OFFICE OF THE UNDER SECRETARY OF WAR
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND READINESS

The Honorable Roger F. Wicker
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

NOV 25 2025

Dear Mr. Chairman:

The Department's response to section 746(f)(2) of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116–283), "Extramedical Maternal Health Providers Demonstration Project," is enclosed. Section 746(f)(2) requires that the Secretary provide an annual report on an extramedical maternal health provider demonstration, which the Department has titled the Childbirth and Breastfeeding Support Demonstration (CBSD).

The CBSD offers continuous labor support and antepartum/postpartum support services from certified labor doulas and breastfeeding support services from certified lactation consultants and counselors not otherwise TRICARE-authorized for most TRICARE-eligible beneficiaries receiving maternity services in private sector care. The CBSD began January 1, 2022, and is set to expire on December 31, 2026, with overseas implementation beginning January 1, 2025.

Thank you for your continued strong support for the health and well-being of our Service members and their families. I am sending a similar letter to the House Armed Services Committee.

Sincerely,

[redacted]

Sean O'Keefe
Deputy Under Secretary of War for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

[redacted]

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
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PERSONNEL AND
READINESS

The Honorable Mike D. Rogers
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

NOV 25 2025

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[redacted]

Sean O'Keefe
Deputy Under Secretary of War for Personnel
and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

[redacted]

Report to the Committees on Armed Services of the Senate and the House of Representatives

Extramedical Maternal Health Providers Demonstration Project

November 2025

The estimated cost of this report or study for the Department of Defense is approximately $20,000 in Fiscal Years 2024 - 2025. This includes $0 in expenses and $20,000 in DoD labor.
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INTRODUCTION

This report updates Congress on the demonstration project mandated by section 746(f)(2) of the William M. (Mac) Thornberry National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2021 (Public Law 116–283), which required that the Secretary of Defense establish a 5-year demonstration project to evaluate the cost, quality of care, and impact on maternal and fetal outcomes of using extra medical (i.e., non-medical) maternal health providers under TRICARE to determine the appropriateness of making coverage of such providers permanent. The NDAA for FY 2021 required an initial report on implementation of the demonstration and annual reports due beginning 1 year after the start of the demonstration. All mandated reporting elements are addressed in this report to the fullest extent possible.

BACKGROUND

The Defense Health Agency (DHA) implemented the congressionally mandated extra medical maternal health provider demonstration through a Federal Register notice (FRN) published on October 29, 2021 (86 Federal Register (FR) 60006). The demonstration project was titled the Childbirth and Breastfeeding Support Demonstration (CBSD). The CBSD added as authorized providers certified labor doulas (CLDs), who meet certain requirements, with up to six antepartum or postpartum visits covered, plus one episode of continuous labor support. The services of certified lactation consultants/counselors (LCs), not otherwise TRICARE-authorized providers, such as registered nurses (RNs) (henceforth collectively referred to as "non-RN LCs"), who meet certain requirements are also covered for up to six total prenatal or postnatal breastfeeding counseling visits per birth event. The CBSD also added coverage of group breastfeeding counseling sessions (including prenatal breastfeeding classes) by a CBSD non-RN LC or another TRICARE-authorized provider, to be included in the six total visit allowance. In addition to the congressionally mandated study elements, the Department of Defense notified the public in the FRN of its intent to study the administrative feasibility of a permanent benefit. The demonstration began in the United States on January 1, 2022.

Congress described annual reporting expectations in section 746 of the NDAA for FY 2021, which included addressing rates of use for demonstration services, qualitative results via survey responses, and the financial/logistical feasibility of creating a permanent benefit. This report addresses each requirement set forth by Congress, along with a description of the limitations in the reported data. Reports are expected each year on or by the anniversary of demonstration commencement; this report details the status of the CBSD in year 3. Each report must address, at a minimum, the following matters:

> (i) The number of covered beneficiaries who are enrolled in the demonstration project.
> (ii) The number of enrolled covered beneficiaries who have participated in the demonstration project.
> (iii) The results of the required survey under subsection (e).
> (iv) The cost of the demonstration project.
> (v) An assessment of the quality of care provided to participants in the demonstration project.

(vi) An assessment of the impact of the demonstration project on maternal and fetal outcomes.

(vii) An assessment of the effectiveness of the demonstration project.

(viii) Recommendations for adjustments to the demonstration project.

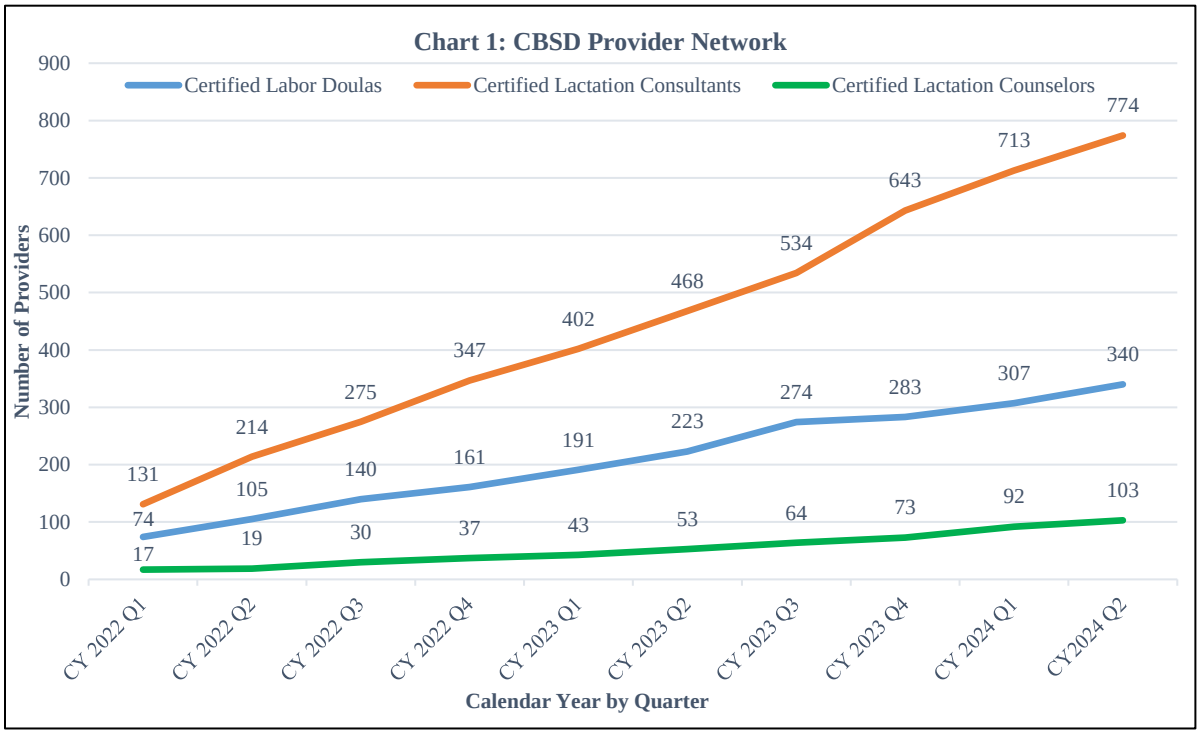
(ix) The estimated costs avoided as a result of improved maternal and fetal outcomes due to the demonstration project.

(x) Recommendations for extending the demonstration project or implementing permanent coverage under the TRICARE program of extramedical maternal health providers.

(xi) An identification of legislative or administrative action necessary to make the demonstration project permanent.

DISCUSSION

DHA began the CBSD on January 1, 2022, and has seen steady increases in both beneficiary utilization and provider participation. In the last report, DHA shared that 5,116 beneficiaries had used CBSD services based on claims data from January 2022 to May 2023. This year DHA can report that a total of 10,579 beneficiaries have accessed the benefit (claims for January 2022 to July 2024). DHA's Managed Care Support Contractors (MCSCs) continue to add new providers, both in-network and out-of-network (see Chart 1). For the period of January 2022 to January 2024, TRICARE reimbursed the services of 199 unique CLDs and 298 unique non-RN LCs.



Since last year's report, DHA has made modifications to improve the benefit for TRICARE's pregnant beneficiaries. Each update has been intended to increase access and create

a benefit that could be sustainable in the long-term, while informing the evaluation, which began in earnest this year. Changes to the CBSD and its evaluation since last year's report are discussed below.

Update 1: Addition of an Independent Evaluation Contractor

In late September 2023, DHA contracted with Booz Allen Hamilton (BAH) to perform an independent evaluation of the CBSD. The intent of contracting with an organization to perform this evaluation was to minimize bias in the reporting of CBSD outcomes and analysis of data, minimize bias in conducting a feasibility assessment of the CBSD, and leverage advanced analytics and other capabilities, such as natural language processing. The evaluation is designed as a program evaluation, as opposed to a clinical study, although it reports the statistical significance of findings where appropriate.

