HUSKY Maternity Bundle Payment Program

Frequently Asked Questions (FAQ)

Published October 2024 for Effective Date January 1, 2025

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Key Updates

In response to stakeholder feedback, DSS incorporated the following key changes in the September and October 2024 versions of this document.

October Updates

- **New Case Rate Trigger Guidance (Q25):** DSS will implement new Case Rate trigger event guidance for the first quarter of Performance Year 1, effective 1/1/2025 to 3/31/2025, to only allow trigger events in the 2nd trimester to initiate Case Rate payments. Subsequently, effective 4/1/2025, trigger events in the 2nd trimester, 3rd trimester, and postpartum period will initiate Case Rate payments. DSS made this change in response to provider feedback – Limiting to 2nd trimester trigger events only for the first three months ensures that a provider will be eligible to receive Case Rate payments for the full duration of the episode.
- **835 CARC Code (Q33):** DSS revised the CARC for the 835 from CO97 to CO245. The Department recently conducted a provider survey to request feedback on the proposed CARC code. Based on survey results, DSS has updated the CARC to CO245.
- **Supplemental Payment Report (Q31):** DSS revised the answer to this question to include details about the supplemental payment report, which all providers under the accountable TIN may access through their secure provider portal.
- **Exclusion Criteria (Q6):** DSS revised the exclusion criteria to remove the criterion "If there is a missing a facility claim in the episode (i.e., "orphan episode")." This principle was used for attribution and draft Case Rate calculations during the historic program testing but is no longer relevant for Performance Year 1. As such, DSS removed it from the program's exclusion criteria.

September Updates

- **Updated Program Go Live Date (Q2, Q12):** DSS revised the launch date for the HUSKY Maternity Bundle Payment Program from September 1, 2024 to January 1, 2025. After careful consideration, DSS decided to update the launch date of the program to enable consideration of program refinements and provide additional provider resources and guidance. DSS will continue to engage stakeholders throughout this period, providing additional information and opportunities for providers to ask questions and share feedback.
- **Provider Specialty Type Criteria (Q3, Q12, Q18):** DSS revised the provider specialty type criteria for program participation to exclude Family Medicine physicians and nurse practitioners. DSS made this change in response to provider feedback – to simplify billing processes for providers and ensure non-maternal health care services delivered by Family Medicine providers are not unintentionally incorporated in the Case Rate.
- **Members with TPL Coverage (Q7):** DSS revised member inclusion criteria to exclude members with TPL coverage. DSS will pay claims with a TPL paid amount using standard FFS processes. DSS made this change in response to provider feedback – to minimize disruption and simplify billing processes for providers, given constraints providers face with billing for members with Medicaid as secondary coverage.
- **Case Rate Trigger Criteria (Q18, Q24):** DSS revised the case rate trigger criteria to include two additional qualifying place of service locations: 19 (off-campus outpatient hospital), and 22 (on-campus – outpatient hospital). DSS made this change in response to provider feedback - to identify appropriate attribution changes between participating Accountable Providers in office and outpatient hospital settings.

- **Doula Certification (Q46):** All doulas, whether receiving reimbursement in partnership with a practice or through direct fee-for-service reimbursement, should complete the Department of Public Health's certification requirements.
- **Additional questions added include:** Q22-Q23, Q26-Q27, Q32, Q40, Q53-Q55

Program Overview

1. What is the HUSKY Maternity Bundle Payment Program (Maternity Bundle Program)?
The Maternity Bundle Program is a value-based care program which implements an episode-based payment model for maternity care services. With an emphasis on reducing health disparities and improving the patient's care experience, this program aims to drive coordinated, efficient, and high-value maternity care through the use of Case Rate payments (episode-based payments), upside only incentive payments (shared savings), performance- and reporting-based quality measures, and expanded services that support positive maternal and infant health outcomes.

2. When will the Maternity Bundle Program start?
The Department of Social Services (DSS) anticipates launching the program on January 1, 2025.

