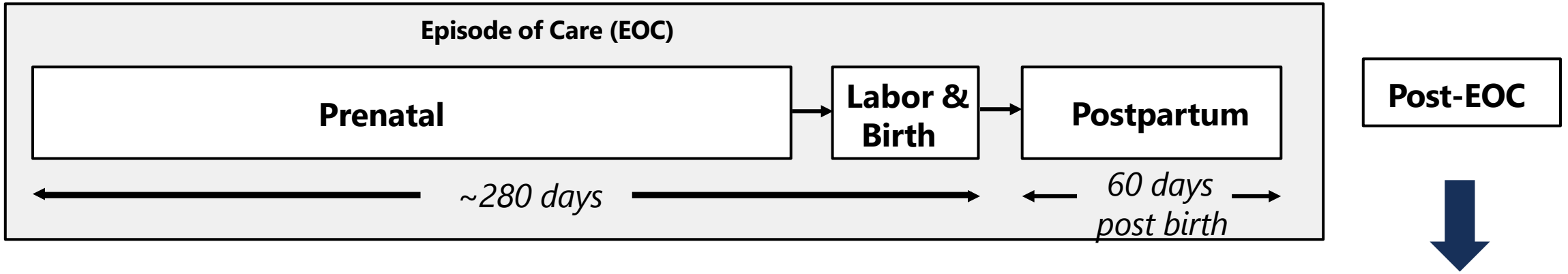
★ Current Model Year

Retrospective Shared Savings (Starting in 2029)



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.

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.

Potential Prospective Payments

Under Consideration

Monthly Payments – also known as “fixed monthly payments” or “case rates” – for the TMaH VBP model

What’s Next

CMS will provide additional information on prospective payment at a later date, which will then be shared with providers accordingly

How Do Providers Participate in the TMaH VBP Model?

DHCS

Provider Participation Standards: CA TMaH

Providers must be:

- An enrolled Medi-Cal provider
- Contracted with at least one Medi-Cal MCP in the TMaH counties (Fresno, Kern, Kings, Madera, Tulare)
- Located in or serve Medi-Cal members from the TMaH counties
- Willing to strengthen data collection/reporting and quality improvement capabilities to enable payment in the TMaH VBP model
- Meet additional criteria set out by CMS outlined in later slides

MCPs operating in TMaH counties will be responsible for conducting monitoring of TMaH participating providers through contractually required practices to ensure participating providers meet and maintain TMaH participation standards.

*Review DHCS' Provider Participation Standards for more detail. DHCS will update these standards as more information becomes available from CMS.

Accountable Entity (AE) Structure

Managed Care Plan (MCP)

Option 1

AE is a single organization that provides ALL perinatal services

Contracting Participant Organization (Org)

Medicaid Billing Identification Number (ID): 1234

Org Taxpayer Identification Number (TIN): 111222333

Option 2

AE is made up of multiple organizations that collectively provide perinatal services

Contracting Participant Org

Medicaid Billing ID: 1234

Org TIN: 111222333

Participant Org(s)

Medicaid Billing ID: 5678

Org TIN: 444555666

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.

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 Medi-Cal-enrolled** with an active TIN and organizational Medicaid Billing ID.

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** (minimum delivery volume threshold of 30 births per year) annually for Medi-Cal 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

TMaH Qualifying Maternal Health Providers

The following types of providers/practices could participate in the TMaH VBP Model as AEs if they meet AE eligibility criteria*:

- Obstetrics and Gynecology Physicians (OB/GYN)
- Maternal-Fetal Medicine physicians (MFM)
- Midwives, including Certified Nurse Midwife (CNM), Licensed Midwife (LM)
- Obstetric Nurse Practitioner
- Women's Health Nurse Practitioner
- Family Medicine
- Family and Adult Nurse Practitioners (NP)
- Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes providing perinatal services
- Tribal Health Centers and Indian Health Service (IHS) facilities providing perinatal services

*This list is subject to change.

