Report to the General Assembly

Doula Advisory Group

Doula Services and Maternal-Infant Health Outcomes

Pursuant to Ohio Revised Code 4723.90

In Accordance With Ohio Revised Code 101.68

On Doula Services Under Ohio Revised Code 5164.071

For Calendar Year 2025

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Contents

Executive Summary

The Ohio Department of Medicaid (ODM) coverage of doula services in Ohio is demonstrating early reach and engagement. Coverage began in October 2024, with core service utilization and all outcomes in this report reflecting calendar year 2025. During this period, ODM's coverage of doula services supported 455 pregnant women and contributed to the care of 268 infants across the state. Doulas delivered 1,046 paid services, including 901 prenatal visits and 244 delivery attendances. Because the number of Medicaid members served by doulas to date remains small, none of the outcome metrics are considered statistically valid or significant when compared to the outcomes for the overall Medicaid population. Outcomes are provided for informational purposes only to drive discussion of potential areas to consider for future, more robust analyses and outcome reporting.

To date, doula services are reaching diverse and historically underserved populations. In 2025, doulas served primarily Black or African American members (62.9 percent) and largely urban communities (67.3 percent). Medicaid members supported by doulas during this period demonstrated strong engagement with recommended prenatal and postpartum care. Doula-served members had high rates of early prenatal care initiation; maternal screenings for Hepatitis B, HIV, mental health, and tobacco use; Tdap vaccination; breastfeeding; postpartum visit completion; and primary care follow-up. Preterm birth rates were lower among doula-supported pregnancies, and neonatal intensive care unit utilization appears slightly reduced.

Overall, early findings indicate that doula services are complementing access to perinatal care in Ohio. Continued monitoring and evaluation will be essential to understanding the extent to which doulas contribute to improved outcomes across the Medicaid population.

Board Overview

Mission-Vision-Goals

At the Ohio Board of Nursing (OBN), our vision is to be a leader through innovative and efficient health care regulation positively impacting the wellbeing of every Ohioan.

Our mission is to actively safeguard the public through equitable regulation of nursing and other health care professions.

The OBN is committed to safeguarding public health by ensuring that every individual entering or remaining in Ohio's health care workforce meets all statutory and regulatory requirements. Through a streamlined licensing and certification system, the OBN prioritizes efficiency through enabling qualified applicants to begin practice as quickly as possible without compromising standards. Public protection remains paramount, as nursing and health care impact virtually every Ohioan.

The OBN is nationally recognized by the National Council of State Boards of Nursing (NCSBN) for its regulatory excellence and leadership in public protection. With a proven track record, the OBN not only enforces rigorous standards but also invests in initiatives to address the nursing shortage, implements innovative programs to enhance patient safety, and oversees the largest population of licensed professionals of any agency in the State of Ohio. The combination of regulatory integrity and forward-thinking solutions positions the OBN as a trusted leader in advancing health care quality and safety statewide.

Doulas

The OBN began certifying doulas in response to legislative action aimed at improving maternal and infant health and ensuring quality standards for non-medical birth support. House Bill 142 from the 134th Ohio General Assembly directed OBN to establish certification requirements, including training standards, continuing education on racial bias and health disparities, fee waivers for low-income applicants, and the creation of a Doula Advisory Group to guide the process. These changes were implemented to ensure doulas are formally recognized providers, eligible for Medicaid reimbursement, and held to consistent standards of practice. Full implementation of Doula certification occurred in October 2024.

Total Active Doula Certificates
Calendar Year 2025
224

Doula Advisory Group

The Doula Advisory Group is composed of individuals appointed by the OBN. Membership positions include:

- President, Ohio Board of Nursing
- Ohio Department of Health Representative
- Ohio Commission on Minority Health Representative
- Two Consumer Members
- Three Representatives from Communities Most Impacted by Negative Maternal and Infant Outcomes
- Five Certified Doulas with Current, Valid Credentials
- Physician
- Nurse
- Two Representatives of Doula Certification Programs or Organizations Established in Ohio

Charge of the Doula Advisory Group

The Doula Advisory Group is charged with providing general advice and recommendations to OBN regarding doula certification and the adoption of rules under divisions (D)(3) and (5) of Section 4723.89 of the Revised Code, including requirements for training on racial bias, health disparities, and cultural competency as conditions for initial certification renewal, as well as requirements and standards of practice for certified doulas in the state of Ohio.

The group advises OBN on matters related to individuals seeking eligibility for Medicaid reimbursement as certified doulas and offers guidance and recommendations to the Ohio Department of Medicaid concerning Medicaid coverage of doula services as required under Section 5164.071 of the Revised Code.

Beginning two years after April 30, 2024, and annually thereafter, the group is to submit a report to the General Assembly in accordance with Section 101.68 of the Revised Code, detailing:

(a) The number of pregnant women and infants served;
(b) The number and types of doula services provided; and
(c) Outcome metrics, including maternal and infant health outcomes.

Data Sources and Limitations

The preparation of this report was made possible through the collaboration and support of the Ohio Department of Medicaid (ODM). ODM is supportive of increasing access to doulas, understanding that doulas serve as an effective way to enhance member experience and improve maternal and infant health. ODM is committed to sharing aggregated Medicaid data, consistent with federal and state laws governing privacy and program administration. All measurements were sourced from ODM Administrative Data current as of March 13, 2026, as available in ODM's Electronic Data Warehouse, with the exception of the number of doulas enrolled by Managed Care Organization (MCO), which was reported by each MCO.

Data are for calendar year 2025, which includes any claims submitted to and accepted by ODM through the end of February 2026. Data from October to December 2024 were not included, owing to the low number of claims as doulas became enrolled with Medicaid and contracted with the MCOs prior to claiming.

Outcome metrics including prenatal and postpartum visit rates, breastfeeding rates, screening rates, etc., were calculated by the Government Resource Center using Medicaid Administrative data per the Comprehensive Maternal Care Measures Methodology found on ODM's website and in Appendix A.

Outcomes are provided for informational purposes only, to drive discussion of potential areas to consider for future, more robust analyses and outcome reporting. Because only a small number of individuals have received doula services, none of the outcome metrics are considered statistically valid or significant when compared with outcomes for the overall Medicaid population. As a new Medicaid provider type and service package, doula services have initially been disproportionately available in select communities. Additionally, members who seek and receive doula services may differ substantially from the broader statewide population in education level, pregnancy history and risk status, or other unmeasured factors. Given the short history of Medicaid doula services and the low level of utilization overall, drawing broad conclusions about any causal relationship between doula services and statewide outcomes would not be advisable.

Within the data provided in this report, "NA" indicates that the value has been suppressed to protect the privacy of Medicaid members when reporting could allow for potential identification.

Doula Services and Maternal–Infant Health Outcomes

Doula Services Utilization Overview

Doula Service Utilization	
Measure	**Value**
Total Number of Active Doulas Enrolled in Medicaid	151
Number of Paid Doula Claims	1,046
Number of Paid Doula Claims — CPT T1032 (Prenatal)	901
Number of Paid Doula Claims — CPT T1033 (Delivery)	244
Number of Doulas with a Paid Claim	50
Medicaid Members that Received Doula Services	455
Number of Babies of Medicaid Members that Received Doula Services	268
Average Number of Doula Services per Person	2.3

The doula service utilization data provides an overview of participation and service delivery within Medicaid. A total of 151 doulas were actively enrolled, and 50 of them submitted at least one paid claim. In total, 1,046 paid doula claims have been processed, with 901 associated with prenatal services billed under CPT T1032 and 244 associated with delivery services billed under CPT T1033. These services reached 455 Medicaid members, supporting 268 babies. On average, each person receiving doula services utilized 2.3 services.

Demographic Profile of Members Receiving Doula Services

Total Medicaid Members Who Received Doula Services = 455

Race		
Measure	Count	Share
Black or African American	286	62.9%
White	129	28.4%
Other	40	8.7%
Total	455	100%

Ethnicity		
Measure	Count	Share
Non-Hispanic or Unknown	423	93.0%
Hispanic	32	7.0%
Total	455	100%

County Type		
Measure	Count	Share
Urban	306	67.2%
Suburban	113	24.8%
Rural	18	4.0%
Appalachian	18	4.0%
Total	455	100%

Age Group		
Measure	Count	Share
20 or Younger	47	10.3%
21 to 25	113	24.8%
26 to 30	133	29.2%
31 to 35	104	22.9%
36 and Older	58	12.8%
Total	455	100%

The demographic profile of the 455 Medicaid members who received doula services shows that the majority identified as Black or African American, representing 62.9 percent, while 28.4 percent were White and 8.7 percent were categorized as Other races. Most members were non-Hispanic or of unknown ethnicity, accounting for 93.0 percent, with Hispanic members making up the remaining 7.0 percent.