3. Who is eligible to participate in the program?
All Obstetrics and Licensed Midwife practices that perform 30 or more deliveries annually in Connecticut's Medicaid program will be automatically enrolled in the program. Participating maternity providers will be transitioned from the OB Pay for Performance (OBP4P) program to the HUSKY Maternity Bundle Payment Program. See the Member and Provider Participation section for more details.

4. How does the Maternity Bundle Program work?
DSS defines the maternity episode of care as the total amount of care provided throughout the perinatal period – from 280 days prior to delivery to 90 days post-delivery. For a subset of services, DSS will pay maternity providers monthly "Case Rate" payments for the majority of prenatal and postpartum care that a birthing person receives. Services not covered under the Case Rate will be reimbursed through fee-for-service (FFS) payments.

At the end of the Performance Year, DSS will perform a reconciliation process to compare the episode's total cost against the provider's target. Reconciliation includes the costs for all maternity services provided during the episode, regardless of being paid by Case Rate or by FFS payment. If episode costs are below the "target price" (the target benchmark), providers will receive a retrospective (i.e., at the end of the bundle) "incentive payment" (shared savings) based on their quality performance. This program is upside only, which means providers can only earn incentive payments as a bonus for delivering high-quality, cost-efficient care; there are no penalties if the provider's costs exceed the target price.

For more information on key terms mentioned above, please see the Glossary within the Maternity Bundle Overview document **here**.

Member and Provider Participation

Member Participation

5. Which HUSKY Health (Medicaid) members are included in this program?

All pregnant and birthing Connecticut Medicaid members are eligible to participate in the Maternity Bundle Program if they are attributed to a participating provider, with certain rare exclusions.

6. What are the patient exclusions for the program?

If a patient meets one or more exclusion criteria below, DSS will no longer include them in the Maternity Bundle program. In these instances, the Accountable Provider may still receive Case Rate payments; however, their patient's episode of care (whether complete or incomplete) will be excluded from retrospective reconciliation (i.e., ineligible for incentive payments).

- Age <12 or >55
- Mother/birthing person left the hospital against medical advice prior to discharge
- Any substantial gap in enrollment or eligibility during the delivery episode
- Patient began prenatal care in the third trimester (i.e., there were no claims incurred during the first two trimesters of the pregnancy)
- Patient switched providers in the third trimester
- Missing a facility claim in the episode's delivery
- Baby is stillborn
- Miscarriage or abortion

7. Are members with Medicaid as the secondary payer included in the program?

No, members with third party liability (TPL) coverage are not included in the Maternity Bundle Program. DSS will pay claims with a TPL paid amount using standard FFS processes. Note that providers who currently bill global code for members with Medicaid as secondary coverage can continue billing for these members using global code instead of triggering Case Rate payments.

8. Are undocumented Medicaid members included in the program?

Yes, all Medicaid members regardless of their citizenship status will be included in the Maternity Bundle Program.

9. Are members with high-risk pregnancies included in the program?

Yes, to ensure members with high-risk pregnancies can access the benefits of the Maternity Bundle Program, DSS will include members with high-risk pregnancies. Several design features (e.g., clinical and social risk adjustment and winsorization for outlier high-cost episodes) will be put in place to reward providers who care for patients with greater clinical and social needs.

10. Are members with multiple births included in the program?

Yes, to ensure members with multiple births can access the program's benefits, multiple birth deliveries are paid through the Case Rate and can continue through the end of the 90-day postpartum period. Episodes with multiple births will be excluded from reconciliation.

11. Can members opt out of the program?

Medicaid members will always retain the right to choose and change their provider. If a member seeks care from a provider who is not participating in the program, they would not be included in the

Maternity Bundle Program. Members who are not included in the program may still receive access to doula care through

Provider Participation

12. Does my practice need to register for the Maternity Bundle Program? Is there a penalty for not participating?

On January 1st, 2025, DSS will automatically enroll non-FQHC Obstetrics and Licensed Midwife practices that perform 30 or more deliveries annually in Connecticut's Medicaid program. Program participation is required for eligible providers. In Performance Year 1 (1/1/2025 – 12/31/2025), the minimum volume threshold (30 births per year) will be determined at the TIN level based on deliveries incurred between 10/1/2022 to 9/30/2023.

