STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 24-M: Bundled Payment for Maternity Services

The State of Connecticut Department of Social Services (DSS) proposes to submit the following Medicaid State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS). Public comment information is at the bottom of this document.

Proposed Changes to Medicaid State Plan

Effective on or after April 1, 2024, this SPA will amend Attachment 4.19-B of the Medicaid State Plan to update the payment methodology for maternity services as set forth below and as described in more detail in the SPA pages and program specification document, both of which will be posted to the DSS webpage listed below. Additional information is also posted to the DSS Maternity Bundle website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/HUSKY-Maternity-Bundle/Details-of-Connecticut-Maternity-Bundle

Purpose

The purpose of this SPA is to enable implementation of the Maternity Bundle Payment within Connecticut's Medicaid program, which is designed to improve maternal and birth health outcomes and health equity. Improving maternal and birth outcomes is a particular priority for DSS because Connecticut's Medicaid program covers almost half of the pregnancies and births in the state. This program design incorporates ongoing dialogue with and feedback from providers and other stakeholders.

Overall Scope

This SPA will implement an alternative payment methodology, specifically a bundled payment program, for maternity services. This model is episode-based, in which the episode describes the total amount of care provided to a member during a set timeframe. The maternity bundle episode will include services and care delivered during the perinatal period (prenatal, labor and birth, and postpartum), spanning 280 days before the date of delivery to 90 days after the date of delivery. Maternity providers or provider groups will be designated as the Accountable Provider over the maternity episode, based department's bundle accountability methodology. As detailed below, the Maternity Bundle Payment Program includes two key components: (1) monthly Case Rate payments for certain services included in the maternity bundle episode and (2) incentive payments for Accountable Providers who deliver high-quality, cost-effective services throughout the episode.

Case Rates

This SPA will update the reimbursement methodology for qualifying maternity providers (i.e., qualified licensed physicians, nurse practitioners, physician assistants, and nurse-midwives). Accountable Providers will receive prorated monthly Case Rate payments for office-based services provided during the prenatal and postpartum periods for a subset of services included in the maternity episode.

All claims in the first trimester of pregnancy will be paid fee-for-service (FFS) and will be excluded from the Case Rate. Subsequently, DSS' bundle accountability methodology will be used to determine the Accountable Provider that is responsible for the beneficiary's maternity episode. After bundle accountability is established, the Accountable Provider will initiate receipt of Case Rate payments, as determined by a claim with a trigger code, and all the subsequent claims for services included in the Case Rate will have no separate payment. The Accountable Provider will continue to submit all encounters as $0-pay claims to document services provided to the beneficiary. Case Rates will be rebased no less than annually, based on updated, historical cost and utilization for services included in the case rate.

In addition, $2.5 million annually has been appropriated to reimburse maternity Accountable Providers for providing doula services and lactation supports to their attributed members, which are high-value services associated with positive maternal and infant health outcomes.

The Case Rate payment does not change any other reimbursement methodology that is available to nonparticipating providers. Additionally, applicable FFS payments will continue to be made to all participating providers for any Medicaid covered service outside the scope of the maternity Case Rate.

Incentive Payments

As part of the maternity bundled payment accountable providers will have the opportunity to earn upside "incentive payments." At the end of the episode, DSS will conduct a retrospective reconciliation to calculate the incentive payment amount. Accountable Providers can earn incentive payments (upside only) when the actual total cost of care for the maternity episode does not exceed the target price, which is the expected total cost of care for the maternity episode, if they also meet quality performance criteria and comply with under-service prevention requirements. The provider-specific target price will be based on a blend (a 50/50 ratio) of the statewide average cost for maternity care and the specific provider's historical cost.

The distribution of incentive payments will be adjusted based on the Accountable Provider's quality performance. Providers will receive payment in accordance with their highest earnings between two methodologies, either the overall quality performance in relation to peer performance or the percent improvement over baseline from historical performance. Specifically, incentive payments will be adjusted based on quality performance criteria to incentivize and maintain accountability for high-quality care and

maternal and infant health outcomes within the program. Quality performance will be monitored through the program's quality measure slate, currently proposed to be comprised of ten outcomes and process measures. Within the measure slate, there is a subset of pay-for-performance measures, in which financial reimbursement is tied to quality performance outcomes. The remaining subset consist of pay-for-reporting measures, in which financial reimbursement is tied to the submission and reporting of the data related to each applicable quality measure.

Fiscal Impact

Overall, DSS does not anticipate that the implementation of the Maternity Bundle Payment Program will significantly change annual aggregate expenditures, with the exceptions and details noted below.

The implementation of Case Rate payments in general are anticipated to have minimal overall impact on annual aggregate expenditures because the Case Rate payment amount will be based on the provider's historical cost. In addition, as noted above, $2.5 million annually has been appropriated to reimburse maternity providers for providing doula services and lactation supports.

More generally, by aligning financial and quality performance incentives, DSS anticipates that the Maternity Bundle Payment Program will result in approximately $850,000 in annual savings compared to projections without the implementation of the bundled payment program by encouraging providers to help reduce unnecessary caesarian sections, adverse maternal events, and avoidable neonatal intensive care unit (NICU) utilization. Based on that projection, that amount is set as a savings target incorporated for purposes of determining eligibility for incentive payments. As noted above, the incentive payments are upside-only, which means that there are no payment reductions or penalties for providers.

Obtaining SPA Language and Submitting Comments

The proposed SPA is posted on the DSS website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-State-Plan-Amendments and which, in addition to the proposed SPA pages, also includes draft Program Specifications and code lists, which contain additional information regarding episode definitions, quality measures, service inclusion and exclusion criteria, and risk adjustment. The proposed SPA may also be obtained at any DSS field office, at the Town of Vernon Social Services Department, or upon request from DSS (see below).

To request a copy of the SPA from DSS or to send comments about the SPA, please email: Public.Comment.DSS@ct.gov or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. Please reference "SPA 24-M: Bundled Payment for Maternity Services".

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than **January 11, 2024**.

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Bundled Payment for Maternity Services

I. Overview

Effective April 1, 2024, Connecticut Medicaid will establish episode-based payments for maternity care to improve maternal health and birth outcomes. An "episode" is a defined group of related Medicaid covered services provided to a specific patient over a specific period of time. Additional information regarding episode definitions, quality measurement, service inclusion and exclusion criteria, and risk adjustment are available at the Connecticut Bundled Payment for Maternity Services website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/HUSKY-Maternity-Bundle/Details-of-Connecticut-Maternity-Bundle.

As determined by the bundle accountability methodology set forth below, the "Accountable Provider" will be responsible for both the quality and cost of care delivered to a beneficiary for the maternity episode. The Accountable Provider is the maternity billing provider entity delivering services under the physicians' services benefit category (i.e., services provided by or under the supervision of a qualified physician (i.e., qualified licensed physicians and qualified allied health professionals working under the physician's supervision). Note that for services not provided under the supervision of a physician but that are provided by or under the supervision of nurse practitioners, physician assistants, and nurse-midwives are provided under the applicable benefit category for such practitioner.

Episode-based payments, using the Case Rate methodology below, will be made to the Accountable Provider. The Accountable Provider will receive prorated, provider-specific, monthly Case Rate payments for a subset of office-based services included in the maternity episode and provided during the prenatal and postpartum periods. The Case Rate payment does not change any other reimbursement methodology that are available to nonparticipating providers. Also, applicable fee-for-service (FFS) payments will continue to be made to all participating providers for any Medicaid covered service outside the scope of the maternity Case Rate.

In addition, Accountable Providers can earn upside only incentive payments when delivering high-quality, cost-effective services throughout the maternity episode. The Department of Social Services (DSS), Connecticut's single state Medicaid agency, will collect and analyze data at the end of the episode of care and conduct a retrospective reconciliation to calculate the incentive payment amount. Accountable Providers will have limited risk for staying within the designated budget threshold (i.e., the target price or expected total cost of care for a maternity episode) and are eligible for incentive payments when the target price is not exceeded, if they also meet quality performance criteria and comply with under-service prevention requirements. The provider-specific target price will be based on a blend of the statewide average cost for maternity care and the specific Accountable Provider's historical cost.

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II. Populations Included in the Episode

All pregnant and birthing Connecticut Medicaid beneficiaries attributed to qualified Accountable Providers, in accordance with the attribution methodology described below, are eligible for the maternity Case Rate, except if the beneficiary meets the one or more of the program's exclusion criteria.