As part of this evaluation, DHA worked with BAH to update methodologies and measures initially discussed in the October 2021 FRN, including which health outcomes to measure and the study design to be used for the claims data analysis. These modifications led to an improved and stronger study design, as well as outcome measures that were grounded in the literature and accessible in the available data set. The evaluation methodology and outcome data for the first 2 years of the CBSD are discussed in greater detail further in this report.

Update 2: Improvements in the Childbirth Support Services Benefit under the CBSD

Fewer than 2,000 beneficiaries have accessed childbirth support services under the CBSD compared to around 10,000 that have accessed breastfeeding counseling (some beneficiaries used both services). While use of childbirth support services (i.e., use of a doula) has increased and the number of TRICARE-authorized CLDs has grown, DHA determined that modifications were required to increase beneficiary access to childbirth support services. On April 11, 2024, DHA published an FRN (89 FR 25617) announcing these modifications, which represent a second phase of the childbirth support services portion of the CBSD. No changes were made to breastfeeding support services.

The FRN informed the public of the creation of a Phase 2 reimbursement structure for childbirth support services, under which a new reimbursement methodology, derived in part from Medicaid rates, was adopted. It also included a requirement for CLDs to be participating providers; changed the antepartum and postpartum visit allowance from six untimed visits to six hours of visits billed in 15-minute increments as agreed on by the beneficiaries and their doulas; and adopted new Current Procedural Terminology (CPT) codes. Additionally, DHA added a CLD certification body, the National Black Doulas Association (NBDA), and waived the certification requirement for CLDs actively enrolled in a state Medicaid program as a doula. Phase 2 of the CBSD was implemented over several months in 2024. The changes to CLD requirements were effective the date the FRN published. The new reimbursement methodology, new CPT codes, and new 15-minute visit increments were available to CLDs who were either in-network or a participating out-of-network provider starting June 10, 2024. All CLDs are required to be participating providers by January 1, 2025.

Most of the changes were made with the goal of increasing access to care. The modification to reimbursement rates should increase payments to CLDs, which DHA expects to increase the number of CLDs participating in the CBSD and thus improve TRICARE beneficiary access to childbirth support services. The participation requirement ensures that TRICARE beneficiaries would know at the time that they hired their doula if the services would be covered, with doulas filing claims for reimbursement instead of requiring beneficiaries to file their own claims, which removes a significant barrier for accessing CBSD-covered childbirth support services. The addition of the NBDA also expands the number of CLDs eligible to participate in the CBSD, which DHA expects to improve access to childbirth support services, as well. The waiver of the certification requirement for CLDs participating in state Medicaid programs is expected to be a temporary demonstration provision unlikely to be continued if the benefit is permanently adopted. The purpose of the waiver is to allow DHA to test the impact of different doula credentialing models on quality of and access to care. More information on the modifications can be found in the FRN referenced above.

Update 3: Overseas Implementation

On January 1, 2025, DHA expanded services under the CBSD to overseas locations managed by the TRICARE Overseas Program (TOP) contractor. The CBSD began later for overseas locations compared to the United States due to the complexity of implementing the novel benefit in the over 40 countries where TRICARE beneficiaries give birth each year. DHA initiated discussions regarding implementation of the CBSD overseas with the TOP contractor midway through the first year (2022), and formally authorized the TOP contractor to begin implementation activities over a year prior to the expansion of the CBSD.

Because of the complexity of the overseas program, and because most certification bodies selected by DHA for the CBSD in the United States are U.S.-centric, DHA established flexibilities for overseas implementation, as announced in an FRN that published August 2, 2023 (88 FR 50850). In addition to the certification organizations accepted in the United States, the TOP contractor may authorize additional bodies that are comparable to the U.S.-based organizations, or, for CLD certification organizations, to request authorization when the group does not meet the requirements to be identified as comparable. As of the drafting of this report, DHA has granted the TOP contractor permission to use two additional organizations, Childbirth International (CBI) and Mondo Doula. As the demonstration progresses overseas, the TOP contractor will have the ability to propose additional organizations that may or may not be approved, depending on the alternate criteria able to be agreed upon. For example, for CBI doulas to be eligible for CBSD reimbursement, in place of recertification (which CBI does not require), the TOP contractor must collect proof of continuing education and birth experience from interested doulas with certifications more than 5 years old. More information on the implementation overseas (including flexibilities permitted) is available in the TRICARE Operations Manual (TOM) 6010.62M, Chapter 18, Section 11, or TOM 6010.59-M, Chapter 18, Section 12, both available at https://manuals.health.mil/.

DHA also required that beneficiaries overseas register in the CBSD to participate, a requirement which does not exist for beneficiaries in the United States. This is due to the varying health care systems abroad and because the beneficiary may not be aware of the

flexibilities permitted for providers to qualify under the CBSD overseas. Additionally, a registration process is more easily managed because, compared to the United States, far fewer TRICARE beneficiaries give birth overseas in private sector care (about 1,500 annually compared with approximately 65,000 in the United States).

In preparation for implementation, DHA and the TOP contractor collaborated to create and share educational information for beneficiaries, establish a registration process, build provider networks in countries with the most TRICARE births annually, and conduct briefs for customer service teams to equip them to address questions.

On October 3, 2024, registration began. Beneficiaries enrolled to the TOP contract who give birth overseas are eligible for breastfeeding support services; and those who give birth outside a military medical treatment facility (MTF) are also eligible for childbirth support services. The registration process involves a phone call or e-mail to the TOP contractor where information (such as medically appropriate birth location and services of interest) is collected to assure beneficiary eligibility. Once eligibility is determined, beneficiaries receive a personalized response e-mail describing their eligibility status and outlining in detail the benefits available to them. Even if CBSD services are not available, a link is provided to the website which emphasizes breastfeeding support benefits already available under the basic benefit, as well as customer support contact information.

Provider networks with public directories have been established for Germany, Italy, South Korea, Puerto Rico, Japan, and the United Kingdom. Ideal network sizes for these countries were calculated and are expected to be met. Outside of these higher-volume countries, the TOP contractor will work to facilitate contact between each individual registered beneficiary and an eligible provider. Within 14 days of registration confirmation, DHA requires the TOP contractor to inform the beneficiary whether there is a provider in their country/region able to provide the desired services.

With such significant lead time to prepare for overseas inclusion in the CBSD, DHA is pleased with how the implementation has progressed. This time allowed for extensive research into the cultural views of doulas in TOP countries and increased the likelihood that most beneficiaries interested in receiving CBSD services for their overseas pregnancy/birth can be accommodated. Next year's report will be able to include usage numbers for the first months of overseas service delivery as well as any challenges encountered during implementation.

Mandatory Reporting Elements

(i) The number of covered beneficiaries who are enrolled in the demonstration project.

For CBSD participation within the United States, DHA considers a beneficiary enrolled in the demonstration when a claim is received for services under the CBSD. That is, enrollment is automatic. For CBSD participation overseas, an enrollment/registration process is required; these numbers will be included in the next report.

(ii) The number of enrolled covered beneficiaries who have participated in the demonstration project.

The number of enrolled beneficiaries is equivalent to the number of beneficiaries who participated in the demonstration. The total number of unique beneficiaries who participated in the demonstration from January 2022 through July 2024 was 10,579. This year's totals are more than double what we reported last year (5,116 through May 2023); last year we reported 4,594 beneficiaries accessed breastfeeding support services and 680 used childbirth support services. The use of childbirth support services saw the largest increase, and each service saw similar increases across beneficiary category. Table 1 shows the number of unique beneficiaries for each service; a small number used both. Around 50 beneficiaries may be listed twice, in both the active duty Service member (ADSM) and active duty family member (ADFM) rows (for example, if an ADSM was married to an ADSM and received some services before separating/retiring and receiving services as an ADFM).

Table 1: Unique CBSD Participants by Beneficiary Category, January 2022 to July 2024

Beneficiary Category	Breastfeeding Support Services	Childbirth Support Services	Total Unique Beneficiaries
ADSMs	1,409	274	1,620
ADFMs	5,479	1,342	6,553
Retirees and Retiree Family Members	2,148	232	2,344
Other*	59	7	62
Totals	***9,095***	***1,855***	***10,579***

***Beneficiaries that do not fit into one of the categories above, including those with an unknown status and those with missing data in the Defense Enrollment Eligibility Report System (DEERS).

