MAPOC Meeting

September 9th, 2022

Agenda

- Covered CT
- Public Health Emergency (PHE) / Unwinding
- Maternity Bundled Payment

Covered CT

[Reminder]: Two slide primer on Covered CT (I / II)

Policy context

Goals:

1. Help close the health insurance affordability gap for low-income individuals

2. Assist with the public health emergency / unwinding

Legislative Context

- June 2021 special session: Public Act 21-2, §15 – 19
- Statute directed Department of Social Services (DSS) to submit an 1115 demonstration waiver to provide federal matching funding for the program
- DSS working with state partners to design and implement the program: Office of Health Strategy (OHS), Access Health CT, and the Insurance Department (CID)
- Federal ARPA enhanced subsidies provide $178M annually in additional premium subsidies for eligible members. These will now be continued for 3 additional years under the recently passed federal Inflation Reduction Act

[Reminder]: Two slide primer on Covered CT (II / II)

Who is eligible?

Populations: (i) parents and caretaker relatives and their tax dependents under age 26; (ii) adults ages 19 to 64 without dependents

Income: Income must be above the Medicaid limit…but not exceeding 175% of the federal poverty level (FPL) ($48,563 for a family of four)

Structure and benefits

- Beneficiaries must enroll in a silver-level Qualified Health Plan (QHP) available through Access Health CT using federal premium subsidies and cost-sharing reductions
- Members access health benefits without paying any out of pocket costs: State will directly reimburse the plans for the monthly premiums + cost-sharing
- Medicaid-like benefits: no cost dental care and non-emergency medical transportation (NEMT) services

Status of 1115 Waiver

Reminder: why we want an 1115 waiver

Medicaid waiver authority would allow the state to receive federal match on the expenditures incurred to cover the out-of-pocket expenses, premiums, cost-sharing, dental, and non-emergency medical transportation services.

What is an 1115 Waiver?

"Section 1115 of the Social Security Act…gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program.

The purpose of these demonstrations…is to demonstrate and evaluate state-specific policy approaches…."

From Medicaid.gov

Update

Submitted to CMS: April 1, 2022

DSS in frequent contact with CMS on the approval process

Received encouraging verbal news from CMS but not formal approval

We are expecting Special Terms and Conditions (STCs). CMS guidance: STCs would be issued early / mid September at the earliest

Summary of outreach efforts to date

Utilization

- Sent out 11,558 Welcome Packets (through 8/8/22)
- Received 452 inbound calls specific to Covered CT (through 8/8/22)
- Dental: 98 Members received dental services at over 70 different dental providers
- Non-Emergency Medical Transportation: 36 trips (through 8/21/22)

Outreach

Details next slide

Access Health CT: Continues to perform enrollment fairs and communication campaigns

OHS:

- RFP for Covered CT Community Outreach posted in July. Closed end of August

Outreach efforts: Access Health CT

Five regional meetings were held in June 2022

Outreach events in August:

a. 8/24/22 South Marshall St Block Party
   Hartford 4-7pm
b. 8/26/22 Evergreen Family Oriented Tree Inc. New Haven 1pm-5pm
c. 8/26/22 Skate Your Way to Health
   Hartford 3-7pm
d. 8/27/22 Resource & Recruitment Fair for all Youth Service Providers
   Bridgeport 9am - 2pm
e. 8/27/22 St. Augustine Church Picnic
   Hartford 10 am - 2 pm

Covered CT Enrollment Fairs:

a. 7/30/22 Otis Library
   Norwich 10am - 1pm
b. 8/3/22 ACT
   Hartford 4-7pm
c. 8/10/22 Bridgeport 4-7pm
d. 8/17/22 Evergreen
   New Haven 4-7pm
e. 9/7/22 New Opportunities
   Waterbury 4-7pm
f. 9/14/22 New Opportunities
   Torrington 4-7pm

Outreach efforts: Office of Health Strategy

Context

Mid-July 2022: OHS released RFP for community focused organizations to assist in outreach, education and enrollment in Covered CT.

$950k budget

Proposers were asked to provide:

- target populations
- outreach and marketing plans
- stakeholder engagement
- prior experience with Access Health CT enrollment processes
- cultural competence approach and budgets
- + optionally…enrollment staff to Access Health CT Certified Application Counselor (CAC) training

Results & next steps

August 22nd: RFP closed. OHS received 12 applications

Awards planned to be made this month

Once awardees have executed contracts with OHS, a formal announcement will be made

Enrollment to date as of August 22nd, 2023

Population	2022	2023	2024	2025	2026
Projected	18,731	33,293	38,725	38,919	39,113
Current	11,556 (10,745 since July 1, 2022)				

Note: enrollment lower than expected because of the extension of the public health emergency

Public Health Emergency Unwinding

Summary of Unwinding Slides

- Recap of general public health emergency (PHE) unwinding rules
- Updates to projected end date of the PHE declaration
- Additional details around unwinding renewal volumes and enrollment
- Recap of operational approach and outreach strategies

What Does "Unwinding" Mean?

Each temporary authority or flexibility adopted by states to respond to the COVID-19 public health emergency (PHE) is scheduled to automatically sunset upon termination of the federal PHE declaration or on another specified date.