If the beneficiary meets one or more exclusion criteria, their episode will be excluded from the retrospective reconciliation (i.e., the incentive payment calculation). In addition, beneficiaries who initially qualify for the Case Rate payment but later meet exclusion criteria (e.g., a beneficiary delivers a stillborn baby) will be excluded from the retrospective reconciliation The exclusion criteria can be found at the Connecticut Maternity Bundle website https://portal.ct.gov/DSS/Health-And-Home-Care/HUSKY-Maternity-Bundle/Details-of-Connecticut-Maternity-Bundle

III. Episode Accountability Methodology

Each episode will be assigned to an "Accountable Provider", which may be a qualified Obstetrics, Family Medicine, or licensed midwife provider or provider practice enrolled in Connecticut Medicaid from whom the beneficiary seeks maternity care. Payment will be directed to the provider group based on the billing Tax ID. More information about the Accountable Provider can be found at the Connecticut Maternity Bundle website https://portal.ct.gov/DSS/Health-And-Home-Care/HUSKY-Maternity-Bundle/Details-of-Connecticut-Maternity-Bundle

Each episode is initially assigned to the Accountable Provider reporting trigger codes from the earliest encounter claim in the second trimester (14-27 weeks of pregnancy) for purposes of Case Rate payment. Trigger codes are a set of codes, ICD-10-CM, HCPCS or service codes, which formally recognize a beneficiary's eligibility for a Case Rate payment and assigns the beneficiary's episode to an Accountable Provider. A comprehensive list of trigger codes can be found at the Connecticut Maternity Bundle website https://portal.ct.gov/DSS/Health-And-Home-Care/HUSKY-Maternity-Bundle/Details-of-Connecticut-Maternity-Bundle

All pregnant and birthing beneficiaries retain the choice to select and change their provider and care site. Therefore, the Accountable Provider may change if another practice group takes over care for the beneficiary. When a change of care occurs, as determined through the submission of another claim with a trigger code by the practice that takes over care, the episode and Case Rate payment will either be reassigned to the new Accountable Provider or transitioned to FFS payment. Given that the Case Rate is developed based on historical cost and service utilization, the historical pattern of transitions of patient care has been built into the provider-specific Case Rate. Episodes with a change of care will also be subject to a continuous lookback process. The continuous lookback process will identify and recover duplicative payment for non-accountable providers in months where multiple case rate payments are made. For the retrospective reconciliation, episodes will be assigned to the practice group that reported the most recent trigger code.

All qualified Medicaid providers will participate in the program so long as they meet the expected minimum episode volume threshold, which is calculated on an annual basis. Non-participating providers and practices, such as those who do not meet the minimum episode volume requirement, will be reimbursed FFS with no opportunity to earn incentive payments. More information on the minimum episode volume threshold can be found at the Connecticut Maternity Bundle website referenced above.

IV. Benefits Included in the Incentive Payment Calculation

All Medicaid claim costs for covered services (regardless of the provider who performed the service, which are paid in accordance with the reimbursement methodology applicable to the provider and service) will be included in the incentive payment calculations. Details about benefits included and excluded from the incentive payment calculation can be found at the Connecticut Maternity Bundle website referenced above**.**

V. Case Rate Payment Overview

Accountable Providers will receive a provider-specific Case Rate payment, based on historical utilization, for a defined set of services that they provide within the timeframe of an episode. The clinical definition of the episode of care and the defined set of service codes included in the Case Rate payment can be found at the Connecticut Maternity Bundle website referenced above.

All maternity related services outside the defined set of Case Rate services but provided within the timeframe of an episode will be included within the episode, but excluded from the Case Rate and reimbursed through FFS payments. For example, the delivery will be carved out of the Case Rate payment and reimbursed using standard FFS to avoid cost variance in the Case Rate resulting from a non-accountable provider delivering the baby. Deliveries, therefore, will only be included in the episode's retrospective reconciliation to determine incentive payments. Furthermore, the cost of benefits provided to the birthing member during the episode, regardless of the specific provider who performed each service, will be included in the incentive payment calculation, even if not provided by the specific Accountable Provider.

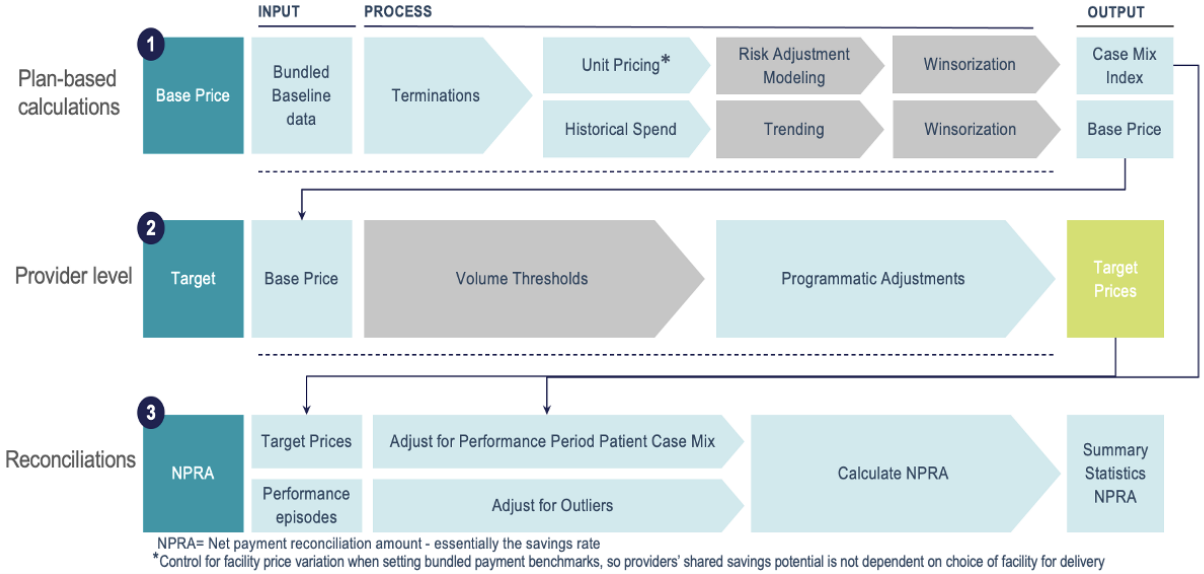
Case Rate payments are paid when the individual has an encounter in the second or third trimester with specific trigger codes (see the Connecticut Maternity Bundle website) to indicate pregnancy (i.e., the minimum service required for the Case Rate). All claims in the first trimester of the pregnancy will be paid FFS and are excluded from the Case Rate. After the minimum service required to pay the Case Rate occurs, all the subsequent claims meeting for services included in the Case Rate have no separate payment. Accountable Providers will continue to submit all encounters as $0-pay claims to document services provided to the beneficiary. Case Rate payments will be part of the retrospective reconciliation process to determine incentive payments (or losses). Case Rates will be rebased no less than annually, based on updated historical cost and utilization for services included in the Case Rate.

Additionally, doula and lactation support services provided by or under the supervision of the Accountable Provider entity will be made as an add-on payment to the Case Rate. Descriptions of doula services and lactation supports can be found at the Connecticut Maternity Bundle website referenced above, and the add-on rates for doula and lactation supports services are posted to the same DSS website. The add-on payment will be calculated by taking the total available add-on funding budget divided by the estimated number of case rate payments. Historical data will be used in future years to determine payments for these services. The add-on payment will be provided prospectively and subject to a retrospective true up process.

VI. General Pricing and Reconciliation Methodology

Risk-adjusted episode base prices for the maternity bundle payment program will be developed using historical claims from the year prior to each performance year as defined below. The base price encompasses the costs of maternity services provided during and included in the maternity episode (i.e., services reimbursed by the Case Rate and maternity services paid in accordance with the reimbursement methodology applicable to the non-accountable providers). These data are then utilized to create episodes and then applied in the following process (Figure 6.1) to develop the base price for each individual episode type.

Figure 6.1 Pricing Process



1. Apply member inclusions and exclusions

   To ensure complete and accurate episodes are used for pricing, a set of exclusion criteria was applied to remove episodes and members from the pricing process as specified above (See Section II. Populations Included in the Episode).

2. Standardized episode cost

   The financial amount used in pricing is the Medicaid allowed amount under the methodology approved in accordance with the applicable section of the Medicaid State Plan for each service. For inpatient hospital services, where price variation between providers is defined by factors, such as DRG base rates, price-standardized allowed amounts were applied to remove differences in prices or rates between providers. Price-standardized allowed amounts are used where there are significant cost differences between providers to disincentivize the use of high-cost providers. Other services were price-standardized where significant variations in costs are due to fee schedule differences, such as differences in fee schedule due to an outpatient setting compared to an office setting. These were then summed up for each individual episode to get the total standardized episode cost, which is used as the predicted outcome in the risk adjustment models.

