

Frequently Asked Questions (FAQ): Connecticut Maternity Bundle Billing and Claims (updated 1/30/2026)

***All red text is new for 1/30/2026**

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. Are there new program changes from Performance Year 1 to Performance Year 2?

There are no major program refinements beyond updating practice-specific Case Rates to reflect updated claims experience and risk adjustment factors. For PY 2, DSS has opted to make limited updates to PY 1 Case Rates to incorporate:

- Clinical and social risk adjustment
- Family Medicine opt-ins, acquisitions, and updated attribution logic
- Applicable fee schedule changes
- Observed changes in relative risk between SFY 2022-2023 (the base period for PY 1 Case Rates) and the first half of CY 2025
- Relevant changes to reflect PY 2 opt-out decisions for the doula care Case Rate add-on payment

Reconciliation for PY 1 and PY 2 will remain upside-only, in which providers may earn shared savings incentive payments based on quality and cost performance, but will not be held financially responsible for costs exceeding the target price.

3. 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](#).

4. 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.

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.

5. Who is ineligible to participate in the program?

FQHC’s, Obstetrics and Licensed Midwife providers who perform less than 30 deliveries per year, and Family Medicine Providers not associated with the Maternity Bundle practices who have attested and opted into the Family Medicine inclusion 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.

6. When does the Maternity Bundle program begin?

1/1/2025.

7. Does my practice need to register for the Maternity Bundle program?

DSS automatically enrolled 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. Automatic program enrollment will be effective at the start of each performance year.

8. 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

9. 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

10. 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. Provider-specific Case Rates provides a uniform, all-encompassing payment designed to cover the anticipated cost of care for an average maternity episode. Variance between actual and projected experience, perhaps material is anticipated.

11. When does the Case Rate end?

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

- The maternity episode is subsequently attributed to another Connecticut Medicaid provider
- The attributed member becomes ineligible for Connecticut Medicaid
- The maternity episode end date is reached (90 days after delivery)
- 9 case rate payments have been made for the maternity episode
- A terminating claim, such as miscarriage or abortion, is submitted (For these instances, the Case Rate will cease in the following month after the stillborn birth, miscarriage or abortion.)

12. How is the Case Rate paid?

Claims that meet the trigger event criteria (see below) in the 2nd trimester, 3rd trimester, and postpartum period will initiate Case Rate payments. 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 the 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 submit claims that 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 and 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 included Obstetrics and Gynecology (including the subspecialty MFM) Certified Nurse Midwife, Obstetric Nurse Practitioner and Women’s Health Nurse Practitioner.

13. 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.

14. 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.

15. Can practices return or refund a Case Rate payment?

No, DSS will not process Case Rate refunds. The aim of the Case Rate is to provide a uniform monthly payment representing total cost of care for an average episode (as defined by each provider's historic member mix). These historic averages include attrition both within and outside of Connecticut Medicaid’s the Case Rate design accounts for typical fluctuations in patient experience (e.g., patients moving out of state or patients requiring varying levels of maternity care). Practices, therefore, should not return or refund a Case Rate payment.

16. 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.

17. 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.

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

18. 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.

19. How are pay-for-reporting measures (P4R) calculated?

P4R measures are binary, in which the practice gets credit for reporting the on measure regardless of the measure's outcome or performance. For the three provider-submitted Encounter Form measures (Breastfeeding, Behavioral Health Risk Assessment, and Doula Utilization), practices are required to meet a submission threshold to get credit for reporting on each measure.

For the Breastfeeding and Behavioral Health Risk Assessment measures, all practices must reach a 90% Encounter Form submission threshold to receive reporting credit on each measure. For the Doula Utilization measure, only practices who have opted into receiving the Doula Care Case Rate Add-on Payment should report on this measure. These practices must reach a 100% Encounter Form submission threshold to receive P4R measure credit; these form submissions are also necessary for the Doula True Up reconciliation process.

20. How do Encounter Form submissions impact my practice's quality performance and incentive payment?

Encounter Form data is essential for calculating quality measure performance and final quality scores, which drives incentive payments for Maternity Bundle practices. The distribution of incentive payments is adjusted based on either the practice's overall performance compared to peers ("Performance Tier Score") or the practice's percent improvement over historical baseline ("Improvement Tier Score"). If the practice generates shared savings during reconciliation, they will receive an incentive payment adjusted according to the higher earnings tier of the two methodologies. While failure to submit forms does not remove a practice from the program, it will negatively impact quality measures and reduce potential incentive payments.