In terms of geography, two thirds of members receiving doula services lived in urban counties (67.2 percent). Suburban counties accounted for 24.8 percent of members, while rural and Appalachian counties each represented 4.0 percent.

Age distribution shows that 10.3 percent of members were age 20 or younger, 24.8 percent were between 21 and 25, and the largest share—29.2 percent—were ages 26 to 30. Members ages 31 to 35 made up 22.9 percent, and those 36 or older accounted for 12.8 percent of the total.

Doula Enrollment by Managed Care Organization

Doula Enrollment	
Managed Care Organization	**Count**
AmeriHealth	77
Anthem	101
Buckeye	95
CareSource	106
Humana	81
Molina	34
United	81

Doula enrollment across Managed Care Organizations (MCOs) shows variation in participation levels. CareSource had the highest number of enrolled doulas at 106, followed closely by Anthem with 101 and Buckeye with 95. AmeriHealth enrolled 77 doulas, while Humana and United each had 81. Molina had the smallest number of enrolled doulas at 34. In total, 128 doulas were contracted with at least one MCO as of the reporting date.

Maternal Health Outcomes[1]

Prenatal Care Engagement

Doula Services				
Population	Measure	Numerator	Denominator	Rate
Received Doula Services	Doula Report of Pregnancy (CPT T1023)	NA	NA	1.6%
Received Doula Services	Doula Prenatal Services (CPT T1032)	174	245	71.0%
Received Doula Services	Doula Attendance at Delivery (CPT T1033)	202	245	82.4%

The maternal health outcomes related to doula services highlight key aspects of member experience. Among members who received doula services, 1.6 percent had a documented Doula Report of Pregnancy, captured through CPT code T1023.[2] Doulas provided prenatal services (CPT T1032) to 174 out of 245 eligible members, resulting in a utilization rate of 71.0 percent. Doula attendance at delivery was the most common service, with 202 of the 245 members receiving delivery support under CPT code T1033, reflecting an 82.4 percent attendance rate for members using any doula services.

"NA" indicates that the value has been suppressed to protect the privacy of Medicaid members when reporting could allow for potential identification.

Prenatal by 9th Week			
Population	Numerator	Denominator	Rate
Statewide	17,693	34,372	51.5%
Received Doula Services	121	196	61.7%

Among those with a live birth, 61.7 percent of members supported by doulas attended a prenatal care visit by the 9th week of pregnancy, while the statewide rate was 51.5 percent.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

[1] Please note due to small number of individuals who have received doula services, none of the outcome metrics are considered statistically valid or significant.
[2] Doulas were not eligible to bill for the Report of Pregnancy CPT code until October 2025, which accounts for the low volume indicated as "NA" for the numerator and denominator.

Prenatal Visits (HEDIS[3])			
Population	**Numerator**	**Denominator**	**Rate**
Statewide	**24,484**	**34,123**	**71.8%**
Received Doula Services	**144**	**174**	**82.8%**

Members who received doula services had a prenatal visit rate of 82.8 percent within the first trimester or within 42 days of enrollment, while the statewide rate was 71.8 percent.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

[3] National Committee for Quality Assurance. (n.d.). *Prenatal and postpartum care (PPC)*. https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/prenatal-and-postpartum-care-ppc/

Maternal Health Screening

Hepatitis B Screening			
Population	Numerator	Denominator	Rate
Statewide	36,255	52,648	68.9%
Received Doula Services	207	245	84.5%

For Hepatitis B screening, 84.5 percent of doula-supported members with a live birth completed the recommended screening during pregnancy. The statewide rate was 68.9 percent.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

HIV Screening			
Population	Numerator	Denominator	Rate
Statewide	36,875	52,637	70.1%
Received Doula Services	214	245	87.3%

Among members with a live birth who received doula services, 87.3 percent were screened for Human Immunodeficiency Virus (HIV) during pregnancy. The statewide rate was 70.1 percent.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

Mental Health Screening			
Population	Numerator	Denominator	Rate
Statewide	14,393	52,711	27.3%
Received Doula Services	110	245	44.9%

Members with a live birth who received doula support had a mental health screening rate of 44.9 percent during pregnancy or the postpartum period, while the statewide rate was 27.3 percent.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

Tobacco Use Screening or Cessation Counseling			
Population	Numerator	Denominator	Rate
Statewide	16,532	42,136	39.2%
Received Doula Services	96	183	52.5%

Among members with a live birth, 52.5 percent of those who received doula services were screened or counseled for tobacco use during pregnancy, while the statewide rate was 39.2 percent.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

Maternal Vaccination

Tdap Vaccination			
Population	Numerator	Denominator	Rate
Statewide	25,134	52,213	48.1%
Received Doula Services	143	244	58.6%

Members with a live birth who received doula services had a maternal tetanus, diphtheria, and acellular pertussis (Tdap) vaccination rate of 58.6 percent during the third trimester, while the statewide rate was 48.1 percent.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

Labor & Delivery

Induced Labor			
Population	Numerator	Denominator	Rate
Statewide	22,372	52,648	42.5%
Received Doula Services	122	244	50.0%

Among those members with doula support, 50.0 percent had an induced labor. The statewide rate was 42.5 percent. Induction of labor is the use of pharmacologic or mechanical methods to initiate labor.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

Augmented Labor			
Population	Numerator	Denominator	Rate
Statewide	14,427	31,149	46.3%
Received Doula Services	63	125	50.4%

Doula-supported members experienced augmentation in 50.4 percent of births, while the statewide rate was 46.3 percent. Augmentation of labor is used to accelerate slow or stalled active labor through medications or other methods that increase the strength and frequency of contractions.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

Spontaneous Labor			
Population	Numerator	Denominator	Rate
Statewide	30,283	52,655	57.5%
Received Doula Services	122	244	50.0%

Among those members supported by doulas, 50.0 percent experienced a natural, unassisted onset of labor. The statewide rate was 57.5 percent. Spontaneous labor refers to childbirth that begins without medical or mechanical interventions.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

Assisted Delivery			
Population	Numerator	Denominator	Rate
Statewide	1,792	52,711	3.4%
Received Doula Services	NA	NA	2.4%

Doula-supported member births had an assisted delivery rate of 2.4 percent, while the statewide rate was 3.4 percent. An assisted delivery refers to a vaginal birth in which forceps or a vacuum device are used during the second stage of labor to expedite delivery in the presence of clinical indications such as fetal distress, labor arrest, maternal exhaustion, or malpresentation.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

“NA” indicates that the value has been suppressed to protect the privacy of Medicaid members when reporting could allow for potential identification.

Low Risk Cesarean Section			
Population	Numerator	Denominator	Rate
Statewide	2,800	11,378	24.6%
Received Doula Services	NA	NA	30.2%

The cesarean rate among doula-supported members with a live birth that had a nulliparous, full-term, singleton, vertex-presenting delivery by cesarean section was 30.2 percent, and the statewide rate was 24.6 percent.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

“NA” indicates that the value has been suppressed to protect the privacy of Medicaid members when reporting could allow for potential identification.

Birth Outcomes

Preterm Birth			
Population	Numerator	Denominator	Rate
Statewide	5,634	51,401	11.0%
Received Doula Services	NA	NA	8.2%

The preterm birth rate for doula-supported member deliveries was 8.2 percent, defined as a live birth occurring before 37 weeks of gestation during the measurement year. All preterm and very preterm births were included. Statewide, the preterm birth rate was 11.0 percent.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

“NA” indicates that the value has been suppressed to protect the privacy of Medicaid members when reporting could allow for potential identification.

Low Birthweight			
Population	Numerator	Denominator	Rate
Statewide	4,917	51,411	9.6%
Received Doula Services	NA	NA	14.2%

Among doula-supported members with a live birth, 14.2 percent of infants were born weighing less than 2,500 grams during the measurement year. Statewide, 9.6 percent of infants were born weighing less than 2,500 grams.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

“NA” indicates that the value has been suppressed to protect the privacy of Medicaid members when reporting could allow for potential identification.

Postpartum Care

Breastfeeding			
Population	Numerator	Denominator	Rate
Statewide	38,797	52,430	74.0%
Received Doula Services	224	244	91.8%

Within 90 days after delivery, 91.8 percent of doula-supported members with a live birth breastfed. Statewide, 74.0 percent of members breastfed within 90 days after delivery.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

Lacation Supplies			
Population	Numerator	Denominator	Rate
Statewide	1,686	52,637	3.2%
Received Doula Services	NA	NA	11.0%

Among members supported by doulas, 11.0 percent utilized lactation supplies. Statewide, 3.2 percent of members (1,686 of 52,637) utilized lactation supplies.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

“NA” indicates that the value has been suppressed to protect the privacy of Medicaid members when reporting could allow for potential identification.