Use by ADSMs continues to be comparable to or higher than expected given their proportion in the Military Health System (MHS) birthing population. ADSMs account for about 15 percent of CBSD users (14 percent of breastfeeding support service users and 15 percent of childbirth support service users); ADSMs constitute about 16 percent of births in the MHS and 9 percent of private sector care births (the CBSD is only available in private sector care). Around 60 percent of private sector care births are ADFMs, and ADFMs use 62 percent of CBSD services (56 percent of breastfeeding support services and 72 percent of childbirth support services).

Based on claims data, a total of 21,617 breastfeeding support services have been provided to TRICARE beneficiaries under the CBSD (see Table 2). This includes individual counseling performed by non-RN LCs, and group counseling sessions performed by a non-RN LC or any TRICARE-authorized provider (most commonly, RN-LCs or other nurses and nurse practitioners). These totals do not include any lactation counseling received by the beneficiary during an inpatient hospital stay when the LC is employed by the hospital, as such services would not be billed separately.

Table 2: Outpatient Breastfeeding Support Services Provided Under the CBSD from January 2022 to July 2024, by CPT Code

CPT Code	Services Description*	2022 Services	2023 Services	2024 Services **	Total Number of Services
99401	Individual, 15 minutes (total)	154	107	43	304
99402	Individual, 30 minutes (total)	259	488	135	882
99403	Individual, 45 minutes (total)	81	244	182	507
99404	Individual, 60 minutes (total)	1,344	3,005	1,475	5,824
99411	Group, 30 minutes (total)	5	3	0	8
99412	Group, 60 minutes (total)	1,616	7,653	4,823	14,092
	Totals	***3,459***	***11,500***	***6,658***	***21,617***

***Individual sessions are only non-RN LC providers, while group sessions include RN and other TRICARE-authorized providers.*

****2024 data through July.*

A notable development since last year is that a majority of breastfeeding support services under the CBSD are now group breastfeeding counseling sessions. In 2022, group counseling was 46.9 percent of services used, increasing to 66.6 percent in 2023 and 72.4 percent for 2024 (through July). The increase far outpaces our original estimate for group services, which we assumed would be in the minority for breastfeeding counseling. This could be attributable to several factors, including the allowance for prenatal breastfeeding classes and the availability of two nationwide breastfeeding counseling providers (claims from the two nationwide virtual providers account for 74 percent of paid claims for 60-minute group sessions but only 13 percent of individual sessions by non-RN LCs). DHA intends to investigate this use in the following year to determine if any benefit changes are required (for example, whether group prenatal classes should be treated differently than other counseling sessions). Additionally, DHA will continue to monitor the breastfeeding counseling benefit and its use in the coming year, including ensuring that beneficiaries who want access to individual sessions and to in-person counseling have options available.

Reimbursement of childbirth support services increased by more than double from 2022 to 2023 (see Table 3), with the 1,855 unique childbirth support service users being supported before or after delivery two to three times, on average. Fewer labor support encounters exist than users, likely because some beneficiaries had not yet completed the pregnancy when the data was pulled, though in some cases the beneficiary may have miscarried, opted not to use a doula for delivery, or delivered before the doula arrived.

Table 3: Total Childbirth Support Services Provided Under the CBSD through July 2024, by CPT Code

CPT Code	Services Description	2022	2023	2024*	Total Number of Services
99509	Antepartum or Postpartum Visit	967	2,370	1,109	4,446
59899	Continuous Labor Support	300	780	385	1,465
	Totals	***1,267***	***3,150***	***1,494***	***5,911***

***2024 data through July 2024*

While claims through July 2024 do not show a similar increase as is seen from 2022 to 2023, many TRICARE CLDs may not file claims immediately after each service is performed and, in many cases, may provide beneficiaries with a "super bill" after all services are complete so that the beneficiary may file their own claim. Because childbirth support services may occur from 20 weeks gestation to weeks or months after delivery, there may be a delay in our ability to track these services. Next year's report will provide a more complete understanding of use in 2024.

(iii) The results of the required survey under subsection (e).

DHA developed the CBSD survey questions and sent survey invitations to TRICARE beneficiaries who gave birth within the MHS when an email address for the beneficiary was available.[1] Survey response rates are low (see Table 4) but largely consistent with other MHS surveys. 2024 data is not available for this year's report due to the transition from Max.gov to Connect.gov, which hosts the CBSD survey software. This delayed the collection of 2024 survey responses. An analysis of 2024 data will be included in next year's report. Additionally, for births occurring in 2024, DHA slightly modified the survey to more accurately collect certain pieces of information, including questions on the rank and military branch of the respondent's spouse (if their spouse is a current or former ADSM) and how LC services were paid. The survey is referred to as the Maternity Survey; results related to health outcomes are provided in further in this report.

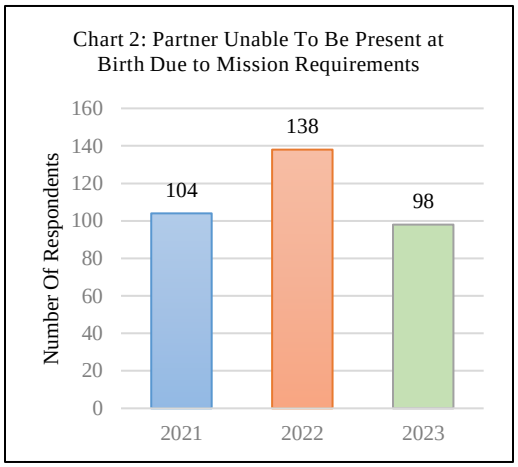
[1] The MCSCs provided DHA with a list (including email addresses) each quarter for beneficiaries who gave birth in the previous quarter; because not all beneficiaries had an email address on file, DHA was only able to send the survey to about 64 percent of beneficiaries who gave birth in private sector care. For direct care, DHA was only able to obtain email addresses for just under 5,000 ADSM beneficiaries who gave birth in MTFs, or what is likely only about 15 percent of the population who gives birth in MTFs.

Table 4: Survey Response Rates

Year	Private Sector Care Emails	Responses	Response Rate	Direct Care Emails	Responses	Response Rate
2021	34,454	2,340	6.79%	4,629	492	10.63%
2022	40,378	3,549	8.79%	4,790	585	12.21%
2023	39,927	4,131	10.35%	4,514	304	6.73%

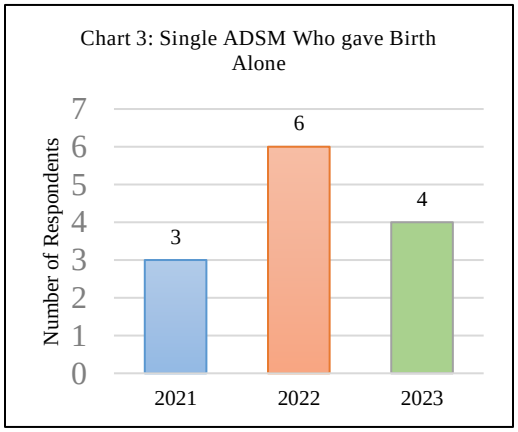
The information below was requested by Congress and includes data starting in 2021 and both private sector care and direct care responses.

a. How many members of the Armed Forces or spouses of such members give birth while their spouse or birthing partner is unable to be present due to deployment, training, or other mission requirements.



The number of respondents who said their partner was not present at their most recent birth event due to mission requirements continues to be relatively small. Chart 2 shows the total count of respondents by year; about 3 percent of survey respondents for 2023 reported their partner was unable to be present due to mission requirements.

b. How many single members of the Armed Forces give birth alone.

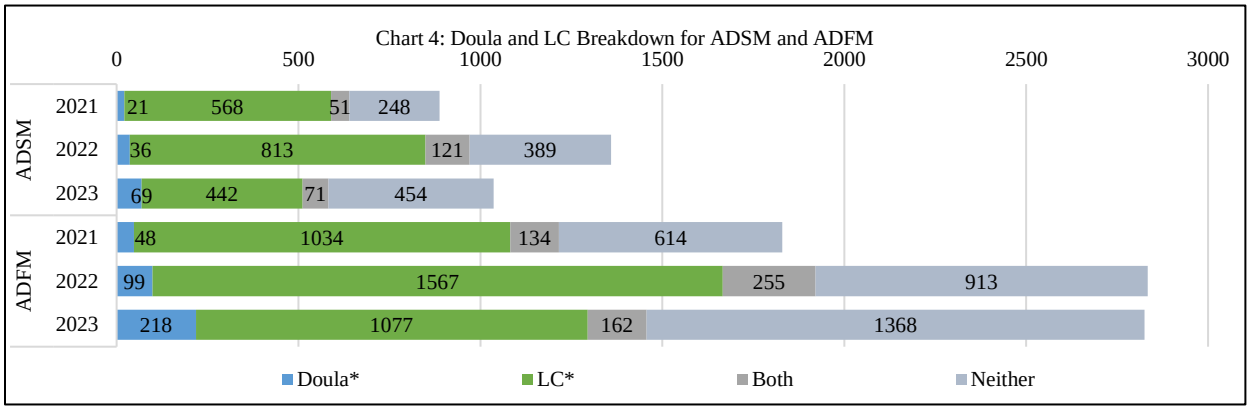


Survey data continues to consistently show that few ADSMs report giving birth alone (see Chart 3). In 2023, there were 116 ADSM survey respondents who reported they were divorced, widowed, single-never married, or separated; only a few (about 3 percent) reported giving birth without any form of personal support (see Chart 3). For the single ADSM population, only 9 reported using a doula with TRICARE paying for one of the doulas. Responses to this question were consistent with prior years.

c. How many members of the Armed Forces or spouses of such members use doula, lactation consultant, or lactation counselor support.