3. Winsorize outliers

   To ensure that episodes with unusually high costs or incomplete episodes that otherwise meet the inclusion criteria do not influence the final episode price, winsorization was applied to the cost of the outlier episodes. 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 5^{th} and 99^{th} percentiles, respectively, were reset to those thresholds.

4. Risk adjustment

   Predictive models were developed to predict episode cost for each bundle. The models use the standardized episode cost as the predicted outcome. Risk factors were then tested and clinically validated to capture the clinical risk of the individual patient and the effect on the episode of care cost. Risk factors include member demographics, episode subtypes, clinical risk factors (e.g., comorbidities), social risk factors (i.e., Area Deprivation Index), and other supplemental risk adjustors. More detail about risk adjustment can be found at the Connecticut Maternity Bundle website referenced above.

   A regularized regression model was implemented with cross-validation techniques. The model parameters were tested rigorously and optimized. The model performance was assessed using industry standard statistics, such as R-Square and mean absolute percent error.

5. Base price

   There are several elements involved in defining the base price. The following steps are the process for calculating the base price:

a. For each Accountable Provider, the trended, winsorized, and average total episode cost was summed up into the provider historical price. The provider historical price includes costs for delivery, prenatal, and postpartum services from the Accountable Provider and other providers.
b. The provider risk factor was calculated as the average risk factor, including both health and social determinants, for winsorized pregnancies that the Accountable Provider was responsible for.
c. The provider risk adjustment factor was calculated as the Accountable Provider's average risk factor divided by the statewide average risk factor, which includes pregnancies for all Accountable Providers.
d. The risk adjusted provider historical price was the provider historical price divided by the provider risk adjustment factor.
e. The provider base price was calculated as the price that each accountable performance period experience was measured against for calculating incentive payments and costs after risk adjustment. Each Accountable Provider's own risk adjusted historical price makes up a portion of their provider-specific target price, 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.
f. Base prices will be updated annually following this process.

6. Target Price and Incentive Payment Reconciliation

After the conclusion of each Performance Year, DSS will determine each Accountable Provider's target price and perform a reconciliation for all eligible episodes to calculate incentive payments (or losses). DSS will allow for a claims run-out period before conducting the reconciliation process. Once the claims run-out period and reconciliation process are complete, Accountable Providers will receive payment no more than 270 days after the end of each Performance Year. The data used for the reconciliation will include all eligible FFS and Case Rate payments, all of which are made via the Department's MMIS, for each particular Performance Year. These payments are only made on behalf of birthing members. Other payments made to Accountable Providers are not included in this reconciliation. This incentive payment calculation is in addition to the annual rebasing of Case Rates using updated claims data for cost and utilization of services included in the Case Rate.

The first Performance Year will be the twelve months beginning on the initial effective date of this section in the Medicaid State Plan. At the incentive payment reconciliation, each Accountable Provider's target price is calculated by multiplying the base price by their specific performance period risk adjustment. The Accountable Providers' performance period risk adjustment factor is calculated using data from the performance period episodes. Providers with increased patient risk in the performance period will subsequently have target prices adjusted accordingly.

Finally, the Accountable Provider's gross saving or losses will be calculated by the sum of the target prices for the eligible episodes, less the total aggregate performance period FFS Payments of the eligible episodes. See Table 6.2 for illustration. For Year 1, Providers will not be responsible for losses but will share a portion of savings based on quality performance.

Table 6.1 Base Price Example

Provider	Historical Price	Risk Adjustment Factor	Risk Adjusted Historical Price (50%)	Statewide Historical Price (50%)	Base Price
Provider A	$1,200	1.10	$1,091	$1,100	$1,096
Provider B	$1,100	1.00	$1,100	$1,100	$1,100
Provider C	$1,000	0.90	$1,111	$1,100	$1,106

Table 6.2 Risk Adjusted Price and Reconciliation Example

Provider	Base Price	Performance Risk Factor	Target Price	Performance FFS	Net Saving or Loss
Provider A	$1,096	1.05	$1,150	$1,100	$1,150 - $1,100= $50
Provider B	$1,100	1	$1,100	$980	$1100 - $980 = $120
Provider C	$1,106	0.98	$1,083	$1,100	$1083 - $1,100 = -$17

VII. Quality and Incentive Payment Methodology

Specific details pertaining to the quality measures, quality scorecard calculations, and methodologies for distributing incentive payments based on quality performance can be found at the Connecticut Maternity Bundle website referenced above.

1. Quality Measures

Incentive payments are contingent upon Accountable Providers meeting quality performance criteria established by Medicaid. The quality slate comprises a mix of pay for performance measures, in which the Accountable Provider's performance level determines the financial reimbursement or penalty, and pay for reporting measures, in which financial reimbursement is tied to the submission and reporting of the measure data. For Year 1, pay for performance measures are subject to financial reimbursement only (resulting in a portion of savings based on quality performance).

2. Quality Scorecard Calculations

Quality scorecards are derived using baseline data to set quality performance targets against which performance during the live program is measured. Scores are derived from the baseline period and the performance period in the same way, and both are normalized to the ranges found in the baseline period.

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3. Distribution of Incentive Payment Earnings

The distribution of incentive payments is adjusted based on either the overall performance in relation to peer performance or the percent improvement over baseline from historical performance. Providers will receive payment in accordance with their highest earnings tier between the two methodologies.

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(ii) Naturopaths – The current fee schedule was set as of January 1, 2012 and is effective for services provided on or after that date. The fee schedule for naturopaths can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download." Rates are the same for private and governmental providers and are published at www.ctdssmap.com.

(iii) Nurse practitioners – 90% of physician fees as referenced in (5) above, except for physician-administered drugs and supplies and services rendered by certified registered nurse anesthetists, which are reimbursed at 100% of the physician fees. For qualifying providers and services, maternity services provided by nurse practitioners are paid in accordance with the Bundled Payment for Maternity Services detailed in (5) above.

Nurse practitioner groups and individual nurse practitioners are eligible to participate in the Person-Centered Medical Home (PCMH) initiative detailed in (5) above under Physician's Services. Nurse practitioner services within PCMH practices run by nurse practitioners are authorized by Section 1905(a)(6) (services by other licensed practitioners). Nurse practitioners working in a physician group or a solo physician practice are eligible to participate in the PCMH initiative as part of the physician group or solo physician practice under the Physician's Services section of the State Plan.

(iv) Dental Hygienists - 90% of the department's fees for dentists as referenced in (10) below).

(v) Licensed behavioral health practitioners to include licensed clinical social workers, licensed marital and family therapists, licensed professional counselors, and licensed alcohol and drug counselors. The fee schedule for licensed behavioral health practitioners can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page go to "Provider," then to "Provider Fee Schedule Download." The agency's rates were set as of November 17, 2021 and are effective for services on or after that date. Rates are the same for private and governmental providers and are published at www.ctdssmap.com.

(vi) Physician assistants – 90% of the department's fees for physicians, as referenced in (5) above, except for physician-administered drugs and supplies, which are reimbursed at 100% of the physician fees. For qualifying providers and services, maternity services provided by physician assistants are paid in accordance with the Bundled Payment for Maternity Services detailed in (5) above.

Physician assistants working in a physician group or a solo physician practice are eligible to participate in the Person-Centered Medical Home (PCMH) initiative detailed in (5) above under Physician's Services as part of the physician group or solo physician practice under the Physician's Services section of the State Plan in Section (5) above.

(vii) Acupuncturists - 100% of physician fees as noted in (5) above. The current fee schedule was set as of October 1, 2021 and is effective for services provided on or after that date. The fee schedule for acupuncturists can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download." All governmental and private providers are reimbursed according to the same fee schedule.

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(17) Nurse-mid wife services - are paid ~~off of~~ using the physician fee schedule at 100% of physician fees, as referenced in (5) above. For qualifying providers and services, maternity services provided by nurse-midwives are paid in accordance with the Bundled Payment for Maternity Services detailed in (5) above.

(18) The Medicaid Hospice rates are set prospectively by CMS based on the methodology used in setting Medicare Hospice rates, which are adjusted to disregard the cost offsets attributable to Medicare coinsurance amounts. Hospice payment rates are also adjusted for regional differences in wages, using indices published in the Federal Register and daily Medicaid hospice payment rates announced through CMS's memorandum titled "Annual Change in Medicaid Hospice Payment Rates—ACTION". The hospice fee schedule can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider" then to "Provider Fee Schedule Download". All governmental and private providers are reimbursed according to the same fee schedule. For clients living in a nursing facility, the per diem nursing facility rate will equal 95% of the rate for that nursing home under the Medicaid program.