Maternal Postpartum Emergency Department Visit			
Population	Numerator	Denominator	Rate
Statewide	5,317	52,711	10.1%
Received Doula Services	NA	NA	14.3%

During the postpartum period, 14.3 percent of members who received doula services visited the emergency department. Statewide, 10.1 percent of postpartum individuals had an emergency department visit.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

“NA” indicates that the value has been suppressed to protect the privacy of Medicaid members when reporting could allow for potential identification.

Maternal Hospital Readmission			
Population	Numerator	Denominator	Rate
Statewide	1,042	52,711	2.0%
Received Doula Services	NA	NA	3.3%

The postpartum inpatient readmission rate was 3.3 percent among members who received doula services during the postpartum period. Statewide, 2.0 percent of postpartum individuals were readmitted to the hospital.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

“NA” indicates that the value has been suppressed to protect the privacy of Medicaid members when reporting could allow for potential identification.

Postpartum Visit Completion

Postpartum Visits (Comprehensive Maternal Care Program)			
Population	Numerator	Denominator	Rate
Statewide	24,937	37,275	66.9%
Received Doula Services	153	182	84.1%

Doula-served members with a live birth with at least one postpartum visit between 7 and 84 days after delivery was 84.1 percent. The statewide rate was 66.9 percent.

Ohio's Comprehensive Maternal Care (CMC) program emphasizes timely, team-based postpartum care to improve maternal health outcomes. The CMC program promotes scheduling postpartum visits within 7 to 84 days after birth, consistent with national guidelines recommending a comprehensive postpartum visit within 12 weeks.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

Postpartum Visits (HEDIS[4])			
Population	Numerator	Denominator	Rate
Statewide	24,576	34,123	72.0%
Received Doula Services	154	174	88.5%

The Healthcare Effectiveness Data and Information Set (HEDIS) postpartum visit rate was 88.5 percent among doula-served members, while the statewide rate was 72.0 percent.

The HEDIS measure assesses whether postpartum individuals aged 10–49 received a visit between 7 and 84 days after delivery, with compliance based on documented evidence of key clinical components such as pelvic examination, assessment of weight, blood pressure, breasts, or abdomen, or a clearly noted postpartum care visit. Cervical cytology also meets the measure.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

[4] National Committee for Quality Assurance. (n.d.). *Prenatal and postpartum care (PPC)*. https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/prenatal-and-postpartum-care-ppc/

Primary Care Visits			
Population	Numerator	Denominator	Rate
Statewide	19,860	37,275	53.3%
Received Doula Services	111	182	61.0%

The postpartum primary care visit rate—defined as the percentage of members with a live birth who had a primary care visit within 12 weeks after delivery—was 61.0 percent among doula-served members. Statewide, 53.3 percent of members received a primary care visit during the same postpartum period.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

Pregnancy-Related Costs

Cost of Pregnancy			
Population	Numerator	Denominator	Average Cost per Pregnancy
Statewide	$431,583,058	36,121	$11,948
Received Doula Services	$3,088,338	199	$15,519

The average cost per pregnancy for members who received doula services was $15,519. The statewide average cost per pregnancy for members was $11,948.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

Infant Health Outcomes[5]

Infant Hospital and Emergency Care

Infant Neonatal Intensive Care Unit Stay			
Population	Numerator	Denominator	Rate
Statewide	5,663	45,603	12.4%
Received Doula Services	NA	NA	12.1%

The rate of Neonatal Intensive Care Unit (NICU) stays was 12.1 percent among infants supported by doulas. Statewide, 12.4 percent of infants required a NICU stay.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

"NA" indicates that the value has been suppressed to protect the privacy of Medicaid members when reporting could allow for potential identification.

Infant Emergency Department Visit			
Population	Numerator	Denominator	Rate
Statewide	4,723	45,603	10.4%
Received Doula Services	NA	NA	20.8%

The rate of emergency department visits in the postnatal period was 20.8 percent among infants supported by doulas. Statewide, 10.4 percent of infants had an emergency department visit in the postnatal period.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

"NA" indicates that the value has been suppressed to protect the privacy of Medicaid members when reporting could allow for potential identification.

[5] Please note due to small number of individuals who have received doula services, none of the outcome metrics are considered statistically valid or significant.

Infant Hospital Admission			
Population	Numerator	Denominator	Rate
Statewide	2,094	45,603	4.6%
Received Doula Services	NA	NA	7.2%

The postnatal inpatient admission rate was 7.2 percent among infants supported by doulas. Statewide, 4.6 percent of infants were admitted to the hospital in the postnatal period.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

“NA” indicates that the value has been suppressed to protect the privacy of Medicaid members when reporting could allow for potential identification.

Infant Well-Care Engagement

Infant Well-Care			
Population	Numerator	Denominator	Rate
Statewide	29,753	36,199	82.2%
Received Doula Services	140	153	91.5%

The percentage of infants born to Comprehensive Maternal Care (CMC) program-attributed members supported by doulas who had at least two well-care visits after initial discharge and during the 90 days after delivery was 91.5 percent. Statewide was 82.2 percent.

Statewide outcomes are provided for reference purposes only. Comparisons with statewide data must be interpreted with caution.

Conclusion

In 2025, the Ohio Department of Medicaid's coverage of doula services supported 455 pregnant women and contributed to the care of 268 infants across the state. Doulas delivered 1,046 paid services, including 901 prenatal visits and 244 delivery attendances. These figures reflect early uptake of doula services among Medicaid members in Ohio.

Outcome data shows that doula involvement in Ohio is correlated with several key indicators of maternal and infant health. Medicaid members who received doula services demonstrated high rates of early prenatal care, essential maternal health screenings, Tdap vaccination, breastfeeding initiation, postpartum visit completion, and early primary care follow-up. Preterm birth rates were also low among doula-served members. At the same time, high rates of labor interventions, low birth weight deliveries, postpartum maternal emergency department visits, and infant emergency department and hospital utilization may indicate that doulas are initially supporting individuals with more complex medical or social needs. Together, these early outcomes present important opportunities for future evaluation of the impact of doulas on Medicaid maternal care and outcomes in Ohio.

Appendix A

Methodology: Comprehensive Maternal Care (CMC) Measures

Version 4.0

Last Revised 12/16/2025

Prepared by

The Ohio Colleges of Medicine Government Resource Center

on behalf of the Ohio Department of Medicaid

Overview of Measures by Payment Status and Year

The arrow following payment status indicates whether measure performance improves when the rate increases (↗) or decreases (↘).

Measure Name	Payment Status for PY25
Postpartum Care	For Payment ↗
HIV Screening	For Payment ↗
HIV Screening at First Prenatal Visit	Information Only ↗
Hepatitis B Screening	For Payment ↗
Hepatitis B Screening at First Prenatal Visit	Information Only ↗
Tdap Vaccinations: Vaccine Receipt	Information Only ↗
Tdap Vaccinations: Vaccine Receipt or Vaccine Counseling	For Payment ↗
Tobacco Cessation	For Payment ↗
Primary Care Visits	For Payment ↗
Prenatal Visit by Nine Weeks Gestation	Information Only ↗
Breastfeeding	Information Only ↗
Preterm Birth	For Payment ↘
Percentage of Low Birthweight Births	Information Only ↘
Low-Risk Cesarean Delivery Rate	Information Only ↘
High-Risk Composite: Behavioral Services	Information Only ↗
High-Risk Composite: Opioid Use Disorder Treatment	Information Only ↗
High-Risk Composite: Average Total MME Dispensed Per Delivery	Information Only ↘
Rate of Solid Dose Opioids Dispensed Following Delivery	Information Only ↘
Dental Visit	Information Only ↗
Infant Well-Care Visits	Information Only ↗
Flu Vaccinations	Information Only ↗
Maternal Mental Health Screening	For Payment ↗
Severe Obstetric Complications	Information Only ↘
Enrolled in Women, Infants, and Children (WIC)	Information Only ↗
Estimated Cost of Pregnancy-Related Care	Information Only
Syphilis Screening	Information Only ↗
PRAF Completion	Information Only ↗

General Eligibility and Inclusion Criteria

Eligible Providers and Members:

- Eligible providers are defined as all practices participating in the CMC program during the reporting period.
- Some measures have continuous enrollment criteria in addition to the attribution requirement. The additional criteria for these measures are described within the measure specification.
- Measures are at the pregnancy level. A member may contribute to a measure more than once if they have multiple pregnancies during the period of interest and each pregnancy meets the measure criteria.