Additionally, these forms are required for the Doula True Up reconciliation process if the provider receives the Doula Care Case Rate Add-on Payment.

For additional information on these calculations, please visit the FAQ published on [DSS website](#).

21. How should we submit the Encounter Form?

Authorized users submit forms electronically through the HUSKY Health Secure Provider Portal – Maternity Bundle tab. Forms can be saved partially but must be submitted to meet “Pay for Reporting” requirements. Incomplete or saved forms do not count.

22. What is the submission deadline for Encounter Forms?

DSS expects completed Encounter Forms to be submitted within 30 days after the end of a birthing person’s postpartum period (typically 90 days after delivery).

23. 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.

24. 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.

25. 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.

26. 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.

27. 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.

28. 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.

29. 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.

30. 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.

31. What taxonomy is used for Maternal Fetal Medicine?

207VM0101X – This should be used by individuals/performing providers enrolled with specialty 328 - Obstetrics and Gynecology that consider themselves a MFM provider.

32. I've changed my taxonomy and I'm now seeing members for MFM services, should I include this taxonomy on the claim?

Yes. As the selected rendering/performing provider, your MFM services must match your submitted taxonomy.

For more detailed information regarding taxonomies, please visit the following link: [Taxonomies FAQ](#)

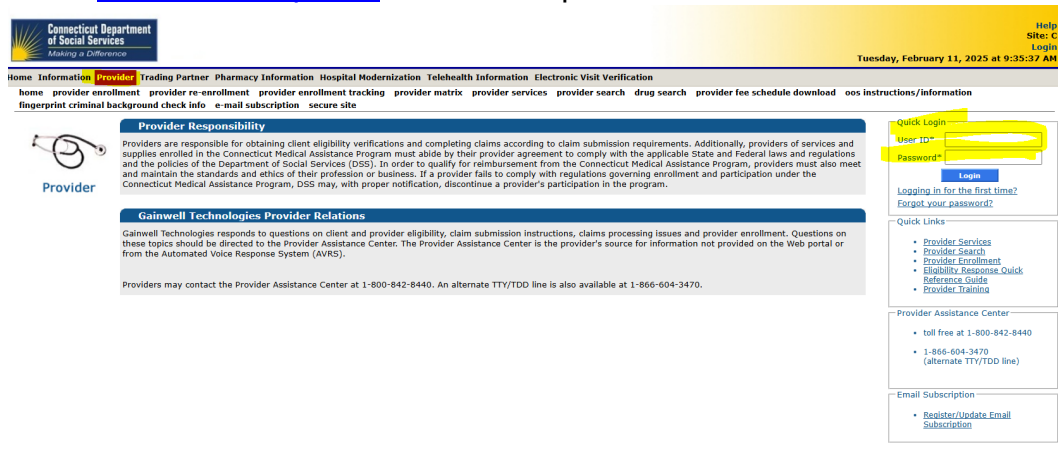
33. Does using Maternal Fetal Medicine taxonomy increase reimbursement via case rate?

At this time, the Maternity Bundle Case Rate is calculated per provider and does not increase, or decrease based on MFM services.