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(21) Pediatric and family nurse practitioners – 90% of physician fees as referenced in (5) above, except for physician-administered drugs and supplies and services rendered by certified registered nurse anesthetists, which are reimbursed at 100% of the physician fees. For qualifying providers and services, maternity services provided by pediatric and family nurse practitioners are paid in accordance with the Bundled Payment for Maternity Services detailed in (5) above.

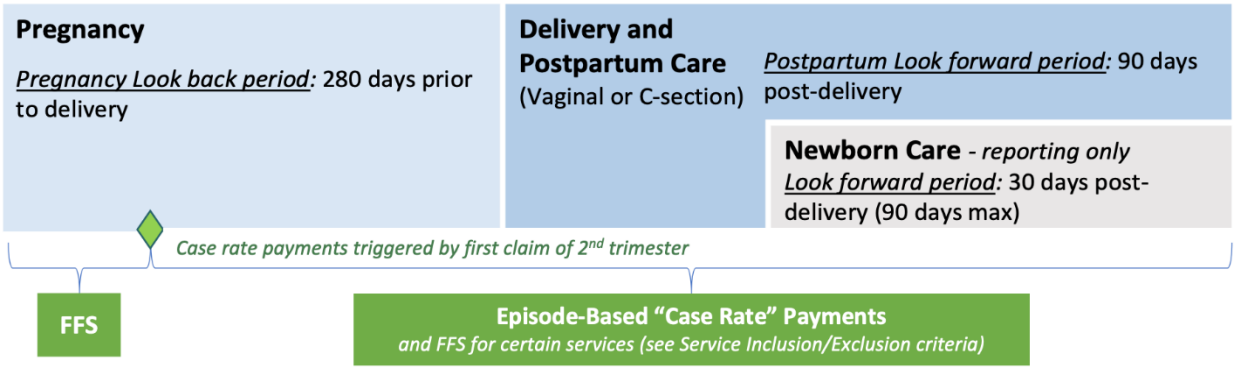
Pediatric and family nurse practitioner groups and individual pediatric and family nurse practitioners are eligible to participate in the Person-Centered Medical Home (PCMH) initiative detailed in (5) above under Physician's Services. Pediatric and family nurse practitioner services within PCMH practices run by pediatric and family nurse practitioners are authorized by Section 1905(a)(21) (services by certified pediatric and family nurse practitioners). Pediatric and family nurse practitioners working in a physician group or a solo physician practice are eligible to participate in the PCMH initiative as part of the physician group or solo physician practice under the Physician's Services section of the State Plan.

HUSKY Maternity Bundle Payment Program
Program Specifications
Preliminary Working Draft

The Connecticut Department of Social Services (DSS) anticipates transitioning to an episode-based payment model for maternity care reimbursement with a planned launch effective on or after April 1, 2024 (i.e., the program is not yet in effect and the implementation date will be finalized, which will be subject to federal approval). This plan to implement the HUSKY Maternity Bundle Payment Program is part of DSS' overarching goal to move toward paying for equitable care in a value-based way.

Note: This draft Program Specifications document was posted in December 2023 for the purposes of Public Notice. DSS reserves the right to update the Program Specifications after reviewing stakeholder input, completing program testing, and additional analysis.

Maternity Episode Definition
An episode of care describes the total amount of care provided to a beneficiary during a set timeframe. As shown below, the maternity episode includes services across the full perinatal period, spanning 280 days before the date of delivery to 90 days after the date of delivery.



Accountable Provider
In episode-based payment models, the "Accountable Provider" is the provider with the greatest influence and responsibility over the quality and cost of care delivered during the maternity episode. The Accountable Provider is the maternity billing provider entity delivering maternity services, and they may be eligible to receive Case Rate and/or incentive payments, which will be provided to the billing Tax ID.

Key Detail	Episode Base Definition
Provider Specialty	• Episode may be attributed to outpatient Obstetrics (OB), Licensed Midwife, and Family Medicine providers or provider groups[1]
Minimum Episode Volume	• Eligible providers that meet the minimum episode volume threshold of 30 episodes in the past 12 months will be automatically enrolled in the program.
Trigger Code	• ICD-10-CM, HCPCS or service codes[2] that formally assign the beneficiary's episode to an accountable provider

[1] Provider groups will designate which provider will receive payment on behalf of the practice.

[2] A full list of codes is available on the DSS website and for public notice purposes, a copy of that list is attached to the public notice document.

Service Inclusion & Exclusion Criteria

Key Detail	Episode Base Definition
Services Included in the Episode	**Services Included for Case Rate Payment[2]** The provider-specific Case Rate payment reimburses a defined set of services rendered by the Accountable Provider during the prenatal and postpartum periods of the episode. Services eligible for or included in the Case Rate payment include: • Office visits • Emergency room visits • Inpatient professional or facility services • Labs, radiology, imaging or ancillary services *if performed by Accountable Provider* • Pregnancy health screenings (inclusive of chlamydia and cervical cancer screenings, intimate partner violence screening, and behavioral health evaluations • New maternal health services provided under the supervision of the accountable practice and within both the scope of the provider's overall services and the provider's plan of care for each beneficiary *(specifically, both doula care and lactation supports)* • Child birth and parenting education services • Care coordination activities **Services Included for Incentive Payment Calculation[2]** All Medicaid claim costs for covered services (regardless of the provider that performed the service, which are paid in accordance with the reimbursement methodology applicable to the provider and service) will be included in the incentive payment calculations. Unless excluded below, these services include, but are not limited to: • Office visits • Emergency room visits • Inpatient professional or facility services • Labs, radiology, imaging or ancillary services • Pregnancy health screenings (inclusive of chlamydia and cervical cancer screenings, intimate partner violence screening, and behavioral health evaluations • New maternal health services provided under the supervision of the accountable practice and within both the scope of the provider's overall services and the provider's plan of care for each beneficiary *(lactation supports only)* • Child education services • Care coordination activities • Birth centers and hospital costs related to maternity care • Specialist/professional services related to maternity (e.g., anesthesia) • General pharmacy related to maternity • Any of the aforementioned services provided via telehealth
Excluded Services from the Episode	**Services Excluded from the Bundle** The following services are excluded from the incentive payment calculations: • Pediatric Professional services • Neonatal Intensive Care Unit (NICU) services • Behavioral Health and Substance Use Disorder services • Long-acting reversible contraceptive (LARC) devices and related services • Durable Medical Equipment (DME), e.g., blood pressure monitors, breast pumps • High-cost medications (specifically, HIV drugs and brexanolone) • Hospital costs unrelated to maternity (e.g., appendicitis) and other care unrelated to maternity that the beneficiary would still receive if they were not pregnant (e.g. Respiratory Care, Home Care, etc.). Other care and services unrelated to maternity are

	defined as services that the birthing person regularly receives or would receive when they were not pregnant.

[2] A full list of codes is available on the DSS website.

New Coverage of Doulas and Lactation Support

DSS plans to incorporate access to doula services and lactation supports as core features of the upcoming HUSKY Maternity Bundle Payment Program to bridge the equity gaps for historically marginalized birthing people. The new high-value services shall be provided under the supervision of the Accountable Provider and within both the scope of the provider's overall services and the provider's plan of care for each beneficiary. Accountable Providers will receive $21 total for add-on funding per member per month, which is comprised of: $14 for doula services and $7 for lactation supports. The add-on payment will be provided prospectively and subject to a retrospective true up process.

Description of Doula Services

Doula services are limited to childbirth education and support services, which includes emotional and physical support, provided during pregnancy, labor, birth, and postpartum. Doula services must be provided under the supervision of a physician, nurse practitioner, or nurse-midwife. Additional background resources for providers and doulas can be found at the DSS website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/HUSKY-Maternity-Bundle/Doula-Integration

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Description of Lactation Support Services

1) Providers should provide first-line breast feeding education and support to all members. This includes information about the benefits of breastfeeding, as well as support for mothers who are struggling. It could also include existing or developed tools to assist mothers gauge breastfeeding success. This program could include online modules, in-person classes, and one-on-one support from lactation consultants.

2) Providers should also screen all members for potential breastfeeding difficulties or additional risk factors that may require additional expertise. Utilize or develop a screening tool to identify members who are at risk for breastfeeding problems. This tool could be used by nurses, midwives, IBCLCs and other healthcare providers during prenatal and postpartum visits.

3) Finally, providers should ensure appropriate access to International Board-Certified Lactation Consultants (IBCLCs) for members at risk or presenting with clinical problems related to breastfeeding/lactation. Establish a system for members who need clinical lactation support with breastfeeding. This system could connect members with IBCLCs who are available to provide in-person, video, or phone support.