General Methodological Notes

Data Sources:

- Vital Statistics birth records linked to Medicaid administrative data are the core dataset for CMC measures. Available Vital Statistics linked data is limited to birth occurrences in Ohio. Please note that this means the population for quality measures is limited to individuals who are attributed to a CMC provider and are in the VS-claims linked files.
- Medicaid administrative data
    - Inpatient, professional, outpatient, pharmaceutical, and dental claims are used for claims-based measure components unless noted otherwise.
    - Final claims that are paid and that are denied are counted for HIV Screening, Hepatitis B Screening, Syphilis Screening, Maternal Mental Health Screening, and Estimated Cost of Pregnancy-Related Care. All other measures only use final paid claims.
- ImpactSIIS vaccination records are used to supplement claims-based vaccine measures. CPT codes provided for these measures apply to both data sources.
- Measure calculations are updated quarterly. See Appendix 1 for a calendar of the cadence of updates for contributing datasets.

Measure Components:

- An arrow is provided to illustrate the direction of better measure performance. The ↗ symbol indicates measure performance improves when the rate increases. The ↘ symbol indicates measure performance improves when the rate decreases. Estimated Cost of Pregnancy-Related Care is an exception and does not have an arrow.
- The Anchor Date establishes a date around which numerator and denominator windows are created.
- Payment status specifies which measures are used to determine compensation for services. There are two options for payment status:
    - For payment

    - Information only
- The following constructed variables will be measured as follows:
    - **Number of Weeks Gestation** is measured using the birth certificate field OWGEST.
    - **Onset of Pregnancy** is measured using date of delivery (DATE_OF_BIRTH) and number of weeks gestation according to birth records (OWGEST).
    - **Singleton Birth** is defined using the birth certificate field PLUR and by identifying multiple deliveries to the same member with a date of delivery within a day of each other.
    - **Live Birth** is defined by the existence of a birth certificate. For postpartum measures focused on infant care, the infant must be alive during the entire measurement period. This is identified by either continuous enrollment of the infant or a death of death on the birth certificate after the end of the measurement period or not indicated (use DATE_OF_DEATH and DEATH_OCCURRED).
    - **Race of member** is defined using the field CDE_RACE from Medicaid demographic data. Categories are Black (CDE_RACE B or N), White (CDE_RACE C or O), and Other race (CDE_RACE not equal to B, N, C, O, 7, 8).

Postpartum Care

Measure Description: The percentage of members with a live birth with at least one postpartum visit between 7 and 84 days after delivery. ↗

Anchor Date: Date of Delivery

Payment Status: For payment

Medicaid Enrollment Requirement: Continuous enrollment 30 days prior to delivery through 90 days after delivery.

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous) and whose pregnancy resulted in a live birth.

Numerator: Members in the denominator with at least one postpartum care visit between 7 and 84 days after delivery.

> **Post-Partum Follow-up Visits:** A follow-up visit with a post-partum event, procedure, or diagnosis and a date in claims between 7 and 84 days following the date of delivery (value sets **Postpartum Care Visit, Cervical Lab Test)** in either a professional medical (claim type "M") or outpatient (claim type "O") setting. Value sets for this measure are available in the CMC Measures Value Sets supplemental document.

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

HIV Screening

Measure Description: The percentage of members with a live birth who received an HIV screening during pregnancy. ↗

Anchor Date: Date of Delivery

Payment Status: For payment

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous) and whose pregnancy resulted in a live birth.

Numerator: Members in the denominator with an HIV screening (value set **HIV Screening**) on or between estimated onset date of pregnancy and delivery.

Exclusions: Members with an HIV diagnosis in the twelve months prior to the estimated onset date of pregnancy (value set **HIV Diagnosis**).

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

Table 1: HIV Screening

Code Category	Code List
CPT	80081, 86689, 86701, 86702, 86703, 87389, 87390, 87391, 87534, 87535, 87536, 87537, 87538, 87539, 87563, 87806, 87901, 87903, 87904, 87906
HCPCS	G0432, G0433, G0435, G0475

Table 2: HIV Diagnosis

Code Category	Code List
ICD-10-CM	O98.7*, B20, Z21

References:

CDC's Recommendations for Screening and Testing for HIV, Viral Hepatitis, STD & Tuberculosis In Pregnancy

HIV Screening at First Prenatal Visit

Measure Description: The percentage of members with a live birth who received an HIV screening at the first prenatal visit. ↗

Anchor Date: Date of Delivery

Payment Status: Information only

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous) and whose pregnancy resulted in a live birth.

Numerator: Members in the denominator with an HIV screening (value set **HIV Screening, see Table 1)** within the 7 days following their first prenatal visit. A prenatal visit is defined as either of the following:

- A standalone prenatal visit (value set **Prenatal Visits**).
- A prenatal visit (value sets **Office Visits**, **Telehealth Visits**) with a pregnancy-related diagnosis code (value set **Pregnancy Diagnosis**).

The visit must be in an outpatient (claim type "O") or professional medical (claim type "M") setting. Value sets for this measure are available in the CMC Measures Value Sets supplemental document.

Exclusions: Members with an HIV diagnosis in the twelve months prior to the estimated onset date of pregnancy (value set **HIV Diagnosis, see Table 2**).

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

References:

CDC's Recommendations for Screening and Testing for HIV, Viral Hepatitis, STD & Tuberculosis In Pregnancy

Hepatitis B Screening

Measure Description: The percentage of members with a live birth who received a Hepatitis B screening during pregnancy. ↗

Anchor Date: Date of Delivery

Payment Status: For payment

Denominator: Members attributed to a CMC for at least six months during their pregnancy or the first two months postpartum (need not be continuous) and whose pregnancy resulted in a live birth.

Numerator: Members in the denominator with a Hepatitis B screening (value set **Hepatitis B Screening)** on or between estimated onset of pregnancy and delivery.

Exclusions: Members with Hepatitis B diagnosis in the twelve months prior to the estimated onset date of pregnancy (value set **Hepatitis B Diagnosis**).

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

Table 3: Hepatitis B Screening

Code Category	Code List
CPT	80055, 80081, 80074, 86704, 86705, 86706, 86707, 87340, 87341, 87350, 87515, 87516, 87517
HCPCS	G0499

Table 4: Hepatitis B Diagnosis

Code Category	Code List
ICD-10-CM	B16.0, B16.1, B16.2, B16.9, B18.0, B18.1, B19.10, B19.11

References:

CDC's Recommendations for Screening and Testing for HIV, Viral Hepatitis, STD & Tuberculosis In Pregnancy

Hepatitis B Screening at First Prenatal Visit

Measure Description: The percentage of members with a live birth who received a Hepatitis B screening at the first prenatal visit. ↗

Anchor Date: Date of Delivery

Payment Status: Information only

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous) and whose pregnancy resulted in a live birth.

Numerator: Members in the denominator with a Hepatitis B screening (value set **Hepatitis B Screening, see Table 3)** within the 7 days following their first prenatal visit. A prenatal visit is defined as either of the following:

- A standalone prenatal visit (value set **Prenatal Visits**).
- A prenatal visit (value sets **Office Visits**, **Telehealth Visits**) with a pregnancy-related diagnosis code (value set **Pregnancy Diagnosis**).

The visit must be in an outpatient (claim type "O") or professional medical (claim type "M") setting. Value sets for this measure are available in the CMC Measures Value Sets supplemental document.

Exclusions: Members with Hepatitis B diagnosis in the twelve months prior to the estimated onset date of pregnancy (value set **Hepatitis B Diagnosis, see Table 4**).

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

References:

CDC's Recommendations for Screening and Testing for HIV, Viral Hepatitis, STD & Tuberculosis In Pregnancy

Tdap Vaccinations (Information Only)

Measure Description: The percentage of members with a live birth who received a Tdap vaccine during the third trimester of pregnancy. ↗

Anchor Date: Date of Delivery

Payment Status: Information only

Denominator: Members attributed to a CMC for at least six months during their pregnancy or the first two months postpartum (need not be continuous) whose pregnancy resulted in a live birth with gestational age of at least 28 weeks.

Numerator: Members in the denominator who had a Tdap vaccine (value set **Tdap Vaccine**) between the 27th and 36th week of pregnancy, inclusive of the 27th and 36th week.