"Unwinding" is the term being used by states and their federal partners to refer to the plans and steps being taken to support states in planning for the end of the PHE.

Unwinding planning seeks to ensure that states can transition back to normal operations efficiently while limiting coverage disruptions in a manner that minimizes the burden for both states and individual enrollees.

Status of Public Health Emergency Declaration

MOST RECENT RENEWAL OF DETERMINATION THAT A PUBLIC HEALTH EMERGENCY EXISTS

"As a result of the continued consequences of the Coronavirus Disease 2019 (COVID-19) pandemic, on this date and after consultation with public health officials as necessary, I, Xavier Becerra, Secretary of Health and Human Services, pursuant to the authority vested in me under section 319 of the Public Health Service Act, do hereby renew, effective July 15, 2022, the January 31, 2020, determination by former Secretary Alex M. Azar II, that he previously renewed on April 21, 2020, July 23, 2020, October 2, 2020, and January 7, 2021, and that I renewed on April 15, 2021, July 19, 2021, October 15, 2021, January 14, 2022, and April 12, 2022, that a public health emergency exists and has existed since January 27, 2020, nationwide."

- HHS can renew PHE determinations in increments of up to 90 days.
- 90 days from July 15, 2022, is October 13, 2022.
- HHS has assured states that it will provide at least 60 days advance notice before the end of the COVID-19 PHE determination.
- Because October 13th is less than 60 days from today, there will be at least one more renewal of the COVID-19 PHE determination.
- 90 days from October 13, 2022, is January 11, 2023.

CMS Unwinding Guidance

CMS provided planning guidance in December 2020 with additional clarifications in August 2021 and March 2022 to support states in planning for the end of the PHE.

- Intended to help states transition back to normal operations efficiently and limit coverage disruptions in a manner that minimizes the burden for both states and individual enrollees.

- The guidance addresses the timeframes and methods states may use to sunset the various flexibilities that were adopted to respond to the COVID-19 pandemic, notably those supporting beneficiaries' access to coverage and services. It includes compliance with the requirements of section 6008 of the Families First Coronavirus Response Act (FFCRA) as amended by the CARES Act which requires states to provide continuous enrollment for the duration of the PHE.

Timeframes to Sunset Flexibilities

- Eligibility and enrollment flexibilities that end the first of the month following the end of the PHE:
  - FFCRA continuous eligibility provision
  - Medicaid/CHIP Disaster Relief SPA authorities
  - Modified Adjusted Gross Income (MAGI) verification plan
  - MOE enhanced FMAP (ends the first day of the month following the calendar quarter in which the PHE ends)

- Eligibility that ends immediately the day the PHE ends:
  - Medicaid COVID-19 Testing Coverage for the Uninsured
  - Emergency Medicaid COVID-19 Testing Coverage for the Uninsured

Methods to Approach Unwinding

- Population-based – prioritizes completing outstanding eligibility and enrollment actions for individuals in groups who are most likely to be no longer eligible (e.g., no longer categorically eligible by age, individuals who gained eligibility only by state's use of a temporary authority, e.g., 20% income threshold)
- Time-based – prioritizes based on length of time an action has been pending, working oldest actions first
- Hybrid – includes combination of population and time-based approaches
- State-developed – states may develop their own approach focusing on those who are most likely to be ineligible or for which there is greater risk that ineligible individuals may remain enrolled longer

Redistribution Plan

There will be a significant volume of eligibility actions to complete following the PHE once the unwinding period begins, particularly renewals and redeterminations based on changes in circumstances.

States are required to develop a comprehensive plan to restore routine operations in their Medicaid and CHIP programs. The plan is intended to help states develop an operational approach for completing outstanding eligibility and enrollment work.

The "unwinding operational plan" should include a description of how the state intends to:

- Address outstanding eligibility and enrollment actions in an efficient manner that minimizes erroneous loss of coverage for enrollees;
- Enable a sustainable distribution of renewals in future years; and
- Ensure timely processing of new applications and eligibility actions within specified timelines.

12-month Timeline to Process Renewals

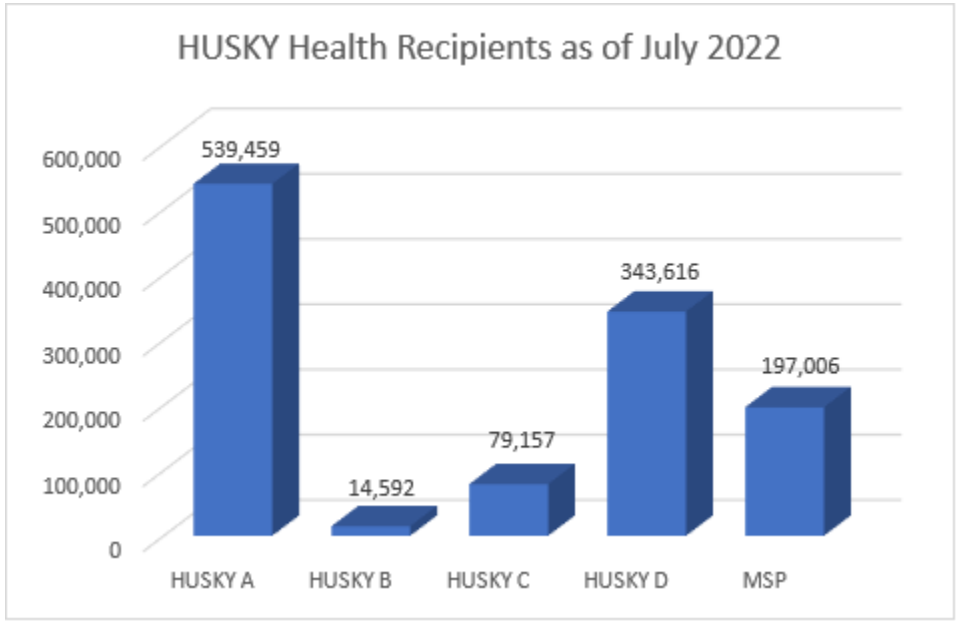
To account for the time needed to initiate and complete renewals, CMS will consider states to be in compliance with the 12-month unwinding period provided the state has:

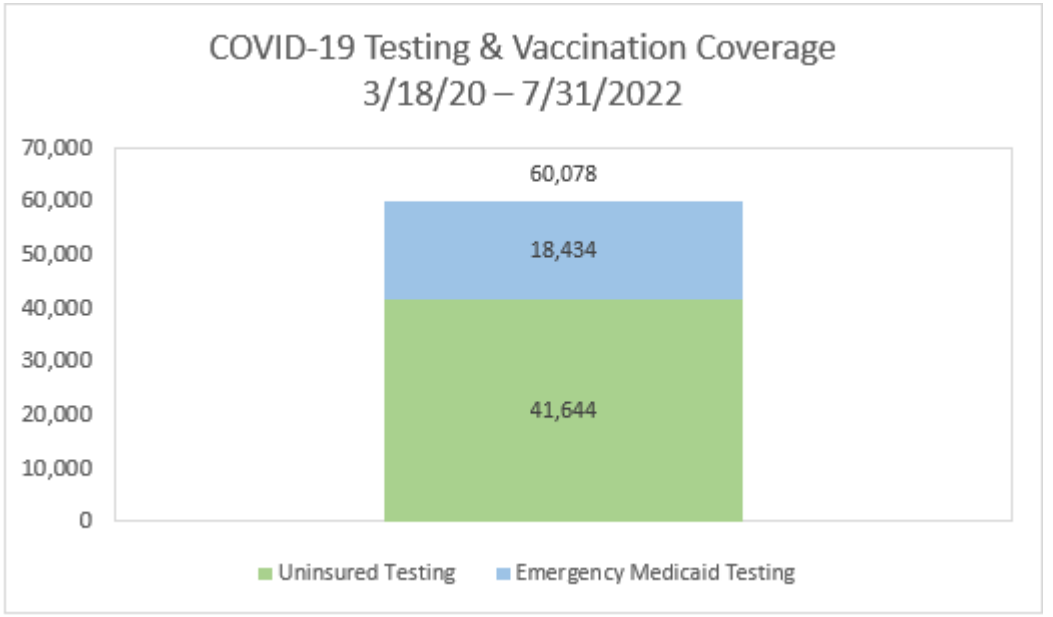
- Initiated all renewals (as well as post-enrollment verifications and redeterminations based on changes in circumstances) for the state's entire Medicaid and CHIP population ("total caseload") by the last month of the 12-month unwinding period.
- Completed such actions by the end of the 14th month from the start of the state's unwinding period.
- Initiated a renewal process that may result in termination of coverage when the continuous enrollment condition ends two months prior to the end of the month in which the PHE ends. States may begin the 12-month unwinding period up to two months prior to the end of the month in which the PHE ends.
- Initiated the 12-month unwinding period no later than the first day of the month following the month in which the PHE ends.