Exclusion Criteria

If the beneficiary meets one or more exclusion criteria below, their Accountable Provider will be ineligible for retrospective reconciliation. In these instances, the Accountable Provider may continue to receive Case Rate payments; however, they will be ineligible for incentive payments.

Key Detail	Episode Base Definition
Exclusion Criteria	*Beneficiary Exclusions:* • Age <12 or >55 • Mother left the hospital against medical advice prior to discharge • Any substantial gap in enrollment or eligibility during the delivery episode *Pregnancy Exclusion:* • There were no claims incurred during the first two trimesters of the pregnancy *Delivery Exclusion:* • Missing a facility claim in the episode (i.e., "orphan" episode) *Newborn Exclusions (for reporting purposes only):* • Baby is stillborn • The baby was born with a serious congenital anomaly • Baby could not be linked with the delivery episode

Risk Adjustment Factors

As described in the SPA, risk adjustment will be applied during retrospective reconciliation. Below are the risk factors that will be included during the clinical and social risk adjustment.

Key Detail	Episode Base Definition
Clinical Risk Adjustment	The following list of risk factors will be used to capture the clinical risk of the individual patient and the effect on the episode of care cost: • Member demographics: age and gender • Episode subtypes: subcategories of an episode that identify different modalities and cost trajectories • Risk factors: comorbidities present at the start of the episode which could influence episode cost • Supplemental risk adjustors: enrollment duration and line of business
Social Risk Adjustment	• To mitigate the disincentive for providers to serve the underserved community and promote health equity in the model design, the Area Deprivation Index (ADI) will be used for social risk adjustment. • The ADI is a relative index of affluence and deprivation between areas at the 9-digit ZIP code level. • The ADI will be determined for the population each Accountable Provider serves, and that information will be used as an adjustment factor similar to the health-based risk adjustment. • For members living in area without an ADI, the average ADI for the Accountable Provider's patient panel will be used.

Quality Methodology

Incentive payments are contingent upon Accountable Providers meeting quality performance criteria established by Medicaid.

Quality Measures and Weights

Pay for Performance (71% Total)

1 Cesarean Birth (24%)

The proportion of live babies born at or beyond 37.0 weeks gestation to women in their first pregnancy, via cesarean birth.

2 Postpartum Care (18%)

Measures rate of timeliness of postpartum care for the maternity bundle project.

3 Prenatal Care (12%)

Measures the timeliness of prenatal care for the maternity bundle project.

4 Low Birth Weight (12%)

The proportion of infants with the International Classification of Diseases codes for light for gestational age, small for gestational age, low birthweight, or intensive care units care for low birthweight infants on newborn records among all births.

5 Maternal Adverse Events (6%)

The proportion of deliveries > = 20 weeks gestation with any of 21 maternal morbidities plus maternal mortality occurring during the delivery hospitalization, risk-adjusted using claims data.

Pay for Reporting (29%)

6 Contraception (6%)

The proportion of mothers with Live Deliveries that reported Contraceptive use within 90 days of Delivery

7 Preterm Birth/Labor (6%)

The proportion of preterm births/labors among the total number of live births

8 Doula Utilization (6%)

Proportion of births attended by a doula.

9 Breastfeeding (6%)

Assesses the proportion of newborns exclusively fed breast milk during the newborn's entire hospitalization.

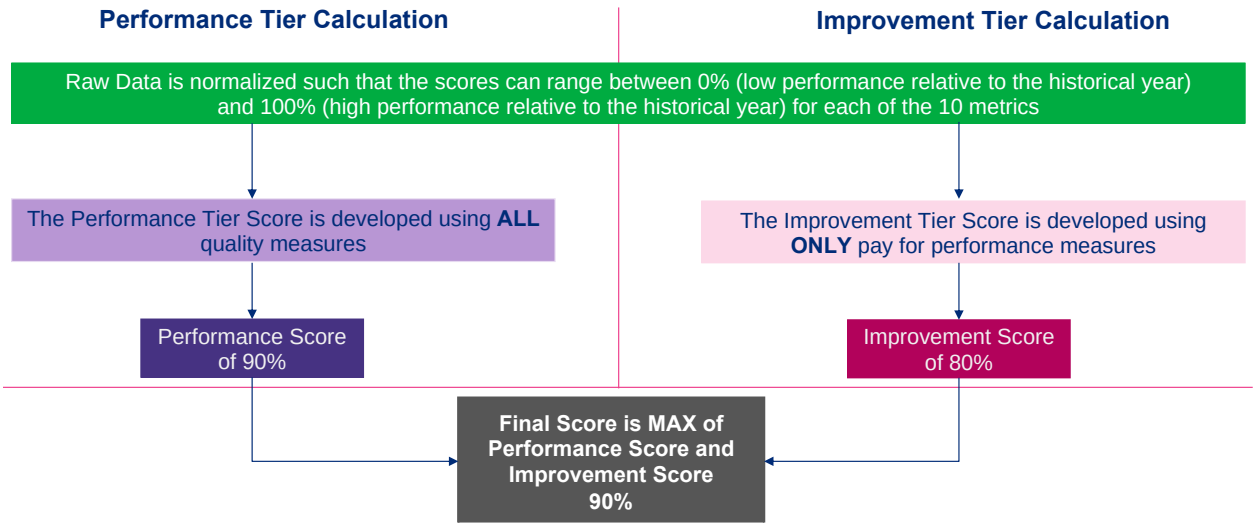
10 Behavioral Health Risk Assessment (6%)

Proportion of patients who gave birth and received a behavioral health screening risk assessment at the first prenatal visit of those patients who gave birth and had at least one prenatal visit

Methodology and Assumptions

The distribution of incentive payments is adjusted based on either the overall performance in relation to peer performance ("Performance Tier Score") or the percent improvement over baseline from historical performance ("Improvement Tier Score"). As demonstrated in the illustrative example below, Accountable Providers will receive payment in accordance with their highest earnings tier between the two methodologies.

Illustrative Example



Performance Tier Score Calculation

There are four steps to calculating the Performance Tier Score:

- **Step 1:** Normalize each Pay for Performance Metric against the Historical year minimum and maximum values.
  - Pay for Reporting Metrics are assigned a value of 1 if data for the metric is present otherwise 0 if no data is present.
- **Step 2:** Invert the appropriate metrics such that a higher score is better.
- **Step 3:** Ensure that the metrics are within the boundaries of 0 and 1.
- **Step 4:** Utilize the metric weights to calculate a final composite, metric-weighted Performance Score.

Improvement Tier Score Calculation

There are three additional steps to calculate the Improvement Tier Score:

- **Step 1:** The improvement tier score is calculated with the same steps as the Performance Tier Score, but from the Pay for Performance Metrics only.
- **Step 2:** Take the difference in the Current (2022) Pay For Performance Score from the Historical (2021) Pay For Performance Score.
- **Step 3:** Divide the difference between the Current (2022) and Historical (2021) scores to get the Improvement Tier Score.

Percentage of Shared Savings Earned

- The Performance Tier Score and Improvement Tier Score are each cross-walked to a Percentage of Shared Savings Earned. **The maximum Percentage of Shared Savings Earned between the two scores is selected as the final Percentage of Shared Earning Earned**.

Performance Tier Score

Overall Performance	Performance Earnings Tier	Performance: % Shared Savings
< 55th Percentile of peer group	F	50%
55–60th Percentile of peer group	D	60%
60–70th Percentile of peer group	C	70%
70–75th Percentile of peer group	B	80%
75–80th Percentile of peer group	A	90%
> 80th Percentile of peer group	S	100%

Improvement Tier Score

Improvement	Improvement Earnings Tier	Improvement: % Shared Savings
<0%	F	50%
0–3%	D	60%
3–5%	C	70%
5–10%	B	80%
10%+	A	90%

Accountable Providers who fall into Tier F for both the Performance Earnings Tier and the Improvement Earnings Tier will be required to submit a quality improvement plan in order to earn incentive payments for the Performance Year. In the subsequent Performance Year, if an Accountable Provider consecutively maintains quality performance in Tier F for both tiers, the provider will be ineligible for the incentive payment of that performance period.