13. Who is ineligible to participate in the program?

FQHCs, Family Medicine providers, and Obstetrics and Licensed Midwife providers who perform less than 30 deliveries per year will be excluded from the program and paid according to their current payment methodology. These non-participating providers may still opt to participate in the OBP4P program.

14. Can new practices join the program mid-performance year?

No, new practices may only join at the start of a new performance year.

OBP4P Program

15. Can eligible Maternity Bundle providers also participate in OBP4P?

No, participating Maternity Bundle providers will be transitioned from the OB Pay for Performance (OBP4P) program to the HUSKY Maternity Bundle Payment Program. For these providers, OBP4P ends on May 31, 2024.

16. My practice is currently enrolled in the OBP4P. When should we stop submitting the OBP4P notifications?

Maternity Bundle practices can continue to submit OBP4P notifications forms for the current OBP4P cycle (Cycle 8) until June 30, 2024.

17. When will the OBP4P Cycle 8 payments be made to the practices?

OBP4P participating practices will receive their Cycle 8 payments during Q2 of 2025.

Accountable Provider

18. How is the Accountable Provider defined?

The Accountable Provider is the ambulatory maternity provider group who has the greatest role in delivering obstetric care in the episode. To qualify for Case Rate payment as an Accountable Provider, providers must meet the following criteria:

- Perform 30 or more deliveries annually
- Submit a claim with a trigger diagnosis code (outlined in the Code List on the DSS website **here**) and one of the following Evaluation & Management (E&M) codes 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215.
- Submit a claim with a qualifying place of service location: 11 (office), 19 (off-campus outpatient hospital), or 22 (on-campus – outpatient hospital)

- Bill as a qualifying maternity bundle specialty type, which includes Obstetrics and Gynecology (including the subspecialty MFM), Certified Nurse Midwife, Obstetric Nurse Practitioner, and Women's Health Nurse Practitioner.

19. Does the Accountable Provider mean a maternity provider who bills professionally under the same TIN?

Yes, after the Case Rate is triggered by a practice, providers who bill professionally under the same TIN with an eligible maternity bundle specialty type will be considered as the same Accountable Provider who initiated/receives the Case Rate payment.

20. Will the provider attribution change monthly for multi-specialty groups?

No, if the qualifying specialty types are billed and provided under the attributed practice TIN, provider attribution will be maintained for multi-specialty groups. For example, if a patient receives care from various OB Physicians, Certified Midwives, and/or Advanced Registered Nurse Practitioners (ARNPs), and physician assistants within the same TIN, the practice will maintain episode attribution and the Case Rate payment will be directed to the practice's designated AVRS ID.

Case Rate Payment

*For more information, please view the Case Rate Overview video on the DSS website **here**.*

Case Rate Development

21. How is the Case Rate set?

Each provider's initial Case Rate is based on historical second trimester, third trimester, and postpartum claim expense for historically attributed episodes. Prior to Go Live, DSS will establish and provide the provider-specific Case Rate reimbursement amount that will be effective as of 1/1/2025.

22. What date range will be used to calculate the Case Rates effective for Go Live?

Prior to Go Live, DSS will refresh draft Case Rates previously provided with a more recent claim set to establish the rate that will be effective as of 1/1/2025. DSS anticipates that rates effective as of 1/1/2025 will be based on deliveries incurred from 10/1/2022 to 9/30/2023, though the department is still finalizing this timeframe.

23. What is the estimated payment per patient for an entire pregnancy?

To calculate your estimated payment for the pregnancy, use the following formula: First trimester FFS payments + second and third trimester Case Rate payments (up to 6 months of payment) + postpartum Case Rate payments (up to 3 months of payment).

Billing Guidance

24. How is the Case Rate paid?

In the second or third trimester, the Case Rate payment may begin by billing a claim with specific trigger codes to indicate the initiation of the prenatal care services. After the trigger event(s), Case Rate payments will be made at the end of each month, and the claim with the trigger codes and all subsequent claims meeting the services included in the Case Rate criteria (listed below) will be zero-paid.