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: CMC-specific measure using CDC guidance

Table 5: Tdap Vaccine

Code Category	Code List
CPT	90715

References: Tdap Vaccination for Pregnant People

Tdap Vaccinations (For Payment)

Measure Description: The percentage of members with a live birth who received a Tdap vaccine or vaccine counseling during the third trimester of pregnancy. ↗

Anchor Date: Date of Delivery

Payment Status: For payment

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous) whose pregnancy resulted in a live birth with gestational age of at least 28 weeks.

Numerator: Members in the denominator who had a Tdap vaccine (value set **Tdap Vaccine,** see Table 5**)** or received vaccine counseling (value set **Vaccine Counseling**) between the 27th and 36th week of pregnancy, inclusive of the 27th and 36th week. *Note the vaccine counseling code is not in broad use until October 2021.*

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: CMC-specific measure using CDC guidance

Table 6: Vaccine Counseling

Code Category	Code List
ICD-10-CM	Z71.85

References: Tdap Vaccination for Pregnant People

Tobacco Cessation

Measure Description: The percentage of members with a live birth who received a screening for tobacco use OR cessation counseling during pregnancy. ↗

Anchor Date: Date of Delivery

Payment Status: For payment

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous) and whose pregnancy resulted in a live birth.

Numerator: Members in the denominator who were screened for tobacco use in the two years preceding the estimated onset date of pregnancy or during pregnancy. Members must have screened negative for tobacco use or screened positive for tobacco use and received tobacco cessation treatment (value set **Tobacco Screening Cessation**).

Exclusions: Members with documentation in the two-years preceding the estimated onset date of pregnancy of medical reason(s) for not screening for tobacco use or receipt of cessation intervention if identified as a tobacco user (value set **Tobacco Screening and Cessation Exclusion**; procedure code and modifier must be on the same line).

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

Table 7: Tobacco Screening Cessation

Code Category	Code List
CPT	99406, 99407, 4004F (without modifier 1P), 1036F
HCPCS	G9903, G9906

Table 8: Tobacco Screening and Cessation Exclusion

Code Category	Code List
CPT + Modifier	4004F with modifier 1P (any position)
HCPCS	G9904, G9907, G9909

References:

The Ohio Department of Medicaid's CHIPRA, PQI, & Tobacco Cessation Methods: CHIPRA's Core Set of Children's Quality Measures, PQI, and Tobacco Cessation Measures

Primary Care Visits

Measure Description: The percentage of members with a live birth who have a primary care visit with a primary care provider between delivery and up to twelve weeks after delivery. ↗

Anchor Date: Date of Delivery

Payment Status: For payment

Medicaid Enrollment Requirement: Continuous enrollment 30 days prior to delivery through 90 days after delivery.

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous) and whose pregnancy resulted in a live birth.

Numerator: Members in the denominator who have a primary care visit (value set **Primary Care**)between 0 and 84 days after delivery. The visits must be with a primary care provider (Appendix 2) in an outpatient (claim type "O") or professional medical (claim type "M") setting. Note that to count as a visit to a primary care provider, the claim must have both a billing provider in the Provider Type list, and a billing or rendering provider specialty code in the Provider Specialty list.

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: CMC-specific measure derived from ACOG guidance

Table 9: Primary Care

Code Category	Code List
CPT	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99420, 99421, 99422, 99423, 99424, 99425, 99426, 99427, 99428, 99429, 90465, 90466, 90467, 90468, 90471, 90472, 90473, 90474, 90460, 90461, 98000, 98001, 98002, 98004, 98005, 98006, 98008, 98009, 98010, 98012, 98013, 98014, 98016

References:

ACOG Committee Opinion: Optimizing Postpartum Care

Prenatal Visit by Nine Weeks Gestation

Measure Description: The percentage of members with a live birth who attended a prenatal care visit by week 9 of pregnancy. ↗

Anchor Date: Date of Delivery

Payment Status: Information only

Medicaid Enrollment Requirement: Enrolled in Medicaid by the end of the 8th week of gestation.

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous) and whose pregnancy resulted in a live birth.

Numerator: Members in the denominator who had a prenatal visit. A prenatal visit is defined as either of the following**:**

- A standalone prenatal visit (value set **Prenatal Visits**).
- A prenatal visit (value sets **Office Visits**, **Telehealth Visits**) with a pregnancy-related diagnosis code (value set **Pregnancy Diagnosis**).

The visit must be in an outpatient (claim type "O") or professional medical (claim type "M") setting. Value sets for this measure are available in the CMC Measures Value Sets supplemental document.

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: CMC-specific measure

Breastfeeding

Measure Description: The percentage of members with a live birth in which breastfeeding occurred during the 90 days after delivery. ↗

Anchor Date: Date of Delivery

Payment Status: Information only

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous) and whose pregnancy resulted in a live birth.

Numerator: Members in the denominator who breastfed or gave their neonates human milk during the 90 days after delivery. An indication of breastfeeding in one or more of the following value sets is numerator compliant:

- **VS Breastfeeding**
- **Breastfeeding Procedures** in the 90 days after delivery
- **Breastfeeding Diagnoses** in the 90 days after delivery
- **Lactation Consultant** in the 90 days after delivery
- **Lactation Counseling Procedures with a Lactation Counseling Modifier** in the 90 days after delivery

Exclusions: Members with an HIV diagnosis in the nine months prior to delivery or in the 90 days after delivery (value set **HIV Diagnosis,** see Table 2). Members for whom all infants were deceased within 90 days of delivery.

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

Table 10: Breastfeeding Procedures

Code Category	Code List
HCPCS	A4281, A4282, A4283, A4284, A4285, A4286, E0602, E0603, E0604, S9443, G9779

Table 11: Breastfeeding Diagnoses

Code Category	Code List
ICD-10-CM	Z39.1, O91.02, O91.03, O91.13, O91.23, O92.03, O92.13, O92.20, O92.4, O92.70, O92.79

Table 12: Lactation Consultant

Code Category	Code List
Provider Taxonomy	174N00000X

Table 13: Lactation Counseling Procedures with a Lactation Counseling Modifier

Code Category	Code List
CPT + Modifier	97802, 97803, OR 97804 with modifier TH (any position)
HCPCS	S9443

References:

American Academy of Pediatrics Policy Statement: Breastfeeding and the Use of Human Milk

Preterm Birth

Measure Description: The percentage of members with a live birth before 37 weeks of gestation during the measurement year. All preterm and very preterm births are included. ↘

Anchor Date: Date of Delivery

Payment Status: For payment

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous) and whose pregnancy resulted in a live birth.

Numerator: Members in the denominator with a live birth at less than 37 weeks of gestation as identified on the birth certificate using the best available estimate.

Exclusions: Deliveries that result in multiple infants according to birth records (using the field PLUR). Members without a valid value for OWGEST (e.g. null, '99', etc.).

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM-IM

Percentage of Low Birthweight Births

Measure Description: The percentage of members with a live birth weighing less than 2,500 grams during the measurement year. ↘

Anchor Date: Date of Delivery

Payment Status: Information only

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous) and whose pregnancy resulted in a live birth.

Numerator: Members in the denominator who delivered a child weighing less than 2,500 grams at birth according to field BWG on the birth record.

Exclusions: Deliveries that result in multiple infants according to birth records (using the field PLUR). Members without a valid value for BWG (e.g. null, '9999', etc.).

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: The Ohio Department of Medicaid's CHIPRA, PQI, & Tobacco Cessation Methods: CHIPRA's Core Set of Children's Quality Measures, PQI, and Tobacco Cessation Measures

Low-Risk Cesarean Delivery Rate

Measure Description: The percentage of members with a live birth that had a nulliparous, full-term, singleton, vertex-presenting delivery by cesarean section. ↘

Anchor Date: Date of Delivery

Payment Status: Information only

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous), whose pregnancy resulted in a live birth, and whose pregnancy and delivery met the following additional criteria**:**

- nulliparous (VS birth fields **PLBL = 0 and PLBD = 0**)
- full-term (gestational age at delivery between 37 and 42 weeks)
- singleton birth (VS birth field **PLUR = 1**)
- vertex presentation – exclude cases with a non-vertex presentation diagnosis (value set **Non-Vertex Presentation)** with a service date within 14 days of the date of delivery)

Numerator: Members with a Cesarean section (value set **Cesarean Section**) in the 14 days before or after delivery, or a cesarean section delivery method according to birth records (value set **VS Cesarean**).