Trigger Codes

Trigger codes should be billed by the Accountable Provider in the 2nd or 3rd trimester to indiciate episode responsibility and initiate the

DX	DX_Description	Trimester	Trigger
Z3A14	14 WEEKS GESTATION OF PREGNANCY	2	Y
Z3A15	15 WEEKS GESTATION OF PREGNANCY	2	Y
Z3A16	16 WEEKS GESTATION OF PREGNANCY	2	Y
Z3A17	17 WEEKS GESTATION OF PREGNANCY	2	Y
Z3A18	18 WEEKS GESTATION OF PREGNANCY	2	Y
Z3A19	19 WEEKS GESTATION OF PREGNANCY	2	Y
Z3A20	20 WEEKS GESTATION OF PREGNANCY	2	Y
Z3A21	21 WEEKS GESTATION OF PREGNANCY	2	Y
Z3A22	22 WEEKS GESTATION OF PREGNANCY	2	Y
Z3A23	23 WEEKS GESTATION OF PREGNANCY	2	Y
Z3A24	24 WEEKS GESTATION OF PREGNANCY	2	Y
Z3A25	25 WEEKS GESTATION OF PREGNANCY	2	Y
Z3A26	26 WEEKS GESTATION OF PREGNANCY	2	Y
Z3A27	27 WEEKS GESTATION OF PREGNANCY	2	Y
Z3A28	28 WEEKS GESTATION OF PREGNANCY	3	Y
Z3A29	29 WEEKS GESTATION OF PREGNANCY	3	Y
Z3A30	30 WEEKS GESTATION OF PREGNANCY	3	Y
Z3A31	31 WEEKS GESTATION OF PREGNANCY	3	Y
Z3A32	32 WEEKS GESTATION OF PREGNANCY	3	Y
Z3A33	33 WEEKS GESTATION OF PREGNANCY	3	Y
Z3A34	34 WEEKS GESTATION OF PREGNANCY	3	Y
Z3A35	35 WEEKS GESTATION OF PREGNANCY	3	Y
Z3A36	36 WEEKS GESTATION OF PREGNANCY	3	Y
Z3A37	37 WEEKS GESTATION OF PREGNANCY	3	Y
Z3A38	38 WEEKS GESTATION OF PREGNANCY	3	Y
Z3A39	39 WEEKS GESTATION OF PREGNANCY	3	Y
Z3A40	40 WEEKS GESTATION OF PREGNANCY	3	Y
Z3A41	41 WEEKS GESTATION OF PREGNANCY	3	Y
Z3A42	42 WEEKS GESTATION OF PREGNANCY	3	Y
O0902	SUPERVISION PREG W/HX INFERTILITY 2ND TRIMESTER	2	Y

DX	DX_Description	Trimester	Trigger
O0903	SUPERVISION PREG W/HX INFERTILITY 3RD TRIMESTER	3	Y
O0912	SUPERVISION OF PREGNANCY HX ECTOPIC PREG 2ND TRI	2	Y
O0913	SUPERVISION OF PREGNANCY HX ECTOPIC PREG 3RD TRI	3	Y
O09212	SUPERVISION PREG W/HX PRE-TERM LABOR SECOND TRI	2	Y
O09213	SUPERVISION PREG W/HX PRE-TERM LABOR THIRD TRI	3	Y
O09292	SUP PREG W/OTH POOR REPRODUCTIVE/OB HX 2ND TRI	2	Y
O09293	SUP PREG W/OTH POOR REPRODUCTIVE/OB HX THIRD TRI	3	Y
O0932	SUPERVISION PREG W/INSUFF ANTENATAL CARE 2ND TRI	2	Y
O0933	SUPERVISION PREG W/INSUFF ANTENATAL CARE 3RD TRI	3	Y
O0942	SUPERVISION PREG W/GRAND MULTIPARITY SECOND TRI	2	Y
O0943	SUPERVISION PREG W/GRAND MULTIPARITY THIRD TRI	3	Y
O09512	SUPERVISION ELDERLY PRIMIGRAVIDA SECOND TRI	2	Y
O09513	SUPERVISION ELDERLY PRIMIGRAVIDA THIRD TRIMESTER	3	Y
O09522	SUPERVISION ELDERLY MULTIGRAVIDA SECOND TRI	2	Y
O09523	SUPERVISION ELDERLY MULTIGRAVIDA THIRD TRIMESTER	3	Y
O09612	SUPERVISION YOUNG PRIMIGRAVIDA SECOND TRIMESTER	2	Y
O09613	SUPERVISION YOUNG PRIMIGRAVIDA THIRD TRIMESTER	3	Y

DX	DX_Description	Trimester	Trigger
O09622	SUPERVISION YOUNG MULTIGRAVIDA SECOND TRIMESTER	2	Y
O09623	SUPERVISION YOUNG MULTIGRAVIDA THIRD TRIMESTER	3	Y
O0972	SUP HIGH RISK PREG D/T SOCIAL PROBLEMS 2ND TRI	2	Y
O0973	SUP HIGH RISK PREG D/T SOCIAL PROBLEMS THIRD TRI	3	Y
O09812	SUP PREG RESULT ASSTD REPRODUCTIVE TECH 2ND TRI	2	Y
O09813	SUP PREG RESULT ASSTD REPRODUCTIVE TECH 3RD TRI	3	Y
O09822	SUP PREG W/HX IN UTERO PROC DUR PREV PG 2ND TRI	2	Y
O09823	SUP PREG W/HX IN UTERO PROC DUR PREV PG 3RD TRI	3	Y
O09892	SUPERVISION OTH HIGH RISK PREG SECOND TRIMESTER	2	Y
O09893	SUPERVISION OTH HIGH RISK PREG THIRD TRIMESTER	3	Y
O0992	SUPERVISION HIGH RISK PREG UNS SECOND TRIMESTER	2	Y
O0993	SUPERVISION HIGH RISK PREG UNS THIRD TRIMESTER	3	Y
O09A2	SUPERVISION PREGNANCY HX MOLAR PREG 2ND TRIM	2	Y
O09A3	SUPERVISION PREGNANCY HX MOLAR PREG 3RD TRIM	3	Y
Z3402	ENCOUNTER SUPRVISN NORMAL FIRST PREG 2 TRIMESTER	2	Y
Z3403	ENCOUNTER SUPRVISN NORMAL FIRST PREG 3 TRIMESTER	3	Y
Z3482	ENC SUPERVISION OTH NORMAL PREGNANCY 2 TRIMESTER	2	Y

DX	DX_Description	Trimester	Trigger
Z3483	ENC SUPERVISION OTH NORMAL PREGNANCY 3 TRIMESTER	3	Y
Z3492	ENC SUPERVISION NORMAL PREGNANCY UNS 2 TRIMESTER	2	Y
Z3493	ENC SUPERVISION NORMAL PREGNANCY UNS 3 TRIMESTER	3	Y
O10012 ICD-10-CM Pre-existing essential hypertension complicating pregnancy, second trimester		2	Y
O10013 ICD-10-CM Pre-existing essential hypertension complicating pregnancy, third trimester		3	Y
O10112 ICD-10-CM Pre-existing hypertensive heart disease complicating pregnancy, second trimester		2	Y
O10113 ICD-10-CM Pre-existing hypertensive heart disease complicating pregnancy, third trimester		3	Y
O10212 ICD-10-CM Pre-existing hypertensive chronic kidney disease complicating pregnancy, second trimester		2	Y
O10213 ICD-10-CM Pre-existing hypertensive chronic kidney disease complicating pregnancy, third trimester		3	Y
O10312 ICD-10-CM Pre-existing hypertensive heart and chronic kidney disease complicating pregnancy, second trimester		2	Y
O10313 ICD-10-CM Pre-existing hypertensive heart and chronic kidney disease complicating pregnancy, third trimester		3	Y
O10412 ICD-10-CM Pre-existing secondary hypertension complicating pregnancy, second trimester		2	Y
O10413 ICD-10-CM Pre-existing secondary hypertension complicating pregnancy, third trimester		3	Y
O10912 ICD-10-CM Unspecified pre-existing hypertension complicating pregnancy, second trimester		2	Y
O10913 ICD-10-CM Unspecified pre-existing hypertension complicating pregnancy, third trimester		3	Y
O112 ICD-10-CM Pre-existing hypertension with pre-eclampsia, second trimester		2	Y
O113 ICD-10-CM Pre-existing hypertension with pre-eclampsia, third trimester		3	Y

DX	DX_Description	Trimester	Trigger
O1202 ICD-10-CM Gestational edema, second trimester		2	Y
O1203 ICD-10-CM Gestational edema, third trimester		3	Y
O1212 ICD-10-CM Gestational proteinuria, second trimester		2	Y
O1213 ICD-10-CM Gestational proteinuria, third trimester		3	Y
O1222 ICD-10-CM Gestational edema with proteinuria, second trimester		2	Y
O1223 ICD-10-CM Gestational edema with proteinuria, third trimester		3	Y
O132 ICD-10-CM Gestational [pregnancy-induced] hypertension without significant proteinuria, second trimester		2	Y
O133 ICD-10-CM Gestational [pregnancy-induced] hypertension without significant proteinuria, third trimester		3	Y
O1412 ICD-10-CM Severe pre-eclampsia, second trimester		2	Y
O1413 ICD-10-CM Severe pre-eclampsia, third trimester		3	Y

Case Rate Codes

Codes in consideration for Case Rate payment (pay prospectively).