A total of 3,282 ADSMs and 7,489 ADFMs responded to the survey from 2021 to 2023. Chart 4 details reported use of services by doulas and LCs among those who responded to the

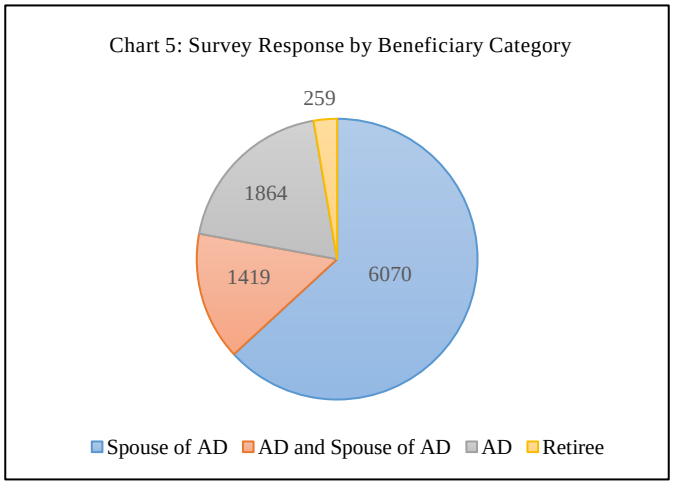
survey. Both ADSMs and ADFMs reported higher LC use than doula use, with a small number using both. This is consistent with claims data discussed earlier in this report.



d. The race, ethnicity, age, sex, relationship status, Armed Force, military occupation, and rank, as applicable, of each individual surveyed.

On average, survey respondents were between 25 to 34 years old, identified as white, and were married or had a domestic partner. Most ADSMs belonged to the Air Force (followed by the Army, Navy, and National Guard), reported a rank between E-4 and E-6, and the top three reported occupations were "administrative," "healthcare," and "engineering, science, or technical" occupations.

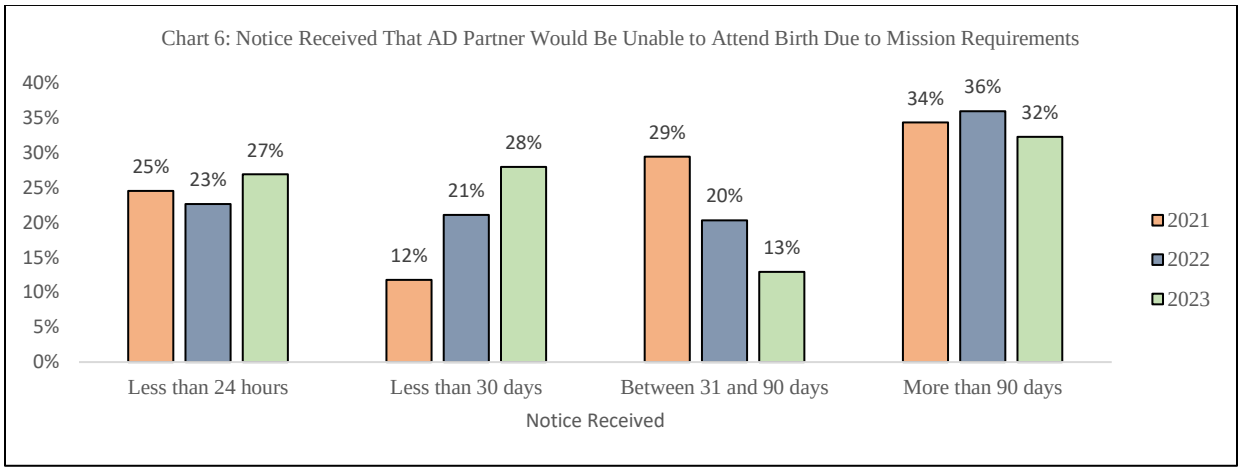
e. If individuals surveyed were members of the Armed Forces or the spouses of such members, or both.



The majority of survey respondents were spouses of ADSMs (7,489) or ADSMs (3,283) (see Chart 5). Within those two groups, were 1,419 respondents who were both an ADSM and married to an ADSM. A much smaller portion were retirees or other beneficiaries (retiree spouses or children of ADSMs, for example). Due to data limitations, the only individuals who gave birth at an MTF who received the survey were ADSMs; therefore, ADFM and other beneficiaries who gave birth at MTFs did not have the opportunity to respond to the survey. This means that the survey may have oversampled ADSMs (or conversely, under sampled ADFM and other beneficiaries), and that this is an additional limitation to the ability to generalize survey findings to all TRICARE beneficiaries.

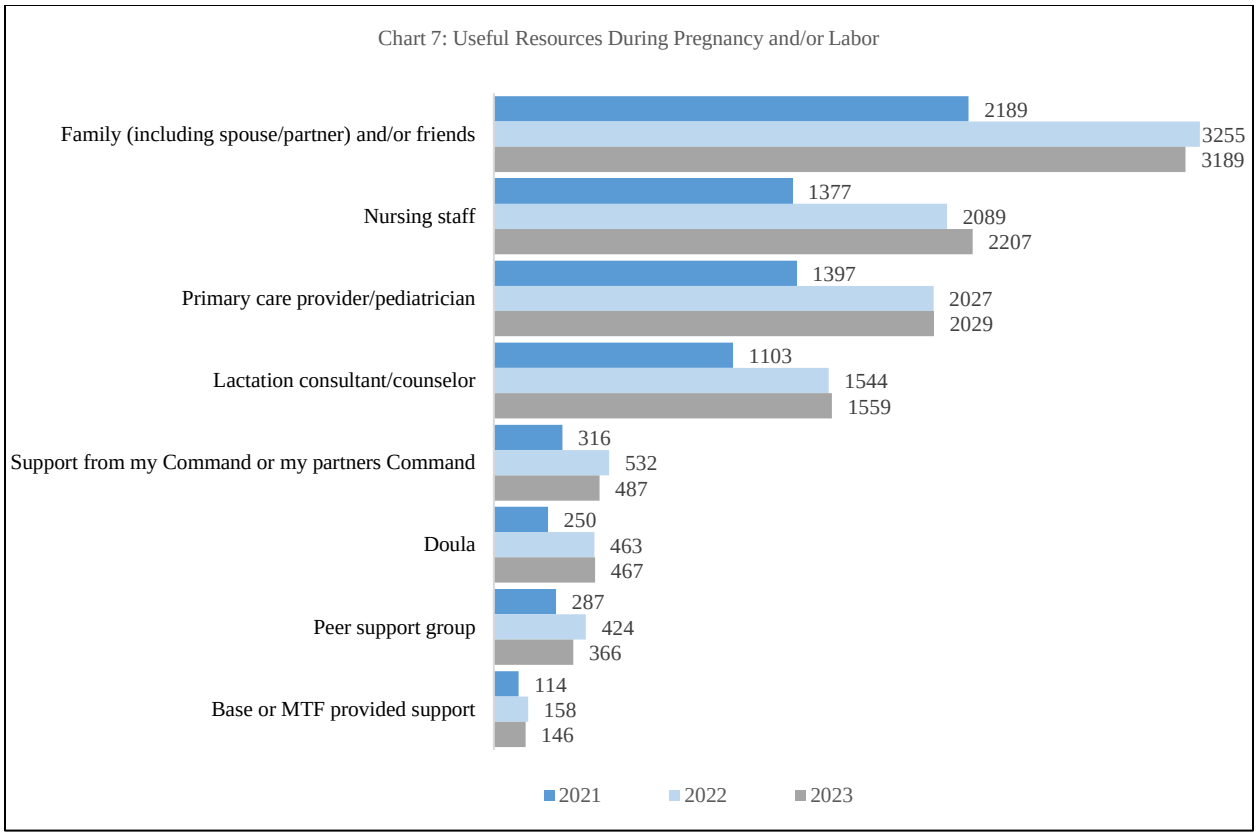
f. The length of advanced notice received by individuals surveyed that the member of the Armed Forces would be unable to be present during the birth, if applicable.