To qualify for Case Rate payment as an Accountable Provider, providers must meet the following criteria:

- Perform 30 or more deliveries annually
- Submit a claim with a trigger diagnosis code (outlined in the Code List on the DSS website **here**) and one of the following Evaluation & Management (E&M) codes 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215.
- Submit a claim with a qualifying place of service location: 11 (office), 19 (off-campus outpatient hospital), or 22 (on-campus – outpatient hospital)
- Bill as a qualifying maternity bundle specialty type, which includes Obstetrics and Gynecology (including the subspecialty MFM), Certified Nurse Midwife, Obstetric Nurse Practitioner, and Women's Health Nurse Practitioner.

Services that are excluded from the Case Rate will not be included in the Case Rate **code list** and will be reimbursed FFS. For example, if an Accountable Provider initiates the Case Rate payment and bills non-Case Rate services, DSS will both (1) provide the Case Rate payment and $0 pay all Case Rate codes and (2) reimburse the non-Case Rate codes through FFS payment.

25. How will providers be reimbursed for patients who are mid-pregnancy at the time of the program's January 1st Go Live?

For the first quarter of Performance Year 1, effective 1/1/2025 - 3/31/2025, trigger events in the 2nd trimester only will initiate Case Rate payments (i.e., providers will not receive Case Rate payments for patients who are in the 3rd trimester or postpartum period for the first three months of the program). Subsequently, effective 4/1/2025, trigger events in the 2nd trimester, 3rd trimester, and postpartum period will initiate Case Rate payments.

Please note, for practices that typically use global billing, global billing does not qualify as a trigger event. DSS will not review claims prior to the 1/1/2025 Go Live da==te, and visits prior to the effective date will be reimbursed through fee-for-service payments.

26. Should we submit claims for the delivery?

Yes, DSS recommends that practices submit a claim for the delivery, which will be reimbursed through the Case Rate if the delivery is performed by the Accountable Provider.

27. When does the Case Rate end?

The Case Rate will cease under any of the following circumstances:

- After completion of the three months postpartum,
- If the episode of care moves away from the Accountable Provider TIN (i.e., attribution change – as determined by the submission of claim that meets the trigger event criteria from another practice),
- If the patient experiences a stillborn birth, miscarriage or abortion – for these instances, the Case Rate will cease in the following month after the stillborn birth, miscarriage or abortion.

Covered Services

28. What services are included in the Case Rate?

The Case Rate will only include professional services, as listed in the Case Rate **code list**, which are submitted under the attributed Tax ID with eligible maternity bundle specialty types. In general, services included in the Case Rate include:

- OB/licensed midwife Professional Services
- OB/licensed midwife Professional-related hospitalization costs (Inpatient, Outpatient, and ED) including professional delivery fees, if performed by the Accountable Provider
- OB/licensed midwife Professional-related Behavioral Health Evaluations, including screening for depression and substance use
- Screenings (general pregnancy, chlamydia, cervical cancer, intimate partner violence, anxiety)
- In-house OB/licensed midwife imaging
- In-house labs and diagnostics
- Prenatal group visits
- Birth education services
- Care coordination activities
- Any of the above services provided via telehealth

29. How will MFM services be reimbursed?

In-house MFM services (i.e., provided within the Tax ID) will be reimbursed by the Case Rate. Since MFM is an OBGYN subspecialty, MFM providers typically bill under the OBGYN billing provider specialty type, which qualifies in-house MFM providers to receive Case Rate payments.

External MFM services (i.e., provided under a different Tax ID than the OB practice) may receive the Case Rate payment if they submit a claim with trigger codes and the service occurs in an office setting. As long as both providers bill with a trigger event, the OB and MFM may both receive Case Rates for the months that patient care is provided.

Claims Payment

30. How are Case Rate payments distributed? Do you anticipate Case Rate payments included in bi-weekly remits or will the payment be distributed in a separate remit file?