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 of 30 births per year

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*.

States with a FQHC APM can put a portion of their existing APM at risk.

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

*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.

Provider Technical Assistance (TA)

DHCS has allocated **~$6.5M over 6 years for a contractor(s) to deliver TA to providers participating in TMaH** beginning in 2026.

Examples of Provider TA:

- **Practice transformation for VBP** including support assessing data systems and operational needs for participating in VBP
- **Quality improvement initiatives** including support raising postpartum depression screening rates and support with AIM bundle implementation in birthing hospitals
- **Training for the perinatal clinical workforce** including on postpartum care, and mental health management and treatment
- **Foundation for regionalization of care** including support with Maternal Levels of Care birthing hospital certification, implementing patient risk stratification tools, and building inter-facility transfer relationships and protocols
- **Operationalizing or augmenting telehealth clinical services** to expand access to care
- **Specialty perinatal mental health care access** including access to a provider consultation line
- **Relationship building between hospitals, perinatal providers, and doulas** to create culture change regarding benefits of having doulas support birthing individuals **and corresponding policy development**

Discussion

Discussion (1 of 5)

- What questions do you have as you consider whether to participate in the TMaH VBP Model?

Discussion (2 of 5)

- What are the biggest gaps or concerns that need to be addressed for your organization to feel ready to participate in TMaH?

Discussion (3 of 5)

- What technical assistance needs do you have?

Discussion (4 of 5)

- How could payment models be designed to more effectively support care coordination, team-based care, asynchronous care, or services that are not traditionally reimbursed?

Discussion (5 of 5)

- What approaches would help ensure that retrospective payment translates into improvements in care delivery before the end of the episode of care, even when financial impacts occur later?

Upcoming Milestones and Provider Next Steps

Upcoming Milestones

- CMS will be releasing additional information on PIPs in Q2 and Q3 2026 and the hospital accountability track (timing TBD)
- DHCS will hold another meeting for interested providers (Medical/Clinical Directors and Chief Financial Officers or practice administrators who support consideration of payment arrangements) in summer 2026 after CMS releases more information
- DHCS must submit list of participating providers to CMS in October 2026

Provider Next Steps:

- ✓ **Review** the TMaH **Provider Participation Standards** and **Accountable Entity criteria**
- ✓ **Consider how your practice could form an Accountable Entity** (e.g., meeting all criteria directly or by contracting with another organization)
- ✓ **Reach out to your MCP contacts** (Kern Family Health Care, Kaiser Permanente, Health Net Community Solutions, Anthem Blue Cross) as soon as possible **if your practice may be interested in participating in the TMaH VBP Model** *(see next slide for contact information)*

MCP Contacts

- **Kern Family Health Care:** Komal Kahlon, Provider Engagement Manager (Komal.Kahlon@khs-net.com)
- **Kaiser Permanente:** Joseph De Los Santos, CA Health Equity Strategy Lead, National Medicaid and State Programs (joseph.j.delossantos@kp.org)
- **Health Net Community Solutions:** Ruby Singh, Quality Improvement Specialist I (Rupinder.Singh@healthnet.com)
- **Anthem Blue Cross:** Dr. Rafael Gonzalez Amezcua, Managing Medical Director (RAFAEL.GONZALEZ-AMEZCUA@elevancehealth.com)

We welcome your ongoing feedback and questions.