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

Table 14: Non-Vertex Presentation

Code Category	Code List
ICD-10-CM	O32.0*, O32.1*, O32.2*, O32.3*, O32.4*, O32.6*, O32.8*, O32.9*

Table 15: Cesarean Section

Code Category	Code List
CPT	59510, 59514, 59515, 59618, 59620, 59622, 01961, 01963, 01968, 01969, 58611, 99360

Table 16: VS Cesarean

Code Category	Code List
BIRROUTE_DESC	'CESAREAN (no labor attempted)', 'CESAREAN (yes labor attempted)'

References: Specifications Manual for Joint Commission National Quality Measures Low-Risk Cesarean Delivery by Medicaid.gov

High-Risk Composite: Overview

The High-Risk Composite measure includes three sub-measures: Behavioral Services, Opioid Use Disorder Treatment, and Average Total MME Dispensed per Delivery.

Anchor Date: Date of Delivery

Payment Status: Information only

High-Risk Composite: Behavioral Services

Measure Description: The percentage of members with a live birth and a serious behavioral health condition during pregnancy who received behavioral health services during pregnancy. ↗

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous), whose pregnancy resulted in a live birth, and who had a diagnosis of a serious BH condition during pregnancy (value set **BH Conditions**).

Numerator: Members in the denominator who received any of the following services during pregnancy**:**

- A behavioral health service (value set **BH Services**) *with* a BH condition diagnosis (value set **BH Conditions**)
- An antipsychotic medication injection (value set **Antipsychotic Injections**)
- A pharmacy-dispensed antipsychotic prescription (value set **Antipsychotic Medications**)
- A pharmacy-dispensed antidepressant prescription (value set **Antidepressant Medications**), excluding those with NDCs in value set **St. John's Wort**. NDC lists are available in the CMC Measures Medication List supplemental document.
- A pharmacy-dispensed prescription for **Other BH Medications**
- Medication for OUD (MOUD) dispensed in a professional medical, outpatient, or inpatient setting. Any of the following qualify**:**
    - Procedure code in value set **Office Dispensed OUD Medication**
    - Procedure Code **S5000**, **S5001**, or **T1502** billed by a **Provider Type 95**
    - Procedure Code **J8499** or **T1502** with an NDC in value set **Medication for OUD** on the same line. NDC lists are available in the CMC Measures Medication List supplemental document.
- A pharmacy-dispensed prescription for MOUD indicated by an NDC in value set **Medication for OUD.** NDC lists are available in the CMC Measures Medication List supplemental document.

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

Table 17: BH Conditions

Code Category	Code List
ICD-10-CM	F10.* - F16.* (inclusive), F18.*, F19.*, F20.* - F29 (inclusive), F30.*, F31.*, F33.*, F53.0, F53.1, R45.850, R45.851, R45.88, T14.91*, T71.112*, T71.122*, T71.132*, T71.152*, T71.162*, T71.192*, T71.222*, T71.232*, X71.* - X83.* (inclusive), Z91.51, Z91.52, specific intentional self-harm codes in T36.*-T65.*

Table 18: BH Services

Code Category	Code List
CPT	90785, 90791, 90792, 90832, 90834, 90837, 90839, 90840, 90847, 90853, 90833, 90836, 90838, 90845, 90846, 90849, 90857
HCPCS	G0396, G0397, G0410, G0411, G0443, H0004, H0005, H0006, H0010, H0011, H0012, H0014, H0015, H0036, H0037, H0038, H0039, H0040, H0047, H0050, H2011, H2012, H2015, H2016, H2017, H2019, H2020, H2034, H2036, T1006, T1007

Table 19: Antipsychotic Injections

Code Category	Code List
HCPCS	J0400, J0401, J1630, J1631, J2358, J2426, J2680, J2794

Table 20: Antipsychotic Medications

Code Category	Code List
HIC3	H2G, H7O, H7P, H7S, H7T, H7U, H7X, H7Z, H8W

Table 21: Antidepressant Medications

Code Category	Code List
HIC3	H2S, H2U, H2W, H7B, H7C, H7D, H7E, H7J, H8P, H8T, H8Z

Table 22: Other BH Medications

Code Category	Code List
HIC3	H2H, H2M

Table 23: Office Dispensed OUD Medication

Code Category	Code List
HCPCS	H0020, J0571, J0572, J0573, J0574, J0575, J2315, Q9991, Q9992

High-Risk Composite: Opioid Use Disorder Treatment

Measure Description: The percentage of members with a live birth who had an Opioid Use Disorder diagnosis (OUD) during pregnancy and received medication for opioid use disorder during pregnancy. ↗

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous), whose pregnancy resulted in a live birth, and who had an OUD diagnosis during pregnancy (value set **OUD Diagnosis**).

Numerator: Members in the denominator who received medication for OUD (MOUD) during pregnancy as indicated by a claim meeting any of the criteria below:

- Medication for OUD (MOUD) dispensed in a professional medical, outpatient, or inpatient setting. Any of the following qualify:
    - Procedure code in value set **Office Dispensed OUD Medication** (see Table 23)
    - Procedure Code **S5000**, **S5001**, or **T1502** billed by a Provider Type **95**
    - Procedure Code **J8499** or **T1502** with an NDC in value set **Medication for OUD** on the same line. NDC lists are available in the CMC Measures Medication List supplemental document.
- A pharmacy-dispensed prescription for MOUD indicated by an NDC in value set **Medication for OUD.** NDC lists are available in the CMC Measures Medication List supplemental document.

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

Table 24: OUD Diagnosis

Code Category	Code List
ICD-10-CM	F11.*

High-Risk Composite: Average Total MME Dispensed Per Delivery

Measure Description: The average total solid dose morphine milligram equivalent dispensed in the 14 days following a delivery via C-section or a vaginal birth with a significant perineal laceration. ↘

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous), whose pregnancy resulted in a live birth, who delivered via a Cesarean section as indicated in birth records (value set **VS Cesarean, see Table 16**) or claims (value set **Cesarean Section**, see Table 15) or who have a third- or fourth-degree perineal laceration (value set **Perineal Laceration**), and who received at least one solid dose opioid prescription in the 14 days after delivery. Note that the denominator for this measure is the same as the numerator for the *Rate of Solid Dose Opioids Dispensed Following Delivery* measure.

Numerator: Average total solid dose morphine milligram equivalent (MME) dispensed per delivery to members in the denominator beginning on the date of delivery and in the 14 days after delivery (value set **Solid Dose Opioid Medication**). NDC lists are available in the CMC Measures Medication List supplemental document.

First, identify opioid prescriptions dispensed in the window after delivery. The MME is then calculated per prescription as**:**

MME per Rx = quantity dispensed * strength * conversion factor

The MME per Rx is then summed across all deliveries and divided by the number of deliveries.

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

Table 25: Perineal Laceration

Code Category	Code List
ICD-10-CM	O70.2*, O70.3

References: ACOG Clinical Consensus on Pharmacologic Stepwise Multimodal Approach for Postpartum Pain Management

Rate of Solid Dose Opioids Dispensed Following Delivery

Measure Description: The percentage of members with a live birth via Cesarean section or a vaginal birth with a significant perineal laceration, who had a solid dose opioid prescription filled during the 14 days after delivery. ↘

Anchor Date: Date of Delivery

Payment Status: Information only

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous), whose pregnancy resulted in a live birth, and who delivered via a Cesarean section as indicated in birth records (value set **VS Cesarean,** see Table 16) or claims (value set **Cesarean Section**, see Table 15) or who have a third- or fourth-degree perineal laceration (value set **Perineal Laceration**, see Table 25**)**.

Numerator: Members in the denominator who were dispensed a solid opioid prescription on the date of delivery or in the 14 days after delivery (value set **Solid Dose Opioid Medication**). NDC lists are available in the CMC Measures Medication List supplemental document.

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

References: ACOG Clinical Consensus on Pharmacologic Stepwise Multimodal Approach for Postpartum Pain Management

Dental Visits

Measure Description: The percentage of members with a live birth who had a dental visit during their pregnancy or in the six months prior to their pregnancy. ↗

Anchor Date: Date of Delivery

Payment Status: Information only

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous) and whose pregnancy resulted in a live birth.

Numerator: Members in the denominator who had a visit with a dental practitioner (value set **Dental Provider**) from professional, outpatient, or dental claims during pregnancy or in the six months prior to the estimated onset date of pregnancy. Note that a provider type or provider specialty code counts as a valid dental visit. The provider can also be a billing or a rendering provider.