Once initiated through the submission of a claim with a trigger event (indicated through a combination of trigger diagnosis codes and Case Rate E&M codes), Case Rate payments will be identified and generated at the end of the month. The expenditures will be included on the existing semi-monthly Remittance Advice (RA) and 835 in the first payment cycle of the month.

For example, if a trigger claim is received in the month of February with a date of service (DOS) in January, the January DOS will $0 pay, a Case Rate payment for the month of January and February will be generated at the end of February, and the provider will see the Case Rate payments for the 2 months in the first payment cycle in March. Case Rate payment for March (if the provider is still the attributed provider) will be paid in the first payment cycle in April.

31. Please explain how the payments will be sent to us. What information accompanies claims payment? Are claims tied to a specific patient claim number?

The RA will display Client ID, Client Name, From DOS and Case Rate payment. The From DOS will always be the first day of the month. The 835 will report the Case Rate in the PLB segment. The PLB03-

1 field (Adjustment Identifier) will indicate LS – Lump Sum. The PLB03-2 field (Reference Identification) will be populated with an internal tracking number. It will be prefaced with a value of MB (maternity bundle).

In response to provider feedback, DSS will also provide a supplemental payment report, which all providers under the accountable TIN may access through their secure provider portal. This report will contain the following information to support the Accountable Provider's ability to attribute TIN level payments among its providers/practices: the Client ID, Last Name, First Name, Middle Initial, Practice ID (TIN), Payment Provider AVRS ID, Accountable Provider AVRS ID, Case Rate Month/Year, Case Rate Amount, Expenditure/Recoupment indicator (E, R) and Transaction #.

32. Will the payments come monthly for each patient and be labeled as such?
The case rate payments will be included on the existing semi-monthly Remittance Advice (RA) and 835 in the first payment cycle of the month. The RA will display the Case Rate payment, Client ID, Client Name, and From DOS (which will always be the first day of the month).

The Case Rate payment will have an expenditure reason code of 8340 – 'Maternity Bundle Case Rate'. The expenditure will be per client and case rate date of service. The 835 transaction will report the maternity bundle payment in the PLB segment. The PLB03-1 field (Adjustment Identifier) will be populated with LS- Lump Sum. The PLB03-2 field (Reference Identifier) will be populated with the client id, expenditure ID with a preface of 'MB' indicating a maternity bundle case rate payment.

33. When Medicaid acknowledges the claim submitted for a service included in the Case Rate payment will they provide a CARC code [i.e. CO24] indicating a per member per month payment was made?
The system will assign a unique EOB code that will display on the Remittance Advice. The 835 will contain a CARC indicating the reason for claim zero payment. Based on provider feedback, the CARC code will be CO245.

Reconciliation

Key FAQs regarding the Reconciliation to determine Incentive Payments are provided below. For more information, see the DSS website ***here*****.**

Target Price

34. What is the target price?
The target price is the expected total cost of care for the maternity episode based on a blend of the statewide average price for maternity care and the specific Accountable Provider's historical price during the program year.

35. How is the target price calculated?
To create the target price, DSS will first calculate the provider historical price for each Accountable Provider. The provider historical price includes costs for delivery, prenatal, and postpartum services from the Accountable Provider and other providers. As part of this calculation, DSS will apply member exclusion criteria; standardize episode costs to remove price variations (e.g., DRG base rates); and winsorize outlier episode costs. Next, DSS will perform risk adjustment, in which the Department applies clinical and social risk adjustment factors to the provider historical price. After determining each

Accountable Provider's risk-adjusted historical price, the provider's historical price will be blended with the statewide historical price, which is the average historical price across all Accountable Providers, weighted by all deliveries attributed to an Accountable Provider.

36. How does winsorization work for episodes with outlier costs?
Winsorization is the transformation of statistics by limiting extreme values in the statistical data to reduce the effect of outliers. Total allowed amounts for episodes below and above the 5th and 99th percentiles, respectively, will be reset to those thresholds. This will ensure that episodes with unusually high costs or incomplete episodes that otherwise meet the inclusion criteria do not adversely influence the final episode price.