Example of Unwinding Timeline

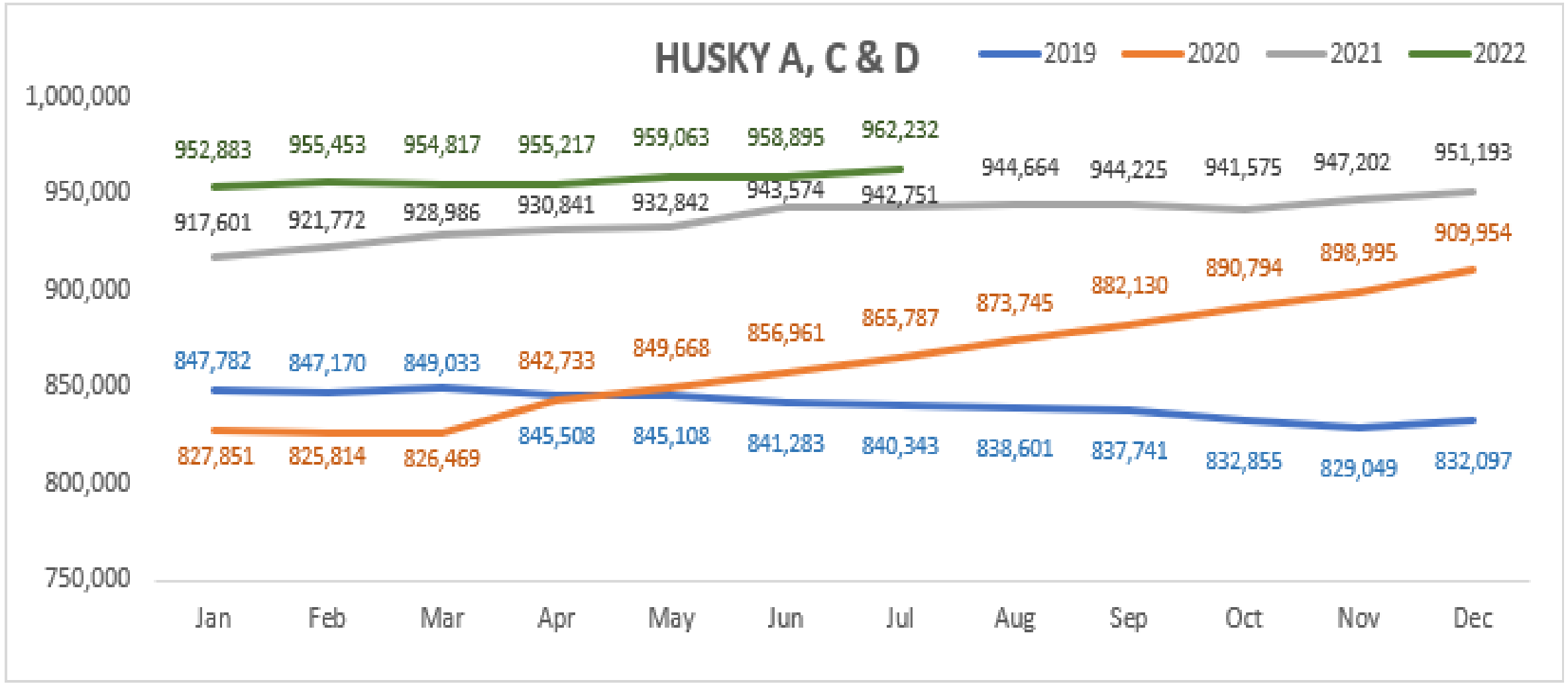
HUSKY Health Enrollment

- As of July 31, 2022, total HUSKY enrollment in full benefit coverage (HUSKY A/B/C/D) is 976,824.
- A large majority of HUSKY enrollees are in MAGI coverage groups (HUSKY A/B/D).