Procedure Codes	Proc Description	Notes
81025	Urinalysis Procedures	
0U7C7ZZ	Dilation of Cervix, Via Natural or Artificial Opening	
0475T	RECORDING, FETAL MAGNETIC CARDIAC SIGNAL, 3 CHAN	
0476T	RECORDING, FETAL MAGNETIC CARDIAC SIGNAL, 3 CHAN	
0477T	RECORDING, FETAL MAGNETIC CARDIAC SIGNAL, 3 CHAN	
0478T	RECORDING, FETAL MAGNETIC CARDIAC SIGNAL, 3 CHAN	
3E030VJ	Approach	
3E033VJ	Approach	
3E040VJ	Introduction of Other Hormone into Central Vein, Open Approach	
3E043VJ	Approach	
3E050VJ	Approach	
3E053VJ	Percutaneous Approach	
3E060VJ	Introduction of Other Hormone into Central Artery, Open Approach	
3E063VJ	Approach	
3E0DXGC	Pharynx, External Approach	
3E0P7VZ	Artificial Opening	
0500F	INITIAL PRENATAL CARE VISIT	
0501F	PRENATAL FLOW SHEET	
0502F	SUBSEQUENT PRENATAL CARE	
0503F	POSTPARTUM CARE VISIT	
1220F	PATIENT SCREENED FOR DEPRESSION	
59025	FETAL NON-STRESS TEST	
59050	FETAL MONITOR W/REPORT	
59051	FETAL MONITOR/INTERPRET ONLY	
59409	OBSTETRICAL CARE	
59410	OBSTETRICAL CARE	
59412	ANTEPARTUM MANIPULATION	
59425	ANTEPARTUM CARE ONLY	
59426	ANTEPARTUM CARE ONLY	
59899	MATERNITY CARE PROCEDURE	
10E0XZZ	Delivery Of Products Of Conception, External Approach	
10S0XZZ	Reposition Products of Conception, External Approach	
0Q820ZZ	Division of Right Pelvic Bone, Open Approach	
0Q823ZZ	Division of Right Pelvic Bone, Percutaneous Approach	
0Q824ZZ	Division of Right Pelvic Bone, Percutaneous Endoscopic Approach	
0Q830ZZ	Division of Left Pelvic Bone, Open Approach	
0Q833ZZ	Division of Left Pelvic Bone, Percutaneous Approach	
0Q834ZZ	Division of Left Pelvic Bone, Percutaneous Endoscopic Approach	
10D07Z8	Extraction Of Products Of Conception, Other, Via Opening	
10D00Z0	Extraction of Products of Conception, High, Open Approach	
10D00Z1	Extraction of Products of Conception, Low, Open Approach	
10D00Z2	Approach	
76805	OB US >/= 14 WKS, SNGL FETUS	
76810	OB US >/= 14 WKS, ADDL FETUS	
76811	OB US, DETAILED, SNGL FETUS	
76812	OB US, DETAILED, ADDL FETUS	
76813	OB US NUCHAL MEAS, 1 GEST	
76814	OB US NUCHAL MEAS, ADD-ON	
76815	OB US, LIMITED, FETUS(S)	
76816	OB US, FOLLOW-UP, PER FETUS	
76817	TRANSVAGINAL US, OBSTETRIC	
76818	FETAL BIOPHYS PROFILE W/NST	
76819	FETAL BIOPHYS PROFIL W/O NST	
76820	UMBILICAL ARTERY ECHO	
76821	MIDDLE CEREBRAL ARTERY ECHO	
76825	ECHO EXAM OF FETAL HEART	
76826	ECHO EXAM OF FETAL HEART	
76827	ECHO EXAM OF FETAL HEART	
76828	ECHO EXAM OF FETAL HEART	
76830	TRANSVAGINAL US, NON-OB	
76831	ECHO EXAM, UTERUS	
76856	US EXAM, PELVIC, COMPLETE	

76857	US EXAM, PELVIC, LIMITED	
80055	OBSTETRIC PANEL	
80081	OBSTETRIC PANEL	
81025	URINE PREGNANCY TEST	
82951	GLUCOSE TOLERANCE TEST (GTT)	82951: Would need to be accompanied by pregnancy
82952	GLUC TOL TEST, EA ADDL AFTER 3	
84702	CHORIONIC GONADOTROPIN TEST	
84703	CHORIONIC GONADOTROPIN ASSAY	
84704	HCG, FREE BETACHAIN TEST	
87535	HIV-1, DNA, AMP PROBE	
87536	HIV-1, DNA, QUANT	
99460	INITIAL HOSP OR BIRTH CTR CARE, PER DAY, E&M, NORM	
99463	INIT CARE, HOSP/BIRTH CTR, E&M, ADMIT/DSCHG SAMEDA	
99464	ATTENDANCE AT DELIVERY, INIT STABILIZATION OF INFA	
99494	INIT/SUBSQ PSYCH COLLBRTV CARE MGMNT, EA ADDL 30 M	
99500	HOME VISIT, PRENATAL	
99501	HOME VISIT, POSTNATAL	
99502	HOME VISIT, NB CARE	
BY49ZZZ	Ultrasonography Of First Trimester, Single Fetus	
BY4BZZZ	Ultrasonography Of First Trimester, Multiple Gestation	
BY4CZZZ	Ultrasonography Of Second Trimester, Single Fetus	
BY4DZZZ	Ultrasonography Of Second Trimester, Multiple Gestation	
BY4FZZZ	Ultrasonography Of Third Trimester, Single Fetus	
BY4GZZZ	Ultrasonography Of Third Trimester, Multiple Gestation	
G9355	ELECTIVE DELIVERY/EARLY INDUCTION NOT PERFORMED	
G9356	ELECTIVE DELIVER/EARLY INDUCTION PERFORMED	
G9357	POST PARTUM SCRNG/EVAL/EDUC PERFORMED	
G9358	POST PARTUM SCRNG/EVAL/EDUC NOT PERFORMED	
H0001	ALCOHOL AND/OR DRUG ASSESS	
H0049	ALCOHOL/DRUG SCREENING	
H1000	PRENATAL CARE ATRISK ASSESSM	
H1001	ANTEPARTUM MANAGEMENT	
H1002	CARECOORDINATION PRENATAL	
H1003	PRENATAL AT RISK EDUCATION	
H1004	FOLLOW UP HOME VISIT/PRENTAL	
H1005	PRENATALCARE ENHANCED SRV PK	
Q0091	OBTAINING SCREEN PAP SMEAR	
S0220	MEDICAL CONFERENCE BY PHYSIC	
S0221	MEDICAL CONFERENCE, 60 MIN	
S3005	EVAL SELF-ASSESS DEPRESSION	
S9436	LAMAZE CLASS	
S9437	CHILDBIRTH REFRESHER CLASS	
S9438	CESAREAN BIRTH CLASS	
S9439	VBAC CLASS	
S9442	BIRTHING CLASS	
S9443	LACTATION CLASS	
S9444	PARENTING CLASS	
S9447	INFANT SAFETY CLASS	
T1014	TELEHEALTH TRANSMIT, PER MIN	
T2101	BREAST MILK PROC/STORE/DIST	

Reconciliation Codes

Codes in consideration of retrospective pay (settle retrospectively).