Incentive Payment

37. How is the incentive payment calculated during reconciliation?
At the end of the Performance Year, DSS will perform a reconciliation process to determine whether Accountable Providers are eligible for incentive payments (upside only). If actual cost for the episode is below the target price (i.e., there are net savings), providers will receive an incentive payment (up to 50% of net savings) based on their final quality score.

38. Will providers be penalized if they do not earn any shared savings?
No, the Maternity Bundle Program is upside only for Performance Year 1, which means providers will not be responsible for losses. They are only eligible to share a portion of savings (up to 50%) based on their quality measure performance.

39. What data will DSS provide related to the incentive payment calculation?
After reconciliation is complete, DSS will provide Performance Year Reports, containing details on the incentive payment, target price, actual costs, quality measure outcomes and final quality score, and the total number of births attributed to the Accountable Provider.

40. When should practices expect the annual incentive payment?
The incentive payment will be provided annually based on the practice's quality and cost experience in the performance year. Once the claims run-out period and reconciliation process are complete, Accountable Providers will receive the incentive payment no more than 365 days after the end of each Performance Year.

Doula and Lactation Supports

*Key FAQs regarding the Doula and Lactation Supports are provided below. For more information, please view the Doula Integration resources on the DSS website **here**.*

Doula Questions

41. How can doulas serve HUSKY Health (Medicaid) members in Connecticut?
With the goal of connecting members with doulas as soon as possible, DSS will utilize a dual approach to provide and fund doula access in Medicaid: (Option 1) paying credentialed doulas through the maternity bundle and (Option 2) paying credentialed doulas fee-for-service (FFS) directly.

Under the new Maternity Bundle Program (Option 1), DSS will provide practices with additional funds to add certified doulas to the care team and to strengthen lactation supports. Doula services will be

rendered and reimbursed under the supervision of the medical provider through the bundle. In addition, DSS anticipates implementing direct Medicaid reimbursement of certified doulas (Option 2) as a separate but parallel doula payment pathway in January 2025, in alignment with the Maternity Bundle Program's launch date. This dual approach will enable all HUSKY Health members, regardless of their participation in the Maternity Bundle Program, to receive access to doula services.

42. How many doula visits does HUSKY Health cover?
DSS will cover 5 doula visits total: 4 outpatient visits and 1 active birth encounter. The 4 outpatient visits can be split up in any way during the prenatal and postpartum periods; for example, 2 in the prenatal period and 2 in the postpartum period, or 1 in the prenatal and 3 in the postpartum period, or any other combination thereof. Given the 4 outpatient visit maximum, in cases where a member has visits with one doula and then wants or needs to switch doulas, the new doula will be able to provide as many outpatient visits as are remaining of the 4 total visits.

43. For Option 1, how can doulas support HUSKY Health members within the Maternity Bundle Program?
Doulas will have two main ways of participating in the maternity bundle:

- Enter into a contractual agreement with a HUSKY Health provider/medical group to provide doula support services to their members according to the provider's treatment plan, working within doula scope of practice.
    - Note: The clinical provider must have attended at least 30 HUSKY Health births to participate in the bundle. Providers who attend fewer than 30 HUSKY Health births are not eligible for the bundle and will not receive payment for doula services.
    - This could be an independent contractor agreement (also called 1099 contractor) or a W2 employee arrangement.
- Work for an organization (health system or hospital, doula organization, or other entity) that serves as a doula services coordinator and administrator who provides doula services to medical practices providing doula support services to members according to the provider's treatment plan, working within doula scope of practice.
    - This agreement could be an independent contractor agreement (also called 1099 contractor) or as a W2 employee.
    - This option may allow you to work with more than one provider and could reduce administrative burden on individual doulas

44. How are doulas reimbursed/paid through the bundle?
Doulas submit invoices for their services to their supervising provider, and the provider pays the doulas from the bundle payments that they receive. Providers and doulas will determine invoice cadence (bi-weekly, monthly, etc.) and payment terms. DSS has created a sample invoice and other doula and provider resources on the DSS website **here**.