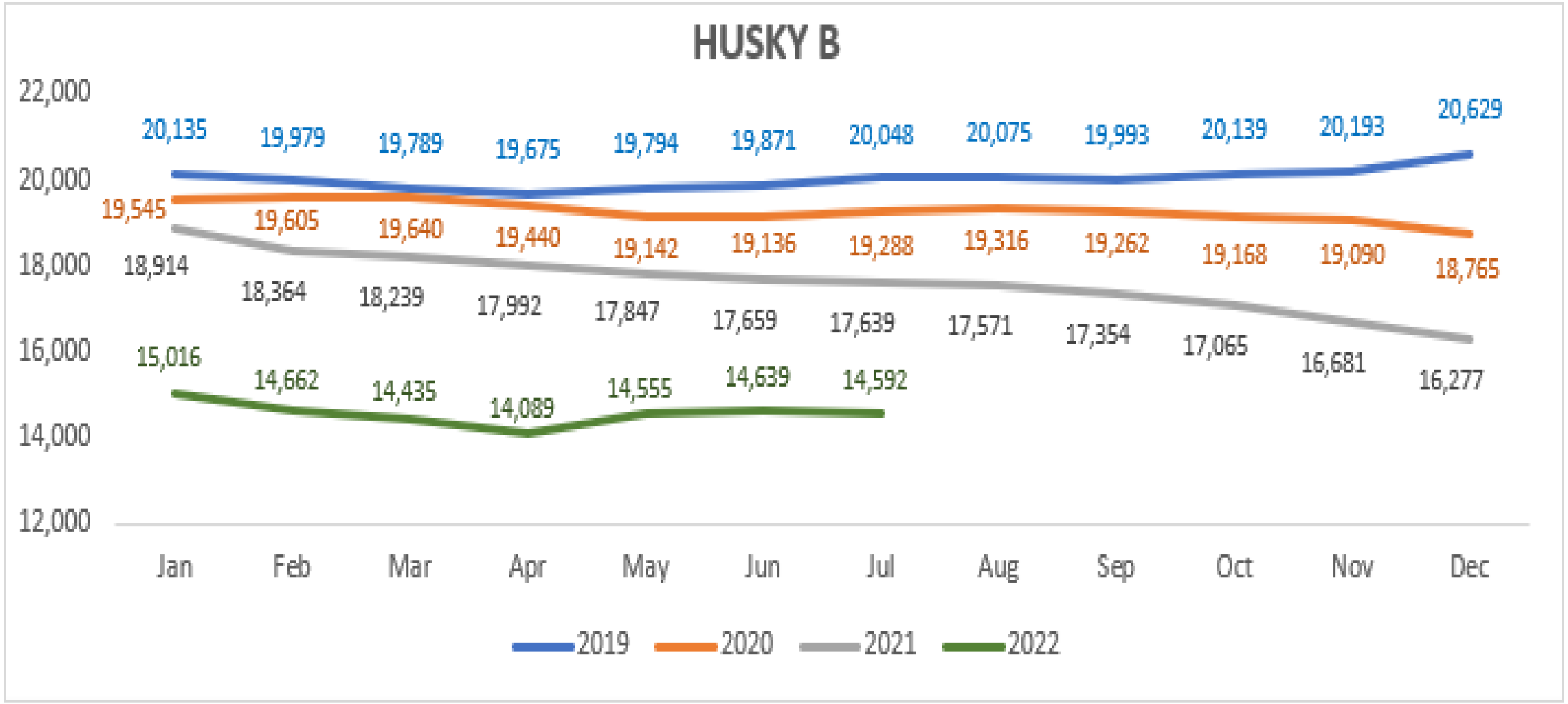




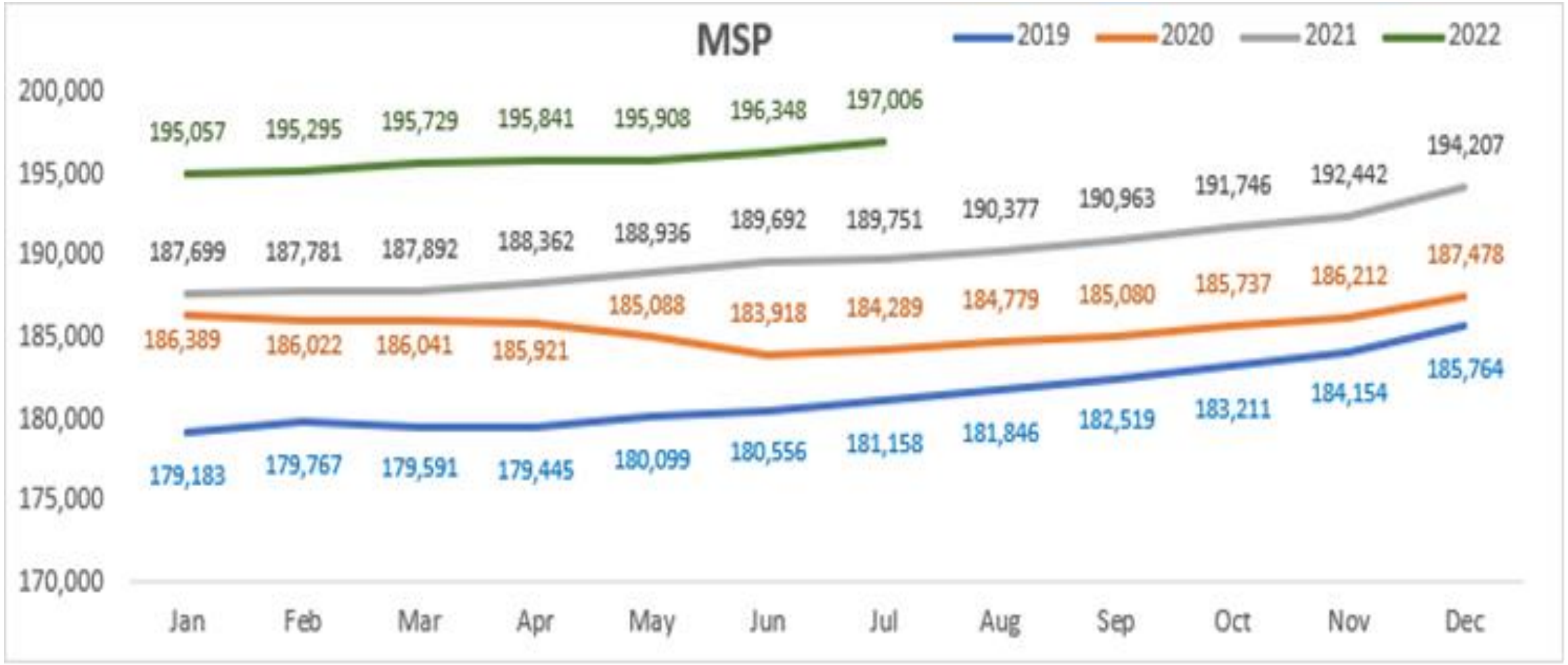
HUSKY Health (Medicaid) Year-Over-Year Enrollment



HUSKY B (CHIP) Year-Over-Year Enrollment



Medicare Savings Plan Year-Over-Year Enrollment



Impact and Planned Approach

- Approximately 42% of all current MAGI (HUSKY A/B/D) enrollees are on a PHE-related extension.
- Approximately 5% of all current non-MAGI (HUSKY C/MSP) enrollees are on a PHE-related extension.

- Total one-year MAGI renewal volume – approximately 540,000 households
  - 235,000 in PHE-related extension
  - 305,000 in regular eligibility period
- Average monthly MAGI renewal volume – approximately 45,000 households
  - 19,000/month of the "unwinding" population
  - 26,000/month of the "regular" population

- Note: The large majority of the PHE-related extension population is in a MAGI coverage group, which has a lower PMPM cost than the non-MAGI HUSKY C population. Therefore, we anticipate, as the PHE unwinds and the percent of our members in non-MAGI HUSKY C increases, the overall average PMPM costs will rise.