Procedure Codes	Proc Description	Notes
81025	Urinalysis Procedures	
00940	ANESTH, VAGINAL PROCEDURES	
0127U	OBSTETRICS BIOCHEM ASSAY	
0128U	OBSTETRICS BIOCHEM ASSAY	
01958	ANESTH, ANTEPARTUM MANIPUL	Anesthesia for obstetric procedures
01960	ANESTH, VAGINAL DELIVERY	
01961	ANESTH, CS DELIVERY	
01967	ANESTH/ANALG, VAG DELIVERY	
01968	ANES/ANALG CS DELIVER ADD-ON	* 67–69 as 67 and 69 are add-ons
0475T	RECORDING, FETAL MAGNETIC CARDIAC SIGNAL, 3 CHAN	
0476T	RECORDING, FETAL MAGNETIC CARDIAC SIGNAL, 3 CHAN	
0477T	RECORDING, FETAL MAGNETIC CARDIAC SIGNAL, 3 CHAN	
0478T	RECORDING, FETAL MAGNETIC CARDIAC SIGNAL, 3 CHAN	
0500T	INFECTS AGENT DETCTN, DNA/RNA, HPV, 5 TYPES	Would be done if pap smear due during pregnancy.
59012	FETAL CORD PUNCTURE,PRENATAL	
59015	CHORION BIOPSY	
59020	FETAL CONTRACT STRESS TEST	
59025	FETAL NON-STRESS TEST	
59030	FETAL SCALP BLOOD SAMPLE	
59050	FETAL MONITOR W/REPORT	
59051	FETAL MONITOR/INTERPRET ONLY	
59070	TRANSABDOM AMNIOINFUS W/US	
59072	UMBILICAL CORD OCCLUD W/US	
59074	FETAL FLUID DRAINAGE W/US	
59160	D & C AFTER DELIVERY	
59200	INSERT CERVICAL DILATOR	
59300	EPISIOTOMY OR VAGINAL REPAIR	
59400	OBSTETRICAL CARE	
59409	OBSTETRICAL CARE	
59410	OBSTETRICAL CARE	
59412	ANTEPARTUM MANIPULATION	
59414	DELIVER PLACENTA	
59425	ANTEPARTUM CARE ONLY	

Procedure Codes	Proc Description	Notes
59426	ANTEPARTUM CARE ONLY	
59430	CARE AFTER DELIVERY	
59510	CESAREAN DELIVERY	
59514	CESAREAN DELIVERY ONLY	
59515	CESAREAN DELIVERY	
59610	VBAC DELIVERY	
59612	VBAC DELIVERY ONLY	
59614	VBAC CARE AFTER DELIVERY	
59618	ATTEMPTED VBAC DELIVERY	
59620	ATTEMPTED VBAC DELIVERY ONLY	
59622	ATTEMPTED VBAC AFTER CARE	
59899	MATERNITY CARE PROCEDURE	
62273	INJECT EPIDURAL PATCH	
0W8NXZZ	Division of Female Perineum, External Approach	
10D07Z4	Artificial Opening	
10D07Z5	Artificial Opening	
10S07ZZ	Opening	
10D07Z3	Artificial Opening	
10D07Z6	Artificial Opening	
10A07Z6	Artificial Opening	
10D07Z8	Opening	
10900ZC	Conception, Open Approach	
10903ZC	Conception, Percutaneous Approach	
10904ZC	Conception, Percutaneous Endoscopic Approach	
10907ZC	Conception, Via Natural or Artificial Opening	
10908ZC	Conception, Via Natural or Artificial Opening Endoscopic	
0U7C7ZZ	Dilation of Cervix, Via Natural or Artificial Opening	
10J07ZZ	Opening	
3E030VJ	Approach	
3E033VJ	Approach	
3E040VJ	Introduction of Other Hormone into Central Vein, Open Approach	
3E043VJ	Approach	
3E050VJ	Approach	
3E053VJ	Percutaneous Approach	
3E060VJ	Introduction of Other Hormone into Central Artery, Open Approach	
3E063VJ	Approach	

Procedure Codes	Proc Description	Notes
3E0DXGC	Pharynx, External Approach	
3E0P7VZ	Artificial Opening	
10E0XZZ	Delivery Of Products Of Conception, External Approach	
10S0XZZ	Reposition Products of Conception, External Approach	
7359	Other Manually Assisted Delivery	
0Q820ZZ	Division of Right Pelvic Bone, Open Approach	
0Q823ZZ	Division of Right Pelvic Bone, Percutaneous Approach	
0Q824ZZ	Division of Right Pelvic Bone, Percutaneous Endoscopic Approach	
0Q830ZZ	Division of Left Pelvic Bone, Open Approach	
0Q833ZZ	Division of Left Pelvic Bone, Percutaneous Approach	
0Q834ZZ	Division of Left Pelvic Bone, Percutaneous Endoscopic Approach	
10D07Z8	Extraction Of Products Of Conception, Other, Via Opening	
10D00Z0	Extraction of Products of Conception, High, Open Approach	
10D00Z1	Extraction of Products of Conception, Low, Open Approach	
10D00Z2	Approach	
76801	OB US < 14 WKS, SINGLE FETUS	
76802	OB US < 14 WKS, ADD'L FETUS	
76805	OB US >/= 14 WKS, SNGL FETUS	
76810	OB US >/= 14 WKS, ADDL FETUS	
76811	OB US, DETAILED, SNGL FETUS	
76812	OB US, DETAILED, ADDL FETUS	
76813	OB US NUCHAL MEAS, 1 GEST	
76814	OB US NUCHAL MEAS, ADD-ON	
76815	OB US, LIMITED, FETUS(S)	
76816	OB US, FOLLOW-UP, PER FETUS	
76817	TRANSVAGINAL US, OBSTETRIC	
76818	FETAL BIOPHYS PROFILE W/NST	
76819	FETAL BIOPHYS PROFIL W/O NST	
76820	UMBILICAL ARTERY ECHO	
76821	MIDDLE CEREBRAL ARTERY ECHO	
76825	ECHO EXAM OF FETAL HEART	
76826	ECHO EXAM OF FETAL HEART	
76827	ECHO EXAM OF FETAL HEART	
76828	ECHO EXAM OF FETAL HEART	
76830	TRANSVAGINAL US, NON-OB	
76831	ECHO EXAM, UTERUS	

Procedure Codes	Proc Description	Notes
76856	US EXAM, PELVIC, COMPLETE	
76857	US EXAM, PELVIC, LIMITED	
80055	OBSTETRIC PANEL	
80081	OBSTETRIC PANEL	
81025	URINE PREGNANCY TEST	
82951	GLUCOSE TOLERANCE TEST (GTT)	would need to be accompanied by pregnancy diagnosis
82952	GLUC TOL TEST, EA ADDL AFTER 3	
84702	CHORIONIC GONADOTROPIN TEST	
84703	CHORIONIC GONADOTROPIN ASSAY	
84704	HCG, FREE BETACHAIN TEST	
87535	HIV-1, DNA, AMP PROBE	
87536	HIV-1, DNA, QUANT	
99460	INITIAL HOSP OR BIRTH CTR CARE, PER DAY, E&M, NORM	
99463	INIT CARE, HOSP/BIRTH CTR, E&M, ADMIT/DSCHG SAMEDA	
99464	ATTENDANCE AT DELIVERY, INIT STABILIZATION OF INFA	
99494	INIT/SUBSQ PSYCH COLLBRTV CARE MGMNT, EA ADDL 30 M	
99500	HOME VISIT, PRENATAL	
99501	HOME VISIT, POSTNATAL	
99502	HOME VISIT, NB CARE	
BY49ZZZ	Ultrasonography Of First Trimester, Single Fetus	
BY4BZZZ	Ultrasonography Of First Trimester, Multiple Gestation	
BY4CZZZ	Ultrasonography Of Second Trimester, Single Fetus	
BY4DZZZ	Ultrasonography Of Second Trimester, Multiple Gestation	
BY4FZZZ	Ultrasonography Of Third Trimester, Single Fetus	
BY4GZZZ	Ultrasonography Of Third Trimester, Multiple Gestation	
G9355	ELECTIVE DELIVERY/EARLY INDUCTION NOT PERFORMED	
G9356	ELECTIVE DELIVER/EARLY INDUCTION PERFORMED	
G9357	POST PARTUM SCRNG/EVAL/EDUC PERFORMED	
G9358	POST PARTUM SCRNG/EVAL/EDUC NOT PERFORMED	
H0001	ALCOHOL AND/OR DRUG ASSESS	
H0049	ALCOHOL/DRUG SCREENING	
H1000	PRENATAL CARE ATRISK ASSESSM	
H1001	ANTEPARTUM MANAGEMENT	
H1002	CARECOORDINATION PRENATAL	
H1003	PRENATAL AT RISK EDUCATION	
H1004	FOLLOW UP HOME VISIT/PRENTAL	

Procedure Codes	Proc Description	Notes
H1005	PRENATALCARE ENHANCED SRV PK	
S0220	MEDICAL CONFERENCE BY PHYSIC	
S0221	MEDICAL CONFERENCE, 60 MIN	
S3005	EVAL SELF-ASSESS DEPRESSION	
S9436	LAMAZE CLASS	
S9437	CHILDBIRTH REFRESHER CLASS	
S9438	CESAREAN BIRTH CLASS	
S9439	VBAC CLASS	
S9442	BIRTHING CLASS	
S9443	LACTATION CLASS	
S9444	PARENTING CLASS	
S9447	INFANT SAFETY CLASS	
T1014	TELEHEALTH TRANSMIT, PER MIN	
T2101	BREAST MILK PROC/STORE/DIST	