Around 3 percent of survey respondents each year reported that their partner would not be at the birth of their child due to mission requirements (see paragraph a. above). The amount of notice received varied from year to year, with about a third of respondents consistently reporting they had more than 90 days notice (see Chart 6). In 2023, there was a statistically significant increase in the number of respondents who received less than 30 days notice (including less than 24 hours notice)(p-value .03717).



g. Any resources or support that the individuals surveyed found useful during the pregnancy and birth process, including doula, lactation consultant, or lactation counselor support.

Survey respondents were asked which resources they found most useful during their pregnancy and labor, with the option to select more than one response (see Chart 7). The ranking of the responses from most selected to least is largely consistent, though there are minor variations. For those respondents who reported that they used a lactation consultant or counselor in response to a different question (6,133 over the 3 years), only 57.9 percent selected "lactation consultant/counselor" as one of the resources they found useful in response to this question. Respondents who reported using a doula (1,068 over the 3 years) were much more likely to select the "doula" option in response to this question (86.4 percent).



(iv) The cost of the demonstration project.

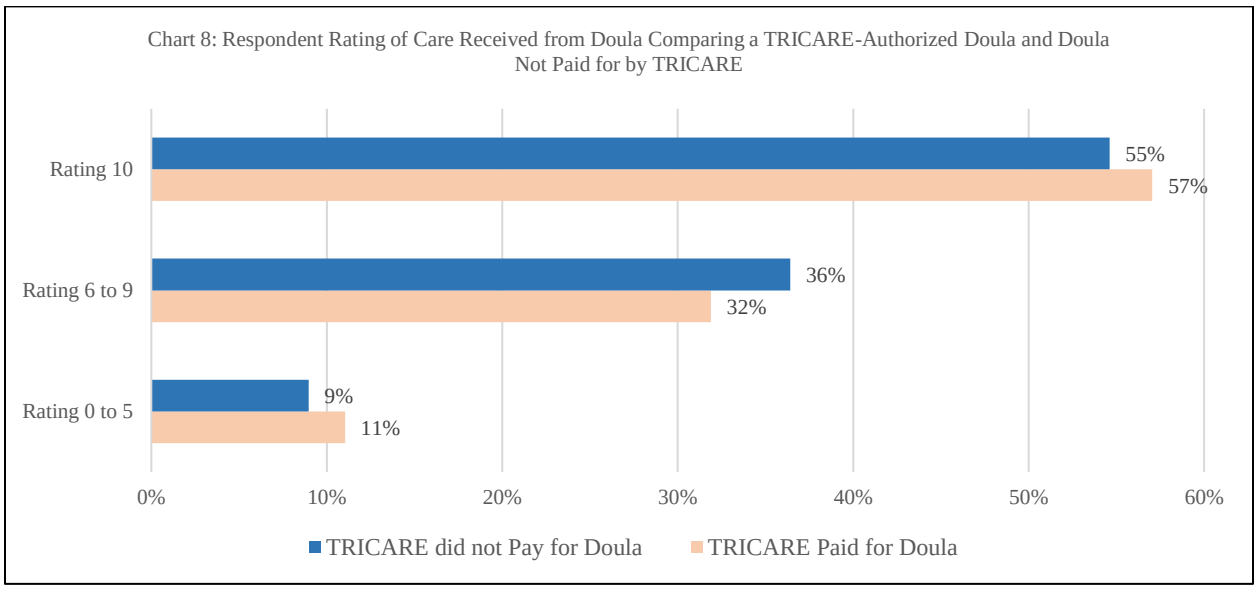
The cost of CBSD services from January 2022 to July 2024 is $2.4 million (M), with the costs slightly higher for childbirth support services (see Table 5). While beneficiaries have used more breastfeeding support services overall, the reimbursement rate for continuous labor support causes the costs associated with childbirth support services to accumulate more quickly. Similarly, while more beneficiaries have used group breastfeeding counseling services than individual counseling, group counseling has only cost about $315,000.00 because it has a reimbursement rate lower than that for individual counseling (about two-thirds of this is for non-RN LCs). For childbirth support services, approximately $1M of the cost is associated with the benefit is attributable to continuous labor support encounters. The amount spent on the CBSD to date is well below the 5-year estimate of $7.05M for breastfeeding support and $40.18M for childbirth support services in the FRN announcing the CBSD (86 FR 60006). These costs do not include administrative costs of health care contractor implementation, Government management and oversight, or the cost for the evaluation contract.

Table 5: Cost for CBSD Services, January 2022 to July 2024

Calendar Year	Breastfeeding Support Services	Childbirth Support Services	Total
2022	$217,380.72	$263,275.24	$480,655.96
2023	$565,002.10	$702,367.20	$1,267,369.30
2024	$312,058.00	$343,440.30	$655,498.30
Totals	***$1,094,440.82***	***$1,309,082.74***	***$2,403,523.56***

(v) An assessment of the quality of care provided to participants in the demonstration project.

The assessment of quality of care from CBSD providers is different for childbirth support services and breastfeeding support services because of the data available and the relationship of those services to the existing TRICARE Basic (i.e., medical) benefit. To assess the quality of childbirth support services under the CBSD, it is necessary to use survey data. Childbirth support services are a new benefit and CLDs are the only provider performing those services under TRICARE. While many beneficiaries obtain childbirth support services from doulas not reimbursed under the CBSD, DHA does not receive claims when they do, and, therefore, DHA cannot compare claims outcome data for childbirth support services received from a TRICARE-authorized CLD to the same services from doulas funded another way. However, the survey collects information about childbirth support services from respondents regardless of funding source, with the ability to compare responses for individuals who used a doula paid for by TRICARE to the overall population responses. Chart 8 shows that the majority of survey respondents rated the care they received from their doula as "10" out of 10. There was no statistically significant difference between those that used a TRICARE-authorized doula and those that paid for the doula in some other way.



For the assessment of the quality of lactation services received under the demonstration, DHA can rely primarily on claims data. Breastfeeding support services are an existing benefit under the TRICARE program when delivered by existing TRICARE-authorized providers such as doctors, nurses, and midwives. Further below discusses the claims evaluation, including that there are currently no indicators that services from CBSD non-RN LCs are of lower quality than the same services received from existing TRICARE-authorized providers.

(vi) An assessment of the impact of the demonstration project on maternal and fetal outcomes.

Two of DHA's hypotheses focused on the relationship between access to the providers authorized under the CBSD and maternal and fetal/infant outcomes. Specifically, DHA hypothesized that TRICARE-authorized CLD services would be associated with improved maternal and fetal/infant outcomes, while TRICARE-authorized non-RN LC services would be associated with the same or improved maternal and infant outcomes when compared to services from providers other than non-RN LCs who provided covered lactation counseling services before the CBSD (e.g., physicians and RNs).

Data sources included quantitative and qualitative survey data from the DHA Maternity Survey, medical diagnostic codes (International Classification of Diseases or ICD-10/ICD-10 Procedure Coding System) and procedural codes (CPT codes) as captured in beneficiary health claims records and survey data. DHA directed in its FRN that the data "will be limited to de-identified evaluation of claims records and survey responses." This limitation precluded the collection of any primary data from new parents that was not already available in claims records or in the DHA Maternity Survey. Additionally, the data does not include electronic health records, MTF records, or other health insurance (OHI) claims.

The evaluation found that use of a TRICARE-authorized CLD was associated with a statistically significant decrease in the likelihood of c-sections, pre-term births, and low birthweight, as well as an increased likelihood of prolonged labor. While there was insufficient data to test maternal outcomes related to breastfeeding, the evaluation also found no significant difference in infant outcomes between beneficiaries who used a TRICARE-authorized non-RN LC and those who received lactation support services from an RN LC. Analysis of survey data generally found that beneficiaries perceived doula and LC services as beneficial and that doula and LC services were associated with a positive birth experience.