Impact and Planned Approach (continued)

- Will employ a 12-month staggered renewal schedule using primarily a time-based approach (e.g., those individuals with the earliest date of extension will be acted upon first).
- Staggered approach and volumes will be finalized once the end of the PHE has been signaled.
- Monthly renewal volumes will include PHE extensions in addition to usual renewal volumes.
- Will evenly distribute renewals over the course of the 12-month period to account for some months where renewal activity is higher or lower, ensuring a sustainable and balanced future workload while avoiding renewal backlogs and reducing risk of inaccurate redeterminations or inappropriate terminations.
    - Example – if in March 2023 there are 28,000 "regular" renewals due, then 17,000 "unwinding" renewals will be included to reach the optimal volume of 45,000 renewals each month
- Will highlight availability of Covered CT as another potential option for no-cost coverage for those going through the renewal process.

Outreach Strategies

The following communication strategies are underway or planned:

- Website and Social Media – messages related to the importance of updating contact information have been issued via Twitter, Facebook and placed on DSS website pages.
- Posters – related to the importance of updating contact information have been developed and placed in DSS service centers.
- Vizio screens – in DSS service centers have been updated with a message about updating contact information.
- Other messages that will focus on attention to renewal packages are being developed and will be timed according to the final renewal distribution schedule.
- Benefit Center interactive voice response (IVR) – messaging regarding the importance of completing renewals will be added prior to the implementation of the renewal distribution schedule.
- Special Mailings – special notices to those enrollees who have remained enrolled due to continuous enrollment requirements are under development and review. These notices will be inserted in renewal application mailings, expected to be distributed monthly according to planned distribution schedule. There will also be a direct mailing to those who are enrolled in the expiring Medicaid COVID-19 Coverage for the Uninsured program.
- Email notices will be provided to those who have opted to receive electronic mailings.

Outreach Strategies (continued)

- Provider Bulletin – A special provider bulletin will be developed and issued via the Gainwell Provider Bulletin distribution list to alert providers of the agency's actions and potential impact to HUSKY Health members. Messaging in provider bulletin will encourage providers to remind beneficiaries of the need for timely responses to renewal notices.
- Leveraging Community Partners – Information on unwinding plans will be shared with partners to facilitate their messaging to shared consumers. Partners include, but are not limited to, provider groups, 2-1-1 Infoline, community action agencies, and federally qualified health centers. Many community partners have shared our initial social media messages with their followers. They have received DSS posters and have hung them up in consumer-facing areas of their organizations.

Strategies under exploration/development:

- Text messaging – pending result of FCC determination of permissibility. DSS submitted public comment in support of this policy.
- Informational tool kits with standardized messaging for partners
- Coordinated communications with Covered CT outreach

We welcome the communication support and ideas of our MAPOC colleagues!

Questions?

Updated CMS unwinding guidance and tools can be found at
www.Medicaid.gov/unwinding

Maternity Bundle

CT Maternity Bundled Payment Program

Medical Assistance Program Oversight Council Meeting

September 9th, 2022

Faulkner CONSULTING GROUP

Project Objectives: DSS Goals & Principles for Design

Goals: Develop an innovative and nation-leading value-based payment for maternity services that:

1. Addresses **racial disparities** in maternal health (including SUD) and birth outcomes
2. Reduces incidence of **unnecessary Cesarean procedures & early elective births**
3. Supports parity between OBs & midwives, and includes **access to doula services, CHWs and breastfeeding support**
4. Creates opportunities to **align payment models** across Medicaid and State Employee Health Plan (particularly quality measures)
5. Ensures implementation remains **cost neutral** for DSS budget, and ultimately program should **save money** attributable to improved maternal & newborn outcomes
6. Considers impact of **timing of enrollment** in limited benefits on maternal health and birth outcome

Principles: Use the following principles when making policy recommendations:

1. Align with DSS Goals
2. Use evidence-based practices and model after best practices, including aligning financial incentives across public payer & providers
3. Health Equity Plan
4. Consider stakeholder input and priorities in bundle design
5. Keep bundle methodology simple wherever possible

Reflected in work completed to date

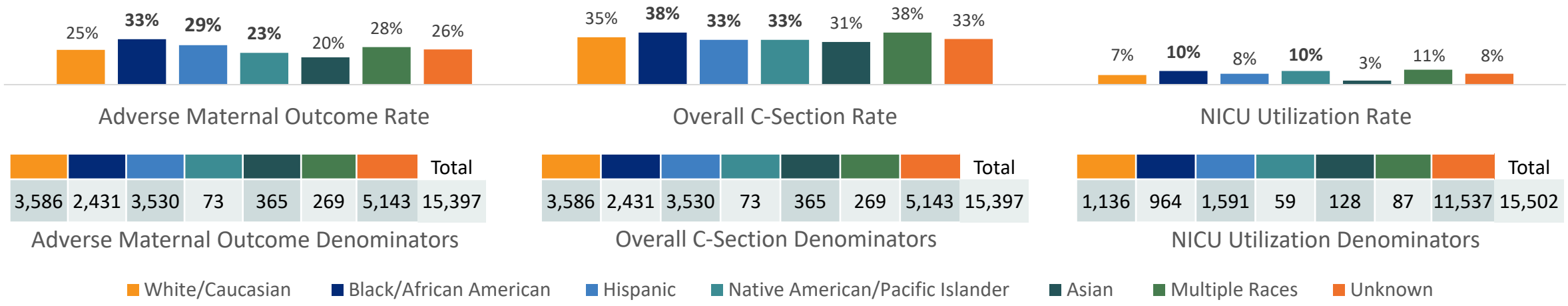
Connecticut's Starting Point in Maternal Health