34. What reporting tools are available to track payments and how do I access them?

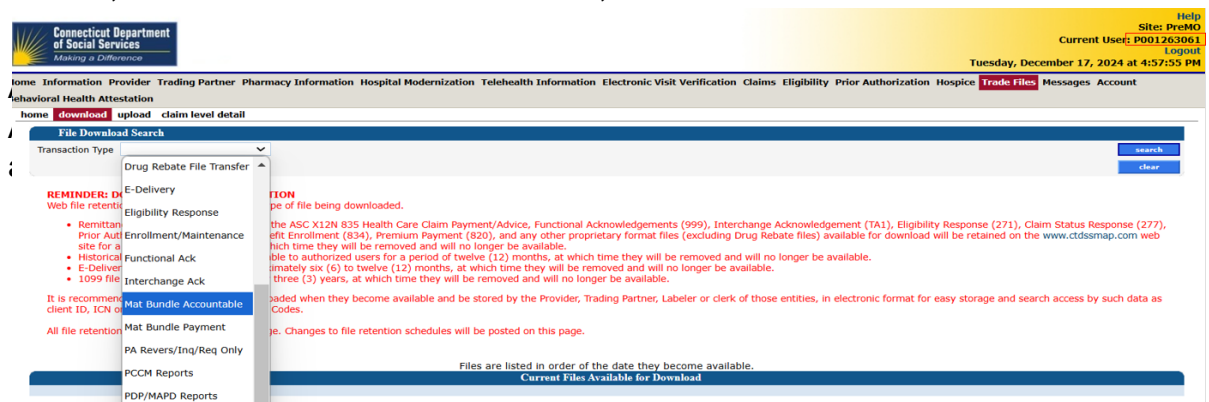
DSS provides a Supplemental Payment Report through the secure web portal, detailing the Client IDs, payment amounts, and other information to help providers manage and attribute payments within their practice.

To access the Supplemental Case Rate Payment Reports, you will need to login to the www.ctdssmap.com secure web portal.



If you are the **Accountable Provider – the provider/group that is actively seeing the member and responsible for the member's care**, follow the instructions below:

Once logged in, click on 'Trade Files' then 'download'. Under File Download Search, choose 'Mat Bundle Accountable', then click 'search'.



File Download Search

Transaction Type: Mat Bundle Accountable search clear

REMINDER: DOWNLOAD WEB FILE RETENTION
Web file retention periods vary based on the type of file being downloaded.

- Remittance Advices (RA) in PDF format, the ASC X12N 835 Health Care Claim Payment/Advice, Functional Acknowledgements (999), Interchange Acknowledgement (TA1), Eligibility Response (271), Claim Status Response (277), Prior Authorization Response (278), Benefit Enrollment (834), Premium Payment (820), and any other proprietary format files (excluding Drug Rebate files) available for download will be retained on the www.ctdssmap.com web site for a period of five (5) months, at which time they will be removed and will no longer be available.
- Historical Drug Rebate files will be available to authorized users for a period of twelve (12) months, at which time they will be removed and will no longer be available.
- E-Delivery letter retention will be approximately six (6) to twelve (12) months, at which time they will be removed and will no longer be available.
- 1099 file retention will be approximately three (3) years, at which time they will be removed and will no longer be available.

It is recommended all electronic files be downloaded when they become available and be stored by the Provider, Trading Partner, Labeler or clerk of those entities, in electronic format for easy storage and search access by such data as client ID, ICN or Explanation of Benefits (EOB) Codes.

All file retention schedules are subject to change. Changes to file retention schedules will be posted on this page.

Files are listed in order of the date they become available.

Current Files Available for Download				
File Name	Original File Name	Transaction Type	Date Available	Date Downloaded
2403547_0_76C21963_MBACTCSVBATCH_0_001263061.csv	MBA_001263061.csv	Mat Bundle Accountable	12/17/2024	
2401479_0_76C21963_MBACTCSVBATCH_0_001263061.csv	MBA_001263061.csv	Mat Bundle Accountable	12/11/2024	12/13/2024

If you are the **Payment Provider** – the designated provider within the TIN that is receiving the case rate payments for all Maternity Bundle providers associated with the TIN, follow the instructions below:

Once logged in, click on the ‘Trade Files’ then ‘download’. Under File Download Search, choose ‘Mat Bundle Payment’, then click ‘search’.

File Download Search

Transaction Type: Mat Bundle Payment search clear

REMINDER: DOWNLOAD WEB FILE RETENTION
Web file retention periods vary based on the type of file being downloaded.

- Remittance Advices (RA) in PDF format, the ASC X12N 835 Health Care Claim Payment/Advice, Functional Acknowledgements (999), Interchange Acknowledgement (TA1), Eligibility Response (271), Claim Status Response (277), Prior Authorization Response (278), Benefit Enrollment (834), Premium Payment (820), and any other proprietary format files (excluding Drug Rebate files) available for download will be retained on the www.ctdssmap.com web site for a period of five (5) months, at which time they will be removed and will no longer be available.
- Historical Drug Rebate files will be available to authorized users for a period of twelve (12) months, at which time they will be removed and will no longer be available.
- E-Delivery letter retention will be approximately six (6) to twelve (12) months, at which time they will be removed and will no longer be available.
- 1099 file retention will be approximately three (3) years, at which time they will be removed and will no longer be available.