The reported data is derived from a mixed methods evaluation design, which collected both qualitative and quantitative data from survey responses and TRICARE claims data to provide a more complete understanding of the CBSD's impact and to mitigate shortcomings of outcome measure data sources. Claims data documents whether a beneficiary had a particular procedure or diagnosis documented on a claim submitted for reimbursement and has the advantages of: 1) being available for most or all eligible study participants; and 2) representing the expert judgment of the health provider (as opposed to self-reported information provided by the beneficiary about their own health). The disadvantages of claims data are that it: 1) does not capture beneficiary behavior (for example, breastfeeding); 2) lacks validity to definitively determine exposure to the treatment (for example, beneficiaries can use a doula or LC without making a claim); 3) can contain inaccuracies; and 4) as an outcome variable, has only two states (claim or no claim), which reduces variability. Survey data can potentially address some of these limitations, since it has the advantages of being able to capture behavior, attitude, and intent, and

generally having more variability, such as when respondents describe their health on a 10-point scale. Its disadvantages are that not everyone responds to surveys and low response rates can raise the likelihood of bias, and the information is self-reported and may not be entirely objective or accurate. Understanding this, there are several limitations that affected the evaluation of the effectiveness of the CBSD on maternal and infant health outcomes: 1) Due to the anonymous nature of the survey and TRICARE claims data limitations, survey data and claims data are unable to be linked, so outcome measures were assessed separately for each data source; 2) no chance of random assignment to the treatment or comparison group; 3) no ability to verify with claims that members of the comparison group did not receive the treatment; 4) no pre-test (baseline) observation to measure outcomes; and 5) missing and/or incomplete claims data. Additionally, the results provided below provide a snapshot of the first 2 years of CBSD data; future data will be necessary to fully assess DHA's hypotheses on the impact of the demonstration on maternal and infant outcomes.

Claims Data

To evaluate the impact of the demonstration on maternal and fetal/infant outcomes, claims data outcome measures were selected that were: 1) feasible to measure (e.g., certain outcome measures may not materialize during the demonstration period or may be too rare to perform statistical testing); 2) possible to collect (e.g., post-partum depression rating scale scores are not visible in claims data); and 3) are linked to the use of a doula or breastfeeding in existing literature. All private sector beneficiary claims data were extracted from the M2 databases for those that gave birth from January 1, 2022, through December 31, 2023. Childbirth support services were extracted from claims data using CPT codes 99509 and 59899 and breastfeeding support services were extracted using CPT codes 99401 to 99404, 99411, and 99412. Results were then filtered based on appropriate provider specialties. A total of 130,599 beneficiaries were identified who gave birth in the private sector through TRICARE from January 1, 2022, through December 31, 2023.

As part of the analysis for both use of CLD services and use of LC services, propensity score matching was used. Propensity score matching is a statistical technique that simulates randomization, to create two groups of matched beneficiaries that are statistically identical on certain control variables, thereby minimizing the effect of unmeasured confounding variables on the estimate of the treatment effect (for example, doula use). Propensity score matching control variables (i.e., those variables used to create matched pairs) were also selected based on published research and included demographic variables (e.g., age, marital status, location, sponsor rank) and the Maternal Comorbidity Index (a validated index that includes 21 variables which are associated with severe maternal morbidity); other covariates such as ethnicity and history of tobacco or drug use could not be included due to TRICARE claims data limitations. The team next conducted logistic regression — expressed in an adjusted odds ratio — to perform hypothesis testing and assess the treatment effect. The odds ratios associated with the treatment provide answers to the main research question of whether beneficiary participation in the CBSD significantly impacts each of the selected health outcomes, as well as a sense of the magnitude of the effect (how strong the effect is in terms of the average difference in outcomes between the treatment and comparison groups). The odds ratio should be interpreted as the likelihood that an event occurs in the treatment group compared to the control group. These statistical methods together create a quasi-experimental study design to simulate randomization, account for covariates and other potential biases, and better estimate the treatment effect of each intervention and infer causality. The propensity score matching paired beneficiaries in the non-treatment

group (i.e., those who did not use a TRICARE-authorized CLD or TRICARE-authorized non-RN LC in the prenatal, perinatal, and/or postpartum periods) with beneficiaries in the treatment group (i.e., those who did receive services from a provider newly authorized under this demonstration).

Selected outcome measures for doulas were c-sections, pre-term births, prolonged labor, low birthweight, maternal re-hospitalizations within 60 days of birth, and postpartum depression. As stated above, outcome measures were selected in part due to findings in studies that indicate a positive relationship between doula services and maternal and fetal/infant outcomes. While doulas are not medical providers, some research demonstrates that they may be able to influence patient behavior or improve the care provided in medical settings by advocating for the patient or helping the patient better advocate for herself. This may occur before, during, or after the birth. For example, before the birth, doulas may provide the patient with healthy pregnancy practices and resources, which could reduce the risk of premature birth, c-section, or low birthweight infants. During birth, doulas advocate for beneficiary wishes and provide labor support, which could reduce the risk of c-sections, subsequent maternal hospitalizations, and postpartum depression. After birth, doulas provide postpartum recovery support and newborn care support, which could reduce the risk of subsequent maternal hospitalizations and postpartum depression.

Selected outcome measures for LCs were: infant ear infections, infant respiratory issues, infant gastrointestinal issues, infant feeding difficulties, engorgement, suppressed lactation, hypogalactia (i.e., low milk supply), and mastitis. Of these measures, engorgement, suppressed lactation, hypogalactia (i.e., low milk supply), and mastitis had extremely low incidence and therefore statistical tests could not be conducted. Possible reasons for the low incidence of these diagnoses could be that health care services were obtained in the direct care system (i.e., in an MTF), were reimbursed through OHI, or these diagnoses may not be reported by all providers. Additionally, it is important to note that, while TRICARE claims data may indicate a visit with an LC, there is no way to measure breastfeeding initiation, duration, or intensity in claims data. Lastly, while it is possible that access to LC services may improve maternal short-term outcomes related to breastfeeding, it is unclear whether the incidence of such outcome measures would actually decrease, as LC services may be able to help these issues but may not prevent them from occurring outright.

For childbirth support services, there was a significant improvement in the rate of c-sections, pre-term births, and low birthweight for beneficiaries who used a TRICARE-authorized CLD. Use of a CLD was also associated with prolonged labor. This may be due to additional differences between populations not captured in this analysis such as having previous births; future evaluation work will further examine this outcome measure. Additionally, there was no significant difference between maternal rehospitalization and postpartum depression. It is likely that the low incidence of postpartum depression in the claims data impeded any meaningful analysis. Considering that the rate of postpartum depression is 10 to 15 percent in the general U.S. population, it is possible that postpartum depression is not being diagnosed by providers; that diagnosis and treatment of postpartum depression are occurring within the private care system, are paid through OHI, or self-pay; and/or that beneficiaries are not seeking medical treatment for postpartum depression. Future evaluation work will be able to include larger sample sizes and will also examine the timing of CLD services on each outcome measure. Table 6 displays the childbirth support service results.

Table 6: Childbirth Support Service Results

Outcome Measure	Proportion of Outcome Measure Occurring		Adjusted Odds Ratio (95% CI)
	CLD Group	Control Group	
C-section*	22.84%	29.06%	0.72 (0.59-0.88)
Pre-term Birth*	2.24%	4.18%	0.52 (0.31-0.87)
Prolonged Labor*	27%	21.6%	1.35 (1.10-1.65)
Infant Low Birthweight*	3.79%	5.73%	0.65 (0.42-0.97)
Maternal Rehospitalization Within 60 Days of Birth	1.17%	2.24%	0.72 (0.59-0.88)
Postpartum Depression	2.62%	1.94%	0.52 (0.31-0.87)

**Indicates statistical significance at $p < 0.05$*

Table 7 compares the differences in maternal health outcomes between the TRICARE-authorized doula group, the non-doula group, and the general U.S. population. The data shows that in some cases, the TRICARE program generally has better outcomes than the general U.S. population (such as for c-section and preterm birth), but also shows areas where additional work may be required to ensure adequate data collection (postpartum depression). It also may indicate that improvements seen in other studies on doula use (such as in the Medicaid population) may have a more muted impact on the TRICARE population for outcomes for which TRICARE beneficiaries already have better results

Table 7: Rates of Health Outcomes between TRICARE-Authorized Doulas and Non-TRICARE-Authorized Doulas in the Propensity Score Matching Logistic Regression, and as Compared to the General U.S. Population for Reference

Health Outcome	TRICARE Doula	TRICARE Non-Doula	General U.S. Population
C-section	22.84%	29.06%	32.4%[2]
Preterm Birth	2.24%	4.18%	10.41%[2]
Prolonged Labor	13.41%	11.37%	8%[3]
Infant Low Birthweight	3.79%	5.73%	8.3%[4]
Maternal Rehospitalization Within 60 Days of Birth	1.17%	2.24%	-

[2] Hamilton, B.E., Martin, J.A., & Osterman, M.J.K. (2024). Births: Provisional data for 2023. Centers for Disease Control and Prevention (CDC). https://www.cdc.gov/nchs/data/vsrr/vsrr035.pdf

[3] Cleveland Clinic. (2023). Prolonged labor (failure to progress). Cleveland Clinic. https://my.clevelandclinic.org/health/diseases/24752-prolonged-labor.