DSS is working with diverse partner stakeholders to address and remedy **disparities of access, utilization and outcomes for pregnant women**, with an **emphasis on birthing people of color**, through development and implementation of a **Medicaid maternity bundle**.

- Rates for Adverse Maternal Outcomes, Overall C-section, and NICU utilization among HUSKY Health members have increased between 2017-2021.
- In 2020, Connecticut's overall c-section rate (34.1%) was the highest in New England and 8th highest in the United States.[1]
- Connecticut has the 8th highest Neonatal Abstinence Syndrome (NAS) rate per 1,000 births in the country[2]

Benchmarking Metrics by Race / Ethnicity, CT, 2021

Data Source: CT DSS Data, provided by CHN



About the Metrics: ***Adverse Maternal Outcome*** – Race based on mother's member record. Current outcomes defined as Adverse Maternal Outcomes: Acute Myocardial Infarction, Cerebral Infarction, Disseminated Intravasular Coagulation, Eclampsia, HELLP Syndrome, Hemorrhage, Maternal Death within 1 year, Peripartum Cardiomyopathy, Placenta Accreta, Placenta Increta, Placenta Infarction, Placenta Percreta, Placenta Previa, Preeclampsia, Premature Separation of Placenta, Stillborn, Thrombosis Embolism. ***Overall C-Section*** – Race based on mother's member record. Determined by match in the C-Section value set. ***NICU*** – Race based on baby's member record. Defined by a stay under revenue codes 0174 or 0203 prior to baby turning 29 days old.

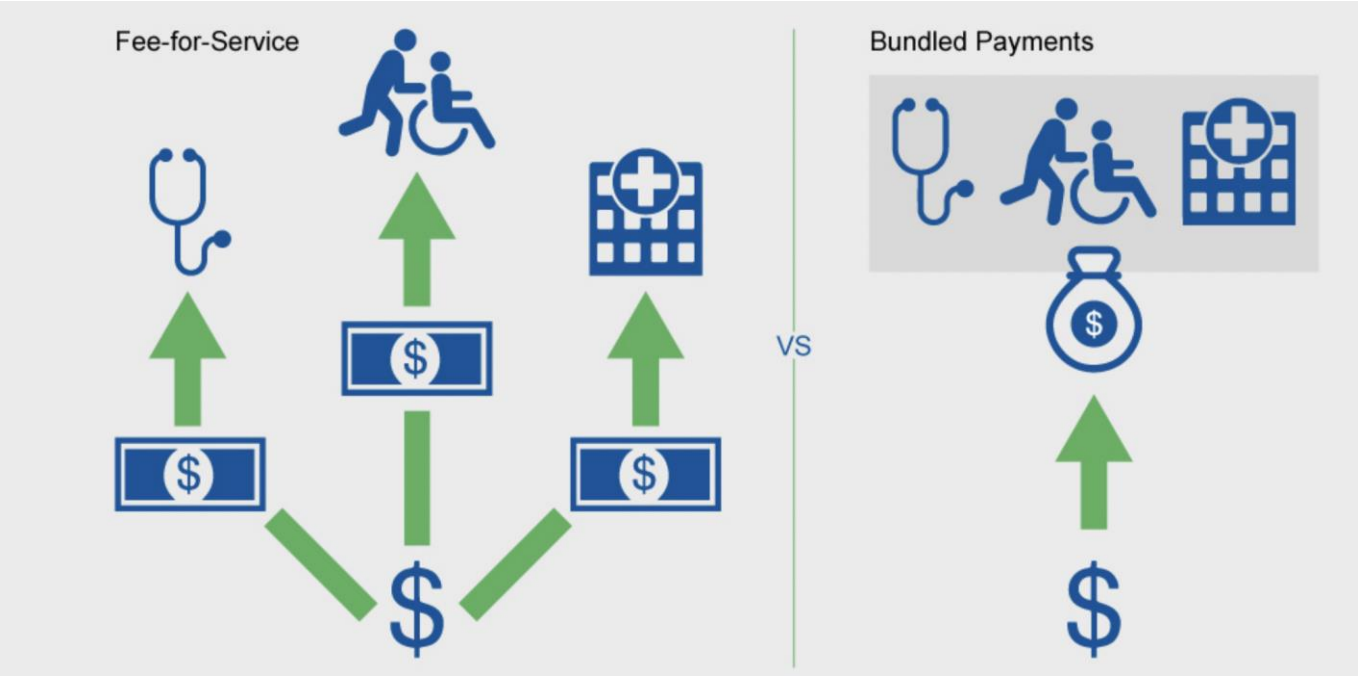
Sources: 1: CDC Natl. Center for Health Statistics: Cesarean Delivery Rate by State 2: CT NAS Data Visualization (9.4.2020)

Faulkner Consulting Group

What are Bundled Payments?

