Frequently Asked Questions (FAQ): Connecticut Maternity Bundle Billing and Claims

ATTENTION: Obstetrics & Gynecology, Family Practice Physicians, Physician Assistants, APRNs and Women's Health APRNs, Certified Nurse Midwives and Doulas

1. **What is the Connecticut Maternity Bundle Payment Program?**
   This program supports the transition from traditional fee-for-service (FFS) payments to "episode-based" or "bundled" payments, for maternity care in HUSKY Health (Medicaid). DSS defines the "maternity episode" or "maternity bundle" as the total amount of care provided throughout the perinatal period – from 280 days prior to delivery to 90 days post-delivery. Providers will receive monthly "case rate" payments for most services during the maternity episode beginning with the second trimester. Services not covered under the case rate will be reimbursed through FFS payments.

   At the end of the Performance Year, DSS will perform a reconciliation process to compare the provider's total cost of care for all attributed episodes against their "target price" benchmark. The total cost of care includes the costs for all maternity services provided during the episode, regardless of being paid by case rate or FFS payment. If total episode costs are below the target price, providers will receive a retrospective "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.

2. **Where can I find further information?**
   More information including Webinar Information, Doula Integration, Program Overview, Technical Details, Case Rate Methodology, Incentive Payment Methodology, Quality Measures and more can be found on the DSS website.

3. **Who is eligible to participate?**

- **Eligible Providers:** Physician/physician groups specializing in obstetrics, Advanced Practice Registered Nurse (APRN)/ APRN groups and Certified Nurse-Midwives/Nurse-Midwife groups performing 30+ annual deliveries for Medicaid patients are automatically enrolled.
- **Excluded Providers:** Federally Qualified Health Centers (FQHCs) and physician/physician groups specializing in obstetrics, APRN/ APRN groups and Certified Nurse-Midwives/Nurse-Midwife groups performing <30 annual deliveries will remain on the FFS model.

To qualify for case rate payment as an Accountable Provider, providers must meet the following trigger event 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.

As a reminder, one provider within the practice was identified and confirmed by the practice to receive the case rate payment.

4. **When does the Maternity Bundle program begin?**
   1/1/2025.

5. **Is my practice able to opt out of this program?**
   Program participation is required for eligible providers.

6. **What services are included in the Maternity Episode?**
   Services included in the maternity episode may be paid by case rate or FFS payment and will be included in retrospective reconciliation calculations. Please see the "Reconciliation Codes" within the Code List on the DSS website for the complete list of services included in the maternity episode.

   The case rate will only include professional services, as listed in the Case Rate code list on the DSS website. Once a maternity episode is triggered through the submission of a claim that meets that trigger event criteria, procedure codes on this list will zero pay. Please see the "Case Rate Codes" within the Code List on the DSS website for the complete list of services included in case rate. Maternity episode services paid via case rate generally include:

   - OB/licensed midwife Professional Services
   - *In-house* OB/licensed midwife Professional-related hospitalization costs (Inpatient, Outpatient, and ED) including professional delivery fees
   - OB/licensed midwife Professional-related Behavioral Health Evals, 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
- Care coordination activities
- Any of the above services provided via telehealth

Maternity episode services that are excluded from case rate reimbursement will be paid FFS. For example, non-professional services like facility claims for labor and delivery fall outside the case rate and are paid FFS. These services generally include:

- *If performed outside the participating Accountable Provider:* OB/licensed midwife imaging & labs
- Birth Centers and hospital costs related to maternity care
- Specialist/Professional Services related to maternity (e.g., anesthesia)
- General Pharmacy related to maternity

7. **What happens to services not included in the Maternity Episode?**
Services excluded from the maternity episode will not be included in retrospective reconciliation calculations and will be paid in accordance with their current payment methodology. Services excluded from the episode generally include:

- Pediatric Professional Services
- Neonatal Intensive Care Unit (NICU)
- Behavioral Health & Substance Use services
- Long-acting reversible contraception (LARC)
- Sterilizations
- DME (e.g., blood pressure monitors, breast pumps)
- High-cost medications (specifically, HIV drugs and brexanolone)
- Hospital costs unrelated to maternity (e.g., appendicitis)
- Other Care, including Nutrition, Respiratory Care, Home Care, etc.
- Maternal Oral Health services

8. **How are payments initiated and managed?**
The case rate is initiated in the 2nd trimester, 3rd trimester, or postpartum period by submitting a claim that fulfill the trigger event criteria, including billing with specific **trigger codes** (e.g., ICD-10, HCPCS, or E&M codes). These codes attribute the patient's care to the provider, starting monthly payments through 90 days postpartum.