[4] World Health Organization (WHO). (2020). Low birthweight prevalence. https://www.who.int/data/gho/data/indicators/indicator-details/GHO/low-birth-weight-prevalence-(-).

Postpartum Depression	2.62%	1.94%	10-15%[5]

For lactation support, the "control group" consisted of beneficiaries who received lactation support services from RN LCs. The "treatment group" consisted of beneficiaries who received lactation support services from CBSD non-RN LCs. This design allowed a direct comparison to existing TRICARE lactation support services, as this demonstration is not designed to determine the benefits of lactation support or breastfeeding, but rather assess the impact of authorizing new provider categories. The analysis detected no statistically significant difference in infant outcomes between each group (see Table 8). As discussed above, there was insufficient data to assess maternal outcomes related to breastfeeding.

Table 8: Lactation Support Service Results

Outcome Measure	Proportion of Outcome Measure Occurring		Adjusted Odds Ratio (95% CI)
	Non-RN LC Group	RN LC Control Group	
Infant Ear Infections	7.14%	5.21%	0.71 (0.42-1.19)
Infant Respiratory Issues	8.30%	6.76%	0.80 (0.50-1.27)
Infant GI Issues	15.44%	14.29%	0.91 (0.65-1.29)
Infant Feeding Difficulties	25.10%	25.10%	1.00 (0.75-1.33)
Engorgement	0.00%	0.00%	-
Suppressed Lactation	0.58%	0.77%	-
Hypogalactia	0.58%	0.00%	-
Mastitis	2.12%	2.12%	-

The prevalence of rates of the maternal and infant health outcomes in this study as compared to the U.S. general population was considered. Due to the data quality and accuracy concerns, comparing rates to the study population and general population is a challenge. Most of the lactation-related measures are taken from self-reported data and not claims data (as this study uses as its data source). Where possible, the closest related measure for the general U.S. population is shown below in Table 9.

[5] Guintivano, J., Manuck, T., & Meltzer-Brody, S. (2018). Predictors of postpartum depression: A comprehensive review of the last decade of evidence. *Clinical Obstetrics & Gynecology*, *61*(3), 591-603. https://doi.org/10.1097%2FGRF.0000000000000368.

Table 9: Rates of Infant Health Outcomes between CBSD Non-RN Lactation Consultant and RN Lactation Consultant in the Propensity Score Matching Logistic Regression, and as Compared to the General U.S. Population

Health Outcome	CBSD non-RN LC	TRICARE RN LC	General U.S. Population
Infant Ear Infections	5.21%	7.14%	17-20%[6]*
Infant Respiratory Issues	6.76%	8.30%	7.0%[7]**
Infant GI Issues	14.29%	15.44%	27%[8]***
Infant Feeding Difficulties	25.10%	25.10%	-
Engorgement	-	-	-
Suppressed Lactation	-	-	10-15%[9]
Hypogalactia	-	-	5-15%[10]
Mastitis	-	-	10%[11]

No outcomes were statistically significant at the $p<0.05$ between the treatment and comparison group.
Maternal health-related lactation outcomes (Engorgement, Suppressed Lactation, Hypogalactia, and Mastitis) could not be analyzed due to poor data quality and low sample sizes, as discussed above.

Survey Data

To analyze and evaluate survey data, responses were converted to quantitative data, then used R statistical package to conduct descriptive statistics and perform chi-squared testing of responses to assess differences in responses between groups. Data analysis tools including Python, R, and Microsoft Power BI were used to clean, visualize, and analyze the distribution of various survey responses, providing an understanding of the overarching trends and patterns regarding beneficiaries' experience with their maternity care. R statistical package was used to conduct descriptive statistics, such as the mean, median, range, and frequency distribution of the survey data. Cross-tabulations allowed for a better assessment of how the different groups compared to one another. Survey responses indicate beneficiary perception of the impact that doula and LC services have on their mental and physical health and well-being. The survey data

[6] Jella, T.K., Cwalina, T.B., Sachdev, R.R., Schmidt, J.E., Shah, J.R., & Otteson, T. (2022). Nationwide disparities in transportation related delays to care experienced by children with frequent ear infections. *International Journal of Pediatric Otorhinolaryngology*, *157*. https://doi.org/10.1016/j.ijporl.2022.111115.

[7] Hermansen, C.L. (2015). Newborn respiratory distress. *American Family Physician*, *92*(11), 994-1002. https://www.aafp.org/pubs/afp/issues/2015/1201/p994.html.

[8] van Tilburg, M.A.L., Hyman, P.E., Walker, L., Rouster, A., Palsson, O.S., Kim, S.M., & Whitehead, W.E. (2015). Prevalence of functional gastrointestinal disorders in infants and toddlers. *The Journal of Pediatrics*, *166*(3), 684-689. https://doi.org/10.1016/j.jpeds.2014.11.039.

[9] Jin, X., Perrella, S.L., Lai, C.T., Taylor, N.L., & Geddes, D.T. (2024). Causes of low milk supply: The roles of estrogens, progesterone, and related external factors. *Advances in Nutrition*, *15*(1). https://doi.org/10.1016/j.advnut.2023.10.002.

[10] Lee, S. & Kelleher, S.L. (2016). Biological underpinnings of breastfeeding challenges: the role of genetics, diet, and environment on lactation physiology. *American Journal of Physiology: Endocrinology and Metabolism*, *311*, E405-E422. https://doi.org/10.1152/ajpendo.00495.2015.

[11] Cleveland Clinic. (2023). Mastitis. Cleveland Clinic. https://my.clevelandclinic.org/health/diseases/15613-mastitis.

limitations center around the precision of the DHA Maternity Survey estimates (margin of error) and the potential for bias in estimates due to non-response (non-response bias). The potential impact of these limitations is that the resulting survey estimates may not accurately reflect the true values within the beneficiary population; these limitations are present in any survey and the evaluation team used a variety of best practices to mitigate these limitations such as clear wording of questions, an introduction screen on the purpose of the survey, and survey reminders.

The independent evaluation's analysis of survey data found that respondents who reported using a doula were significantly more likely to be exclusively breastfeeding (including feeding expressed breast milk) (Table 10). While breastfeeding is a highly personal individual choice and individuals who choose to use a doula likely differ in certain characteristics compared to individuals who do not use a doula, it is possible that doulas may provide beneficial support to individuals who wish to breastfeed. Respondents who used an LC reported similar proportions of exclusive breastfeeding, combination of breastfeeding and formula feeding, and formula feeding as the overall population.

Table 10: Doula and Lactation Counselor and/or Lactation Consultant Breakdown by Respondent Breastfeeding Status

	Overall (n = 7,324)	**Used a doula** (n = 944)	**Used a lactation counselor and/or consultant** (n = 3,925)
Exclusively Breastfeeding	59.9%	72.6%	59.1%
Combination of Breastfeeding & Formula	21.2%	16.8%	22.2%
Exclusively Using Formula	18.9%	9.2%	15.4%

Respondents who used a doula were also more likely to rate their birth experience, physical health postpartum, and mental health postpartum as "very good" or "excellent" compared to the overall population of respondents (Tables 11, 12, and 13); however, this was only statistically significant for birth experience. Respondents who used an LC reported similar ratings as the overall population, although a statistically significant lower proportion of these beneficiaries rated their mental health as "very good" or "excellent". This is likely because many individuals only seek LC care while dealing with breastfeeding problems, which may be associated with increased stress, anxiety, and depression. Lastly, both respondents who used a doula and respondents who used an LC rated their confidence in caring for their infant highly, with 91.9 percent and 92.1 percent of respondents respectively selecting "confident" or "very confident"; there was no difference compared to the overall population (Table 14).

Table 11: Respondent Rating of Their Birth Experience

	Overall (n = 7,324)	Used a doula (n = 944)	Used a lactation counselor and/or consultant (n = 3,925)
Percentage Rating Birth Experience as "Very Good" or "Excellent"	64.1%	68.7%	65.0%

Chi-squared test was significant at the p<0.05 level for used a doula.

Table 12: Respondent Rating of Their Physical Health in the Post-Delivery Period

	Overall (n =7,324)	Used a doula (n = 944)	Used a lactation counselor and/or consultant (n = 3,925)
Percentage Rating Physical Health as "Very Good" or "Excellent" in the Post-Delivery Period	41.0%	44.6%	40.9%

Table 13: Respondent Rating of Their Mental Health in the Post-Delivery Period

	Overall (n = 7,324)	Used a doula (n = 944)	Used a lactation counselor and/or consultant (n = 3,925)
Percentage Rating Mental Health as "Very Good" or "Excellent" in the Post-Delivery Period	30.6%	33.4%	28.9%

Chi-squared test was significant at the p<0.05 level for used a lactation counselor and/or lactation consultant.