45. What is the reimbursement amount for doula services?
Provider practices will receive prospective per member per month payment, called an add-on payment, via the Maternity Bundle Program which will offset the costs of paying doulas. Provider payments will be retrospectively adjusted based on the fee schedule for doula services shown below. Providers will set their own doula subcontract rates.

Visit Type	Limit per Pregnancy*	FFS Payment Rate	Doula Subcontract Rate
Prenatal and Postpartum visits	4	$100	**
Attendance at labor and birth	1	$800	**
Maximum Reimbursement per Doula per member/birth		$1200	**
*Limit is per provider, not per doula. **To be completed by practice			

46. How can doulas register to become a credentialed doula?
Doulas should register to become a credentialed doula or doula agency through the Department of Public Health based on the certification requirements listed **here**.

47. Can a doula contract directly with HUSKY Health to provide doula services to HUSKY members instead of partnering with a provider?
Yes, DSS is working to develop and operationalize direct reimbursement policies and procedures for doula services. DSS is aiming to launch direct fee-for-service reimbursement of credentialed doulas in January 2025, in alignment with the Maternity Bundle Program's launch date. Please note, under this direct reimbursement approach, doulas who enroll as independent CMAP providers may provide services to all HUSKY Health members, including those who are not participating in the program.

Provider Questions

48. What are the benefits of doula services and lactation supports?
As part of this program, DSS is proud to provide new Medicaid coverage of doula services and lactation supports, which are high-value services with evidence of improving health outcomes, health disparities, and patient birthing experiences. In particular, the following positive outcomes are associated with doula care[1, 2, 3, 4, 5, 6, 7, 8, 9]

- Reduced low birthweight babies

[1] Vonderheid S, Kishi R, Norr K, et al. Reducing Racial/Ethnic Disparities in Reproductive and Perinatal Outcomes. New York: Springer Science and Business Media, 2011.
[2] Thomas MP, Ammann G, Brazier E, Noyes P, Maybank A. Doula Services Within a Healthy Start Program: Increasing Access for an Underserved Population. Maternal Child Health J. 2017; 21(1):59-64.
[3] Gruber KJ, CupitoSH, Dobson CF. Impact of Doulas on Healthy Birth Outcomes. J of Perinat Educ. 2013;22(1):49-58.
[4] SaulsDJ. Effects of labor support on mothers, babies, and birth outcomes. J ObstetGynecolNeonatNurs. 2002;31(6):733-741.
[5] Kozhimannil, K. B., Hardeman, R. R., Alarid-Escudero, F., Vogelsang, C. A., Blauer-Peterson, C., & Howell, E. A. (2016). Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth andCesarean Delivery. Birth (Berkeley, Calif.), 43(1), 20–27.
[6] Kozhimannil KB, Attanasio LB, Jou J, Joarnt LK, Johnson PJ, Gjerdingen DK. Potential benefits of increased access to doula support during childbirth. Am J Manag Care. 2014; 20(8):e340-e352.
[7] Kozhimannil KB, Hardeman RR, Attanasio LB, Blauer-Peterson C, O'Brien M. Doula care, birth outcomes, and costs among Medicaid beneficiaries. Am J Public Health. 2013;103(4):e113-e121.
[8] Kozhimannil KB, Hardeman RR, Alarid-Escudero F, Vogelsang CA, Blauer-Peterson C, Howell EA. Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery Birth. 2016;43(1):20-27.
[9] Greiner KS, Hersh AR, Hersh SR, et al. The Cost-Effectiveness of Professional Doula Care for a Woman's First Two Births: A Decision Analysis Model. J Midwifery Womens Health. 2019;64(4):410-420.

- Reduced preterm births
- Reduced cesarean sections
- Reduced labor inductions and other medical interventions (augmentation, artificial rupture of membranes, episiotomy, assisted vaginal delivery, anesthesia use)
- Higher Apgar (Appearance, Pulse, Grimace, Activity, and Respiration) scores following birth (indicator of newborn health)
- Increased breastfeeding

Peer reviewed academic literature also suggests that doula services save money related to the outcomes listed above (savings cited in the literature with reasonable modeling report average savings per client ranging between $300-1,300)[7,8,9], though there are many variables that impact these savings, including states' doula reimbursement rates, birth volume, and current cesarean rates, among others.