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

Table 26: Dental Provider

Code Category	Code List
Provider Type	30, 31
Provider Specialty	122, 300, 506

References: Oral Health Care During Pregnancy: A National Consensus Statement

Infant Well-Care Visits

Measure Description: The percentage of infants born to CMC-attributed members who had at least two well-care visits after initial discharge and during the 90 days after delivery. ↗

Anchor Date: Date of Delivery

Payment Status: Information only

Denominator: Infant members who are continuously enrolled for the first 90 days of life. Infants' mothers must be attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous). Mother-infant dyads are identified using the VS-births linked file; both a mother and a baby Medicaid ID must be present.

Numerator: Infant members in the denominator with at least two well-care visits after delivery and during the 90 days after delivery (value set **Well-Care**). The visits must:

- occur in an outpatient (claim type "O") or professional medical (claim type "M") setting
- have at least a 14-day gap between service dates
- be with a primary care provider (Appendix 2)

Note that to count as a visit to a primary care provider, the claim must have a billing provider in the Provider Type list, and a billing or rendering provider specialty code in the Provider Specialty list.

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

Table 27: Well-Care

Code Category	Code List
CPT	99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461
HCPCS	G0438, G0439, S0302
ICD-10-CM	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2

References:

American Academy of Pediatrics: Recommendations for Preventative Pediatric Health Care AAP Schedule of Well-Child Care Visits – HealthyChildren.org

Flu Vaccinations

Measure Description: The percentage of members with a live birth who had an influenza vaccine administered while they were pregnant or during the six months prior to pregnancy. ↗

Anchor Date: Date of Delivery

Payment Status: Information only

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous) and whose pregnancy resulted in a live birth.

Numerator: Members in the denominator who had an influenza vaccination during pregnancy or in the six months prior to pregnancy (value set **Influenza Vaccination**).

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

Table 28: Influenza Vaccination

Code Category	Code List
CPT	90637, 90638, 90674, 90682, 90694, 90756, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90685, 90686, 90687, 90688, 90689, 90653, 90662, 90682, 90685, 90686, 90687, 90688, 90695
HCPCS	G0008, Q2034, Q2035, Q2036, Q2037, Q2038, Q2039

References: CDC Guidance on Influenza Vaccination for Pregnant People

Maternal Mental Health Screening

Measure Description: The percentage of members with a live birth who had a mental health screening during their pregnancy or postpartum period. ↗

Anchor Date: Date of Delivery

Payment Status: For payment

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous) and whose pregnancy resulted in a live birth.

Numerator: Members in the denominator who received a maternal mental health screening (value set **Mental Health Screening**) during their pregnancy or within 90 days after delivery.

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

Table 29: Mental Health Screening

Code Category	Code List
CPT	96127, 96160, 96161, 1220F, 3351F, 3352F, 3353F, 3354F, 3725F, 1040F
HCPCS	G0444, S3005, G8431, G8433, G8940, G8511, G8432, G9717, G8510, D0190
ICD-10-CM	Z13.31, Z13.32, Z13.3, Z13.30

References:

Universal Screening for Maternal Mental Health Disorders - Issue Brief - Policy Center for Maternal Mental Health

Severe Obstetric Complications

Measure Description: The percentage of members with a live birth that had severe obstetric complications occur during the inpatient delivery hospitalization. ↘

Anchor Date: Date of Delivery

Payment Status: Information only

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous), whose pregnancy resulted in a live birth, with a gestational age at delivery of at least 20 weeks, and with an inpatient hospital admission (claim type "I") within 7 days before or after the date of delivery.

In cases of multiple claims in the window, use this date hierarchy to identify the delivery claim(s)**:**

1. Date of delivery is between the admission and discharge dates.
2. Date of delivery is before the admission date.
3. De of delivery is after the discharge date.

Numerator: Members whose denominator qualifying claim meets any of the following criteria (value sets available in the CMC Measures Value Sets supplemental document)**:**

- A **Severe Maternal Morbidity Diagnosis** or a **Severe Maternal Morbidity Procedure**
- An ICU or CCU revenue code on the claim (value set **ICU or CCU Stay**)
- Discharge disposition of expired (value set **Discharge Disposition of Expired**)
- A transfer to another hospital (value set **Hospital Transfer**)

If there are multiple delivery claims for the member, assess all qualifying claims for numerator criteria.

Exclusions: Members whose denominator qualifying claim meets any of the following criteria (value sets available in the CMC Measures Value Sets supplemental document)**:**

- Inpatient hospitalizations for patients with a diagnosis of COVID-19 (value set **COVID-19 Diagnosis**) who have either a **COVID-related Respiratory Procedure** or a **COVID-related Respiratory Diagnosis** on the same hospitalization

If there are multiple delivery claims for the member, assess all qualifying claims for exclusion criteria.

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM, based on CMS e-Clinical Quality Measure and CDC/Infant Mortality Research Partnership Severe Maternal Morbidity definition.

References:

CDC Identifying Severe Maternal Morbidity (SMM)

eCQI Resource Center: Severe Obstetric Complications

Enrolled in Women, Infants, and Children (WIC)

Measure Description: The percentage of members with a live birth who received Women, Infants and Children (WIC) benefits during pregnancy.↗

Anchor Date: Date of Delivery

Payment Status: Information only

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous) and whose pregnancy resulted in a live birth.

Numerator: Members in the denominator with at least one month of WIC program participation on or between estimated onset of pregnancy and date of delivery as identified by the WIC supplemental attribution file.

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records. Ohio WIC records integrated into the monthly attribution file.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

References:

Ohio Department of Health: Ohio WIC Program Eligibility USDA: WIC Eligibility Requirements

Estimated Cost of Pregnancy-Related Care

Measure Description: The cost of pregnancy-related care for members with live births, calculated for the prenatal period, delivery, and postpartum period.

Anchor Date: Date of delivery

Payment Status: Information only

Medicaid Enrollment Requirement: Enrolled on delivery.

The following measure component definitions will be used**:**

Prenatal period is defined as the day on which the estimated onset of pregnancy occurs through the day prior to the delivery hospitalization (identified in claims as specified below).

Delivery hospitalization period is defined as the first day of the delivery hospitalization through the last day of the delivery hospitalization, including transfers. A delivery hospitalization is defined as an inpatient claim with any of the following occurring on a claim (same or separate) with a date of service within +/- 7 days of the header date of first service on the inpatient claim**:** a delivery procedure code (value set **Perinatal Delivery Codes**), a labor diagnosis (**Perinatal Labor Diagnoses**), or a live birth diagnosis (value set **Perinatal Live Birth Diagnoses**). The delivery hospitalization must occur within +/- 7 days of the date of delivery indicated on the linked birth certificate.

Postpartum period is defined as the day after discharge from the delivery hospitalization (including transfers) through 90 days after the date of delivery.

Denominator: Members who were attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous), whose pregnancy resulted in a live birth, and for whom a delivery hospitalization was identified.

Numerator: Cost of pregnancy-related care, divided into cost during the prenatal period, cost of delivery, and cost during the postpartum period. The following claims are included**:**

Medications**:** All pharmacy-dispensed medications are included; use the date of dispense to determine the period assignment.

Professional services**:** Include all professional medical claims with a pregnancy-related diagnosis (value set **Perinatal Pregnancy Diagnoses**) or with a qualifying service (**Perinatal Pregnancy-Related Procedures**). If a pregnancy-related procedure occurs without a qualifying pregnancy diagnosis on the claim, include all lines on the same claim as the service. Use the date of first service (detail) to determine the period assignment.

Outpatient services**:** Include all outpatient claims with a pregnancy-related diagnosis (value set **Perinatal Pregnancy Diagnoses**) or with a qualifying service (**Perinatal Pregnancy-Related Procedures**). If a pregnancy-related service occurs without a qualifying pregnancy diagnosis on

the claim, include all lines on the same claim as the qualifying procedure. Use the date of first service (detail) to determine the period assignment.

Inpatient services**:** Include all inpatient claims with a pregnancy-related diagnosis (value set **Perinatal Pregnancy Diagnoses**) or with a qualifying service (**Perinatal Pregnancy-Related Procedures**). Use the date of first service (header) to determine the period assignment.

Exclusions: Members who cannot be linked to a delivery hospitalization in claims as defined above. Members with a total cost of pregnancy in the 99th percentile of all deliveries in the measurement period.

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records. Final paid claims are used for all measure components except for identifying the date of delivery in claims; for that component, final denied claims are also used.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

References:

Ohio Department of Medicaid: Linked to Payment

Syphilis Screening

Measure Description: The percentage of members with a live birth who received a syphilis screening test during pregnancy. This measure has three sub-measures: (1) The percentage of members with a live birth who received a syphilis screening at any point in time during pregnancy; (2) The percentage of members with a live birth who received at least two syphilis screenings during pregnancy; and (3) The percentage of members with a live birth who received a syphilis screening during the first prenatal visit. ↗

Anchor Date: Date of delivery

Payment Status: Information only

Denominator: Members attributed to a CMC for at least six months during their pregnancy or the first two months postpartum (need not be continuous) and whose pregnancy resulted in a live birth.