Table 14: Respondent Rating of Their Confidence in Caring for their Infant

	Overall (n = 7,324)	Used a doula (n = 944)	Used a lactation counselor and/or consultant (n = 3,925)
Percentage Rating Confidence in Caring for Infant as "Confident" or "Very Confident"	92.6%	91.9%	92.1%

In total, 944 respondents indicated that they had used a doula; however, only 165 respondents reported that TRICARE had paid for all or a part of their doula's services. Because the subgroup of beneficiaries who reported TRICARE paid for their doula is small, the survey results for this group have a large margin of error (plus or minus 7 percent). This should be kept in mind when reviewing and interpreting the survey results that include doula funding source. Of respondents who used a doula and indicated that TRICARE paid for the doula services, 83.3 percent rated the usefulness of the doula's birth support as "very useful" or "extremely useful," 64.3 percent rated the usefulness of the doula's postpartum support as "very useful" or "extremely useful," and 67.5 percent rated the quality of the childbirth support they received as a

9 or 10 on a scale of 1 to 10. There was no difference when comparing these percentages to respondents whose doula was not paid by TRICARE (Tables 15, 16, and 17).

Table 15: Respondent's Rating of the Usefulness of Their Doula's Birthing Support

	Overall (n = 780)	Doula paid for by TRICARE (n = 134)
Percentage rating their doula's birthing support as "Very Useful" or "Extremely Useful"	85.4%	83.3%

Table 16: Respondent's Rating of the Usefulness of Their Doula During the Postpartum Period

	Overall (n = 611)	Doula paid for by TRICARE (n = 101)
Percentage rating their doula during the postpartum period as "Very Useful" or "Extremely Useful"	67.8%	64.3%

Table 17: Respondent Rating of the Quality of Their Doula

	Overall (n = 635)	Doula paid for by TRICARE (n = 110)
Percentage rating quality of childbirth support received from their doula as a "9" or "10"	68.1%	67.5%

For respondents who used an LC, 82.2 percent selected that they "agreed" or "strongly agreed" that the LC provided useful breastfeeding support, 65.5 percent selected that the LC "frequently" or "very frequently" resolved breastfeeding issues, and 43.8 percent rated the quality of the lactation support they received as a 9 or 10. For births that occurred in 2022 and 2023, the CBSD survey does not differentiate between LCs paid by TRICARE or by other sources; future analyses will incorporate this question.

(vii) An assessment of the effectiveness of the demonstration project.

The CBSD is largely effective for the purposes of assessing the hypotheses under study. There are sufficient claims data and survey responses for the evaluation contractor to assess maternal and fetal outcomes and cost, though that analysis is ongoing. Modifications to the CBSD discussed earlier in this report will allow DHA to better understand the administrative feasibility of a permanent benefit.

(viii) Recommendations for adjustments to the demonstration project.

DHA has recently made several adjustments to the CBSD, discussed earlier in this report. Many of the changes to childbirth support services and the expansion of the CBSD overseas will not be fully in place until around January 2025. Additionally, DHA's new reimbursement

methodology for childbirth support services will see its first annual rate change occur on March 1, 2025; this may result in rates higher or lower than the new rates that became available in June 2024, depending on the state Medicaid doula programs available, their associated rates, and the number of TRICARE deliveries in those states (DHA uses a weighted average in calculating its rates). It will take time for DHA to assess the impact of these changes on access to services, quality of care, and cost. DHA is unlikely to make changes in the next year to these services, as frequent changes will impact DHA's ability to fairly assess the impact of these modifications.

(ix) The estimated costs avoided as a result of improved maternal and fetal outcomes due to the demonstration project.

As stated above, a cost-benefit analysis was not included in the independent evaluation for this reporting year as the evaluation focused primarily on building out the methodology for maternal and fetal outcomes. Next year's report will include a preliminary cost-benefit analysis, which will discuss estimated cost savings from avoided health care utilization (e.g., urgent care visits, inpatient hospital stays, c-sections).

(x) Recommendations for extending the demonstration project or implementing permanent coverage under the TRICARE program of extramedical maternal health providers.

During the upcoming year, DHA anticipates making a decision surrounding extension of the CBSD and may make different decisions for the childbirth support services portion and the breastfeeding support services portion. With only 2 years remaining on the CBSD, it is unlikely DHA could implement a permanent benefit modification before the CBSD ends. If DHA determines it is appropriate to permanently implement all or part of the CBSD, or that additional information would be required to make a decision on permanent implementation, DHA would likely extend the CBSD under the authority provided by 10 U.S.C. § 1092. If DHA were to find that the benefit was not appropriate for permanent implementation and that no further study was required, then such an extension may not be necessary; in that case, DHA would allow all or part of the CBSD to terminate on its current planned end date of December 31, 2026.

(xi) An identification of legislative or administrative action necessary to make the demonstration project permanent.

DHA has no recommendations regarding legislative or administrative action needed to make the CBSD permanent under the Basic (i.e. medical) benefit at this time.

CONCLUSION

Since the previous report, the CBSD has seen meaningful progress. More beneficiaries have been able to access services, provider networks continued to grow, and beneficiaries overseas gained access to the CBSD. The preliminary analysis provides promising indications of the impact of CBSD services on health outcomes for pregnant beneficiaries and their infants; however, significant additional analysis needs to occur before DHA will be able to make recommendations regarding permanent implementation.

Based on claims data, only 0.8 percent of TRICARE beneficiaries who gave birth in the private sector care system used a TRICARE-authorized CLD and only 3.3 percent used a TRICARE-authorized non-RN LC. The Maternity Survey conducted as part of the CBSD found that while 14.8 percent of respondents reported using a doula, TRICARE only paid for about 17.5 percent of these. Based on these numbers, it is likely that some beneficiaries who want to access these services are unable to do so. This is confirmed by comments and responses in the Maternity Survey, which capture beneficiary frustration over lack of access to wanted services. In response to a question asking which part of the demonstration the survey respondent was least satisfied with, about 14 percent selected the option "provider availability." For individuals who reported using a doula, about 30 percent of 687 respondents indicated they were not able to use a CLD under the CBSD because there were no TRICARE-authorized CLDs in their area, their preferred doula did not accept TRICARE, or because their preferred doula did not meet TRICARE's requirements. For individuals who reported using a lactation consultant or counselor (4,173 respondents), the same access issues were reported by only 9.5 percent of respondents. While there are no established metrics for what full access to CLDs would look like, DHA assumes this amount would be closer to 10 to 15 percent of pregnant beneficiaries (or about 6,500 to 9,750 users per year). As discussed throughout this report, these data represent a snapshot of results from births occurring in the first 2 years of the CBSD, but analysis of outcome measures will continue through the duration of the demonstration to provide a more complete understanding of the effectiveness of the demonstration in improving maternal and infant outcomes.

Understanding that access to services remains an issue, the DHA modified the CBSD to increase reimbursement rates for CLDs, added options for CLDs to become TRICARE-authorized providers, and created a participation requirement for CLDs that will protect beneficiaries from unexpected out-of-pocket costs. The next report will have the first indications of the impact of these changes on the number of services used and the costs associated with the higher reimbursement rate.

The fourth year of the CBSD will be an important one. DHA may be able to draw some conclusions regarding whether some services should be made permanent or allowed to lapse. While this initial analysis includes some promising preliminary findings, such as lower c-section rates, additional evaluation is required to fully test these results. For example, next year the evaluation will examine whether these results remain consistent if controlling for use of a certified nurse midwife (CNM) versus a physician (individuals who use a CNM may be more predisposed to lower intervention deliveries compared to individuals who use a physician). Additionally, as the study population grows due to greater participation over time, DHA will have more confidence in the results and will have a better understanding of how a full benefit implementation, if achieved, would impact the entire TRICARE birthing population. Next year, DHA will also have its first opportunity to understand whether the CBSD services can be implemented overseas and will get its first indications on whether the modifications to childbirth support services have had an impact on quality of care and beneficiary access to services. DHA will also likely have to decide on whether to continue the CBSD beyond its initial 5-year period.

While all of this is occurring, the entire TRICARE program started implementing its next iteration of health care contracts, called T5, on January 1, 2025. This new contract makes

improvements to how TRICARE is delivered to beneficiaries and includes changing the health care contractor for the West Region. The move to the new contracts may impact the CBSD, making it more difficult to understand the impact of the changes to the CBSD described above. Next year's report will include an assessment of any changes that have occurred to service use under the CBSD and whether DHA can attribute the changes to the CBSD modifications or the contract change.