Effective 1/1/25 - 3/31/25, trigger events ***in the 2nd trimester only*** *will initiate case rate payment.*

This means providers will not receive the case rate payment for patients who, on 1/1/25, are in the 3rd trimester or postpartum period.

Effective 4/1/25, trigger events in the 2nd trimester, 3rd trimester, and postpartum period will initiate case rate payment.

Claims Payment Example:

1. The practice renders care for their patient in their 2nd trimester prenatal visit in January.
2. The practice submits a trigger claim for the January date of service (DOS) in February. The January DOS trigger claim will $0 pay, and the case rate payments for the month of January and February will be generated at the end of February.
3. The practice will see the case rate payments for January and February in the first payment cycle of March.
4. The case rate payment for March (if provider is still the attributed provider) will be paid in the first payment cycle in April.

9. How are Maternity Bundle (or case rate) payments distributed?

Case rate payments are generated at the end of each month and included in the existing semi-monthly Remittance Advice (RA) and 835 electronic files during the first payment cycle of the following month. The RA will include client information, date of service, and the case rate payment amount. A supplemental payment report will also be available through the provider portal to help providers attribute payments within their practice.

10. Who can I contact to discuss the case rate amount?

For all Maternity Bundle questions, including those regarding your case rate payment, please contact your practice's CHNCT, Inc. PES representative. Your representative is the primary contact who previously shared case rate letters and Historic Performance Reports with your practice, and they will serve as your main point of contact to help your practice navigate the transition to the Maternity Bundle program.

Please note that 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.

11. When Medicaid acknowledges the claim submitted for a service included in the case rate payment, will they provide a CARC code [i.e. 245] indicating a per member per month payment was made?

The system will assign EOB 9950, *Service is covered by monthly maternity bundle case rate payment*, code that will display on the Remittance Advice for claim details subjected to the maternity bundle. The 835 will contain a CARC indicating the

reason for claim zero payment. Based on provider feedback, the CAGC is CO, the CARC code will be 245, and the RARC will be M15.

12. What new services are covered?

DSS will provider new coverage of doula services and lactation support as core features of the Maternity Bundle Program to bridge the equity gaps for historically marginalized birthing people. Please see the Program Specifications on the DSS website here for more information.

Doula Services: Doula services are limited to childbirth education and supports 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.

Please note that DSS is utilizing a dual approach to provide and fund access to doula services in Medicaid, in which doula services may be rendered and reimbursed through the maternity episode or through direct Medicaid reimbursement. Detailed information on doula's enrolling and directly being reimbursed will be published soon.

1. **Lactation support:** Lactation support is broadly inclusive of breastfeeding education, screening for potential breastfeeding difficulties or risk factors, and clinical or non-clinical lactation support for breastfeeding. These services may include but are not limited to the:

- Provision of information about the benefits of breastfeeding;
- Use of existing or developed tools to assist mothers gauge breastfeeding success;
- Use of existing or developing screenings to identify potential breastfeeding difficulties or additional risk factors that may require additional expertise;
- Breastfeeding support resources, such as online modules, in-person classes, and one-on-one support from lactation consultants

13. How are doula and lactation support services billed and reimbursed under Maternity Bundle?

For Accountable Providers who receive doula care add-on funding, providers will receive add-on funding ($21 total per member per month: $14 for doula services and $7 for lactation supports) as part of the monthly case rate payment. The doula care add-on funding will be excluded from the incentive payment reconciliation and will be subject to a retrospective true-up process to prevent duplicate Case Rate Add-on Funding and FFS payment for doula services.

Accountable providers receiving the $14 doula add on payment will be required to report doula utilization via an encounter form. DSS will be creating a doula reconciliation process to ensure that the accountable provider is not receiving the

$14 doula add on payment for a client who is receiving doula services from an enrolled doula provider.

14. 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.

15. What happens if another provider takes over care?

If a patient transfers care to another provider, the case rate payments for the original provider cease. The new provider must submit a claim with trigger codes that fulfill the trigger event criteria to initiate the case rate under their Tax Identification Number (TIN). Attribution will adjust based on the claim data.

Please note, if two providers render care within the same month, each practice may both receive their full case rate payment for the month. In the following month, the last in chain provider (i.e., the practice that takes over care and submitted the trigger event claim later in the month) will be designated the attributed provider and will receive the case rate payment going forward as long as they maintain episode attribution.