Numerator 1: Members in the denominator who received a serologic syphilis screening test (any code in the value set **Syphilis Screening**) at any time during pregnancy.

Numerator 2: Members in the denominator who received at least two serologic screening tests (any code in the value set **Syphilis Screening**) with different service dates during pregnancy.

Numerator 3: Members in the denominator who received a serologic syphilis screening test (any code in the value set **Syphilis Screening**) within the 7 days following their first prenatal visit. A prenatal visit is defined as any of the following**:**

- A standalone prenatal visit (value set **Prenatal Visits**).
- A prenatal visit (value sets **Office Visits**, **Telehealth Visits**) with a pregnancy-related diagnosis code (value set **Pregnancy Diagnosis**).

The visit must be in an outpatient (claim type "O") or professional medical (claim type "M") setting. Value sets for this measure are available in the CMC Measures Value Sets supplemental document.

Data Sources: Medicaid administrative data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

References:

National Library of Medicine: Diagnostic tests for syphilis
The American College of Obstetrics and Gynecologists: Screening for Syphilis in Pregnancy
CDC | Sexually Transmitted Infections Treatment Guidelines, 2021: Syphilis During Pregnancy

PRAF Completion

Measure Description: The percentage of members with a live birth who had a completed Perinatal Risk Assessment Form. ↗

Anchor Date: Date of Delivery

Payment Status: Information only

Denominator: Members attributed to a CMC provider for at least six months during their pregnancy or the first two months postpartum (need not be continuous).

Numerator 1: Members in the denominator with an electronic PRAF with a date of service between the estimated onset date of pregnancy through 90 days after the date of delivery.

Numerator 2: Members in the denominator with an electronic PRAF with a date of service between the estimated onset date of pregnancy and the first prenatal visit (including the date of the visit). A prenatal visit is defined as either of the following**:**

- A standalone prenatal visit (value set **Prenatal Visits**).
- A prenatal visit (value sets **Office Visits**, **Telehealth Visits**) with a pregnancy-related diagnosis code (value set **Pregnancy Diagnosis**).

The visit must be in an outpatient (claim type "O") or professional medical (claim type "M") setting. Value sets for this measure are available in the CMC Measures Value Sets supplemental document.

Numerator 3: Members in the denominator with an electronic PRAF with a date of service between the estimated onset date of pregnancy and the end of the 12th week of gestation (defined as 84 days after the estimated onset date of pregnancy).

Exclusions: Members who do not have a valid gestational age at delivery on the linked birth certificate.

Data Sources: Medicaid administrative data and NurtureOhio PRAF data linked to Vital Statistics Birth records.

Measurement Period: Rolling 12-month measurement period updated on a quarterly basis, based on the latest accurate data available. The date of delivery must occur in the measurement period for inclusion in this measure.

Measure Steward: ODM

Enrolled in Evidence-Based Home Visiting (On hold)

Appendix 1: Primary Care Provider Type and Specialty Combinations

Provider Type	Provider Type Description	Provider Specialty	Provider Specialty Description
01	Hospital	001	General Hospital
01	Hospital	005	Children's Hospital
01	Hospital	006	Major Teaching Hospital
01	Hospital	010	Critical Access Hospital
05	Rural Health Clinic	050	Rural Health Clinic Medical
12	Federally Qualified Health Center	121	FQHC Medical
20	Physician/Osteopath Individual	207	Family Practice
20	Physician/Osteopath Individual	201	General Practice
20	Physician/Osteopath Individual	263	General Preventive Medicine
20	Physician/Osteopath Individual	209	Internal Medicine
20	Physician/Osteopath Individual	215	Pediatric
20	Physician/Osteopath Individual	342	Public Health & Gen Preventive Med
20	Physician/Osteopath Individual	274	Internal Medicine/Pediatrics
21	Professional Medical Group	021	Professional Medical Group
24	Physician Assistant	240	Physician Assistant
50	Clinic	500	Primary Care Clinic
50	Clinic	501	Public Health Clinic
65	Clinical Nurse Specialist Individual	215	Pediatric
65	Clinical Nurse Specialist Individual	651	Adult Health
72	Nurse Practitioner Individual	207	Family Practice
72	Nurse Practitioner Individual	215	Pediatric
72	Nurse Practitioner Individual	651	Adult Health

Appendix 2: Modification History

Version	Date	Modifications
1.0	9/13/2022	Initial version.
1.1	9/30/2022	Revised High-Risk Composite to remove requirement that providers meet thresholds for 2 of 4 component measures to pass the combined measure. Revised High-Risk Composite**:** Average Total MME Dispensed Per Delivery to include only deliveries via C-section or with a significant perineal laceration. Revised Rate of Solid Dose Opioids Dispensed Following Delivery to include only deliveries via C-section or with a significant perineal laceration. Added Estimated Cost of Pregnancy measure specifications.
2.1	11/20/2023	Standardized language across document. Updated value sets for Postpartum Care, Hepatitis B Screening, HIV Screening, Prenatal Visit by 9 Weeks, NTSV Cesarean Birth Rate. Updated Medication Lists for opioid and MOUD value sets. Added value set tables to measure specifications where possible. Retired Progesterone Administration - removed recipe. High-Risk Composite now has three measures. Flipped HRC**:** MME and HRC**:** OUD such that HRC**:** MME is second.
2.2	7/30/2024	Changed measure name Maternal Depression Screening to Maternal Mental Health Screening. Added additional information-only measure, Syphilis Screening. Added clarification regarding use of final paid and final denied claims for measures. Streamlined language for consistency. Added table at the front of document summarizing measures and payment status.
2.2.1	8/14/2024	Changed measure name NTSV Cesarean Birth Rate to Low-Risk Cesarean Delivery Rate. Updated values for PLBL and PLBD to reflect numeric type. Added provider type – specialty pair to Appendix A.
3.0	12/30/2024	Added clarity about how to handle missing values in value sets using Vital Statistics linked data. Updated other references to maternal depression, now maternal mental health screening. Added arrows indicating the direction of improvement for each measure rate. Added description of the arrows to general methods section.

		Updated references to Vital Statistics linked data to reflect changes in source data format. Fixed overview measures table to detail each measure in the high-risk composite Added HIV Screening to overview measures table. Changed Postpartum Care and Dental Visits measure steward from 'HEDIS (unaudited, adjusted)' to 'ODM'. Updated names of value sets in Postpartum Care**:** From 'Cervical Cytology Lab Test' to 'Cervical Lab Test' From 'Postpartum Visits' to 'Postpartum Care Visit' Added information only versions of Hepatitis B and HIV Screening metrics for screening occurring at first prenatal visit. Adjusted page breaks and added headings to intro section. Reviewed and updated reference links.
3.0	1/16/2025	Updated Maternal Mental Health Screening with new codes in value set Updated Primary Care Visits date range from 4-12 weeks after delivery to 0-12 weeks after delivery. Renamed LRCD value set 'VS Primary Cesarean' to 'VS Cesarean' to standardize across measures (distinction was removed).
3.0	2/26/2025	Removed per-month language from Estimated Cost of Pregnancy-Related Care.
4.0	9/3/2025	Updated Preterm Birth payment status to For Payment. Updated Tdap Vaccinations references link. Fixed measure descriptions to follow the same format and language throughout document. Renumbered Value set tables. Added reference in Dental Visits measure. Added Data Sources and Measurement Period section in Infant Well-Care measure to follow format of other measure specs. Updated reference in Flu vaccinations and added HCPCS codes that were in the Value set document but not in the table within the measure specs.
4.0	11/4/2025	Added PRAF Completion Measure Changed format of the 'prenatal visit' definition in Prenatal Visit by 9 Weeks Gestation for consistency. Minor grammar & formatting throughout.
4.0	11/6/2025	Combined Online Assessment value set and Telephone Visits value set into Telehealth Visits value set and added new CPT codes Updated Prenatal Visit value set names and updated the definition of a prenatal visit to reflect the change: • From "Prenatal Visits" to "Office Visits" • From "Standalone Prenatal Visits" to "Prenatal Visits"

		Added CPT 98000 Codes to Telehealth and Primary Care value sets Added Tobacco Screening and Tobacco Cessation HCPCS codes
4.0	12/16/2025	Added high-cost outlier exclusion to Estimated Cost of Pregnancy-Related Care Minor language edits in the data source section of the General Methodological Notes.