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

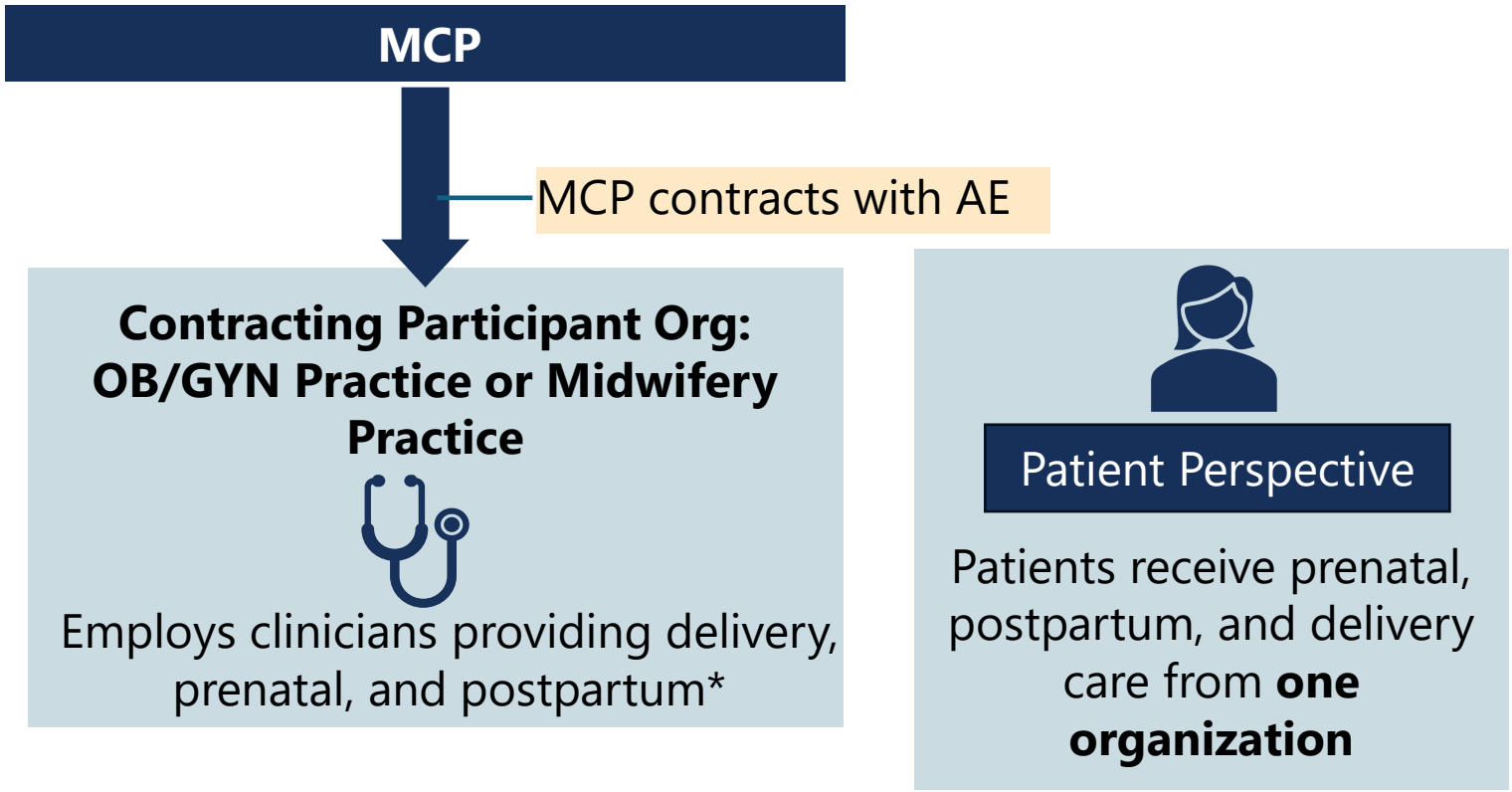
Appendix

Overview of Appendix

- Examples of AE structures
- Non-Attributable Patients or Events
- Risk Adjustment for VBP Model Target Price

What Can an AE Look Like

Example 1: Single Organization as the AE



*Minimum delivery volume threshold of 30 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 MCP to be accountable for cost and quality under

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

What Can an AE Look Like

Example 2: Two or More Organization as the AE

MCP

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 organization**

Why this is an AE

- Two Participant Organizations coordinate to collectively provide the full continuum of perinatal services.
- One organization contracts with the 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

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

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 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

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.

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.

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