16. Are providers required to submit claims for services included in the case rate?

Yes, providers must continue submitting claims for all services, even those included in the case rate. These claim details will be “zero-paid” for case rate services, demonstrating the service was provided.

17. Can global billing codes be used as trigger events?

No, global billing codes do not qualify as trigger events for the case rate. Providers must use specific Evaluation and Management (E&M) and diagnosis codes (and fulfill all other trigger event criteria listed in Question 3) to initiate case rate payment.

18. Will providers see a reason code for zero-paid claims?

Yes, Explanation of Benefits (EOB) code 9950 - *Service is covered by monthly maternity bundle case rate payment* - will display on the claim detail on the RA. The updated Claim Adjustment Group Code (CAGC) is CO, the Claim Adjustment

Reason Code (CARC) for zero-payment is 245 and Remittance Advice Remark Codes (RARC) M15 based on provider feedback.

19. How should providers handle delivery claims?

Delivery claims should still be submitted. Since case rate payments cannot be triggered by labor and delivery services, payment for delivery claims will be determined by whether the practice (TIN) that submits the delivery claim is the same practice that last claimed episode attribution prior to the delivery. Please see below for two example scenarios:

- If Practice A performs the delivery service *and* they are the last office that triggered the case rate for prenatal care prior to the delivery, then Practice A will be paid through the case rate for the delivery.
- If Practice A bills the delivery service but Practice B is the last office that triggered the case rate for prenatal care prior to the delivery, then Practice A will be paid FFS for the delivery.

20. Will postpartum care require additional claims?

Postpartum services are included in the case rate through 90 days after delivery. Providers should continue submitting claims to demonstrate the service provision, even for bundled services.

21. What is the reimbursement process for external Maternal Fetal Medicine (MFM) services?

- In-house MFM services (i.e., provided within the Tax ID) are included in the case rate
- External MFM services (i.e., provided under a different Tax ID than the OB practice) are eligible for separate case rate payments if submitted with trigger codes and the service occurs in an office setting, otherwise the service will be reimbursed as a FFS claim.

22. What stops the case rate payment?

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 a 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.

Please see the Case Rate Termination Codes within the Code List on the DSS website for more information.

23. **What reporting tools are available to track payments?**
    DSS provides a Supplemental Payment Report through the secure web portal, detailing the Client IDs, payment amounts, and other information to help providers manage and attribute payments within their practice.

24. **Are members with third-party liability (TPL) coverage included?**
    No, members with TPL coverage (Medicaid as secondary insurance) are excluded from the program. These claims will be paid under the standard FFS process.

Provider Forums:

In preparation for the program's launch, DSS and Community Health Network of Connecticut, Inc.® (CHNCT) have hosted Provider Forums to incorporate and be responsive to stakeholder and provider feedback throughout the implementation process. To view live and recorded meetings, please click on this link.

Provider Bulletins:

PB 24-44 Maternity Bundle Payment Program

Key Terms:

CAGC: Claim Adjustment Group Code

CARC: Claim Adjustment Reason Code

RARC: Remittance Advice Reason Code

Accountable Provider:

- Ambulatory maternity providers (i.e., qualified licensed physicians, nurse practitioners, physician assistants, and nurse midwives) who have the greatest role in delivering obstetric care will be designated as the episode's Accountable Provider.
- Accountable Providers must meet a minimum volume threshold of 30 or more deliveries annually to participate and will be eligible to receive case rate and incentive payments.

Case Rate Payment:

- Accountable Providers will receive monthly case rate payments for a subset of prenatal, delivery (if performed by the Accountable Provider), and postpartum services
- DSS will calculate each practice's unique case rate amount at the Tax ID level, based on their historic cost and utilization. Case rates will later be recalculated to account for changes in utilization and cost pattern over time.

Episode of Care:

- An episode of care describes the total amount of care provided to a patient for a specific medical condition or illness during a defined period.
- The maternity episode includes care provided throughout the perinatal period, spanning 280 days before the date of delivery to 90 days after the date of delivery.
- May also be referred to as the "maternity episode," the "episode," or the "maternity bundle."

Trigger Codes:

- ICD-10-CM, HCPCS or service codes that formally assign the beneficiary's episode to an Accountable Provider and initiate case rate payment in the 2nd trimester, 3rd trimester, or postpartum period. A full list of Diagnosis Trigger Codes is available within the Code List on the DSS website.