49. What are breastfeeding support services? How do I incorporate these into my practice?
Breastfeeding support services (also known as lactation supports) are utilized throughout the pregnancy and postpartum periods to encourage healthy breastfeeding practices. For example, screening and education about the benefits of breastfeeding may be provided during the perinatal period. For more information regarding how to integrate lactation supports, please see the Description of Lactation Support Services within the Program Specifications on the DSS website **here**.

50. Are participating providers required to provide doula and lactation support services?
No, participating providers have the option to provide doula services or lactation supports through the bundle payment's add-on payment. To encourage utilization of these high-value services, doula services and lactation supports will be excluded from incentive payment calculations.

51. Can I opt out of the doula care add-on payment if I do not contract doulas with my practice?
DSS will allow providers who do not intend to contract with doulas in Year 1 to opt out of receiving the $14/month doula care Case Rate add-on payment. This is to ease the administrative burden for providers who do not intend to contract with doulas in Year 1. If you choose to opt out of the add-on payment for doula inclusion in Year 1, you must report to DSS by submitting the doula opt-out form by July 10, 2024.

52. How will the true-up for doula services and lactation supports work?
The doula services will be subject to a retrospective true-up process, independent of the incentive payment reconciliation. The true-up process will identify, through provider cost reporting, the actual amount of doula services accessed during the performance year by member, by provider. The cost per unit identified in the cost report will be modeled after the State of Connecticut fee schedule for doula services. The cost report information will be compared against FFS doula claims to ensure that payment for duplicative services are identified during the true-up process and not reimbursed via the add-on payment.

Funding for lactation services will not be subject to a retrospective true-up process.

Quality Measures & Reporting

*For more information about this topic, please refer to the Quality Measures Guide and Maternity Bundle Program Specifications (See the Quality Methodology section), which can be found on the DSS website **here**.*

53. How should practices report quality data?

DSS will utilize claims and non-claim sources to produce the measures. Seven measures will be sourced from adjudicated claim information, and three measures will utilize data submitted by OB providers via the CT Maternity Bundle Encounter Form. More information about the encounter form, including an encounter form template, can be found in the Quality Measure Guide.

54. For the Adverse Maternal Event measure, what maternal morbidities does the measure consider?

This measure monitors for severe OB complications, including 21 morbidities (listed below), blood transfusion and mortality.

- Acute heart failure
- Acute myocardial infarction
- Aortic aneurysm
- Cardiac arrest/ventricular fibrillation
- Heart failure/arrest during procedure or surgery
- Disseminated intravascular coagulation
- Shock
- Acute renal failure
- Adult respiratory distress syndrome
- Pulmonary edema
- Sepsis
- Air and thrombotic embolism
- Amniotic fluid embolism
- Eclampsia
- Severe anesthesia complications
- Puerperal cerebrovascular disorder
- Sickle cell disease with crisis
- Conversion of cardiac rhythm
- Hysterectomy
- Temporary tracheostomy
- Ventilation

55. For the Adverse Maternal Event measure, what risk variables are used in this measure's risk adjustment?

The 30 risk variables for this measure include:

- Anemia
- Asthma
- Autoimmune Disease
- Bariatric Surgery
- Bleeding disorder
- BMI >= 40
- Cardiac Disease
- Gastrointestinal Disease
- Gestational Diabetes
- HIV
- Housing Instability
- Hypertension
- Maternal Age (continuous, derived from birthdate)
- Mental Health Disorder
- Multiple Pregnancy
- Neuromuscular Disease
- Other Pre-eclampsia
- Placenta Previa
- Placental Abruption
- Placental Accreta Spectrum
- Pre-existing Diabetes
- Preterm Birth
- Previous Cesarean
- Pulmonary Hypertension
- Renal Disease
- Severe Pre-eclampsia
- Substance Abuse

- Thyrotoxicosis
- Long-term Anticoagulant Use
- Obstetric VTE