It is recommended all electronic files be downloaded when they become available and be stored by the Provider, Trading Partner, Labeler or clerk of those entities, in electronic format for easy storage and search access by such data as client ID, ICN or Explanation of Benefits (EOB) Codes.

All file retention schedules are subject to change. Changes to file retention schedules will be posted on this page.

A list of files available for download will be listed. Click on the ‘Mat Bundle Payment’ report you are interested in viewing. All case rate payments to all maternity bundle providers associated with the TIN will be included in this report.

File Download Search

Transaction Type: Mat Bundle Payment search clear

REMINDER: DOWNLOAD WEB FILE RETENTION
Web file retention periods vary based on the type of file being downloaded.

- Remittance Advices (RA) in PDF format, the ASC X12N 835 Health Care Claim Payment/Advice, Functional Acknowledgements (999), Interchange Acknowledgement (TA1), Eligibility Response (271), Claim Status Response (277), Prior Authorization Response (278), Benefit Enrollment (834), Premium Payment (820), and any other proprietary format files (excluding Drug Rebate files) available for download will be retained on the www.ctdssmap.com web site for a period of five (5) months, at which time they will be removed and will no longer be available.
- Historical Drug Rebate files will be available to authorized users for a period of twelve (12) months, at which time they will be removed and will no longer be available.
- E-Delivery letter retention will be approximately six (6) to twelve (12) months, at which time they will be removed and will no longer be available.
- 1099 file retention will be approximately three (3) years, at which time they will be removed and will no longer be available.

It is recommended all electronic files be downloaded when they become available and be stored by the Provider, Trading Partner, Labeler or clerk of those entities, in electronic format for easy storage and search access by such data as client ID, ICN or Explanation of Benefits (EOB) Codes.

All file retention schedules are subject to change. Changes to file retention schedules will be posted on this page.

Files are listed in order of the date they become available.

Current Files Available for Download				
File Name	Original File Name	Transaction Type	Date Available	Date Downloaded
2403560_0_76C21963_MBPACTCSVBATCH_0_001263061.csv	MBP_001263061.csv	Mat Bundle Payment	12/17/2024	
2401491_0_76C21963_MBPACTCSVBATCH_0_001263061.csv	MBP_001263061.csv	Mat Bundle Payment	12/11/2024	12/13/2024

Below is an example of the file layout of the Supplemental report:
Client DOB added in June 2025.

Client ID	Last Name	First Name	MI	Practice ID	Payment Provider	Accountable Provider	Case Rate Month	Case Rate Amt	Recoupment/Payment	Transaction Number	Client DOB
1111111	DOE	JOHN		99999999	7777777	5555555	1/1/2024	354.84	EXPENDITURE	100004389	7/16/1970
1111111	DOE	JOHN		99999999	7777777	5555555	2/1/2024	354.84	EXPENDITURE	100004393	7/16/1970
1111111	DOE	JOHN		99999999	7777777	5555555	3/1/2024	-354.84	RECOUPMENT	2001377	7/16/1970
1111111	DOE	JOHN		99999999	7777777	5555555	3/1/2024	354.84	EXPENDITURE	100004397	7/16/1970
1111111	DOE	JOHN		99999999	7777777	5555555	4/1/2024	-354.84	RECOUPMENT	2001378	7/16/1970
1111111	DOE	JOHN		99999999	7777777	5555555	4/1/2024	354.84	EXPENDITURE	100004401	7/16/1970
1111111	DOE	JOHN		99999999	7777777	5555555	5/1/2024	-354.84	RECOUPMENT	2001379	7/16/1970
1111111	DOE	JOHN		99999999	7777777	5555555	5/1/2024	354.84	EXPENDITURE	100004405	7/16/1970
2222222	SMITH	JANE		88888888	6666666	4444444	1/1/2024	354.84	EXPENDITURE	100004617	12/10/1970

If you need assistance with logging into the web portal, please contact the Provider Assistance Center at 1-800-842-8440.

35. 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, **submit a claim with a trigger diagnosis code (outlined in the Code List on the DSS website) and one of the following Evaluation & Management**

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) and bill as a qualifying maternity bundle specialty type 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.