Bundled payments are forms of **alternative payment models** that are designed to move towards **value-based care**. In a bundled payment model, providers are accountable for a **single, comprehensive payment for an episode of care**.

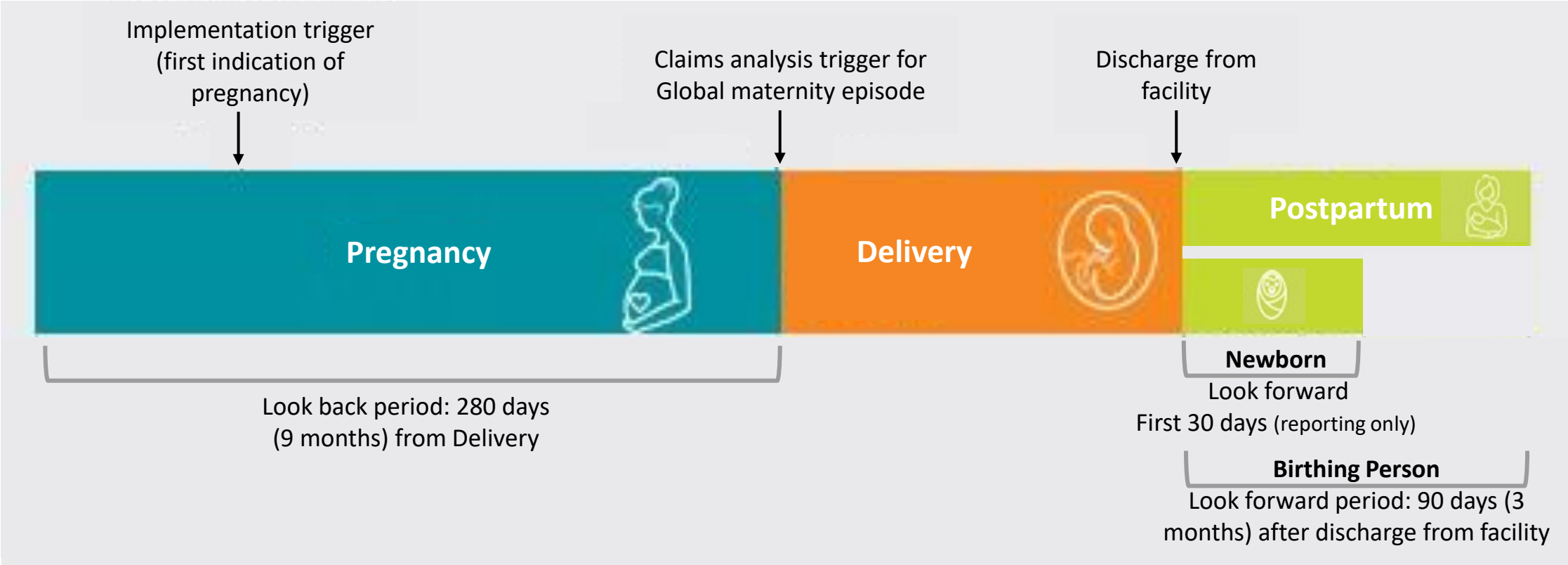
- The bundled payment model is designed to:
  - encourage **greater efficiency and coordination** in the overall management of patients
  - **improve care quality and outcomes**
  - **reduce costs**
- Bundled payments give providers an opportunity to **share in savings** when costs are kept below the bundle's target price; providers may also **assume risk** for costs that go above the target price
- **Quality measures** will be attached to the payment bundle for provider accountability and performance incentives



Sources:
https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0247
https://ldi.upenn.edu/sites/default/files/sumr_docs/WangRobin_InnovationinHealthCareDelivery.pdf

34

Maternity Payment Bundle



Pregnancy:

- Monthly prenatal visits
- Routine ultrasound
- Blood testing
- Diabetes testing
- Genetic testing

- Doulas
- Care navigators
- Group ed meetings
- Childhood ed classes
- Preventive screenings (chlamydia, cervical cancer, etc.)

Labor and Birth:

- Vaginal or C-section delivery

Postpartum:

- Breastfeeding support
- Depression screening
- Contraception planning
- Ensuring link from labor and birth to primary and pediatric care providers occurs for birthing person and baby

Overview of the "Health Equity Yardstick"

Promoting health equity is a central component of Connecticut Government's work.

- The team created a Health Equity Framework that aims to help DSS intentionally apply an equity lens at each program stage of development: initiation, design/implementation, and evaluation
- This tool will be used to ensure that equity is the driving force for all aspects of design and implementation of new DSS programs and existing program updates
- The Maternity Bundle Project will be the first opportunity to put this tool into practice

Section 1: Design Readiness Checklist

- Completed at the beginning of project work and while answers should be consistent throughout the project, this section is open to changes as we learn more throughout the design process

Section 2: "The Equity Yardstick" for Design & Implementation Principles

- Completed for each element of design and thus may be completed several times with different responses (Ex. Responses for Doula Integration details may be differ from those related to Blended Case Rate)

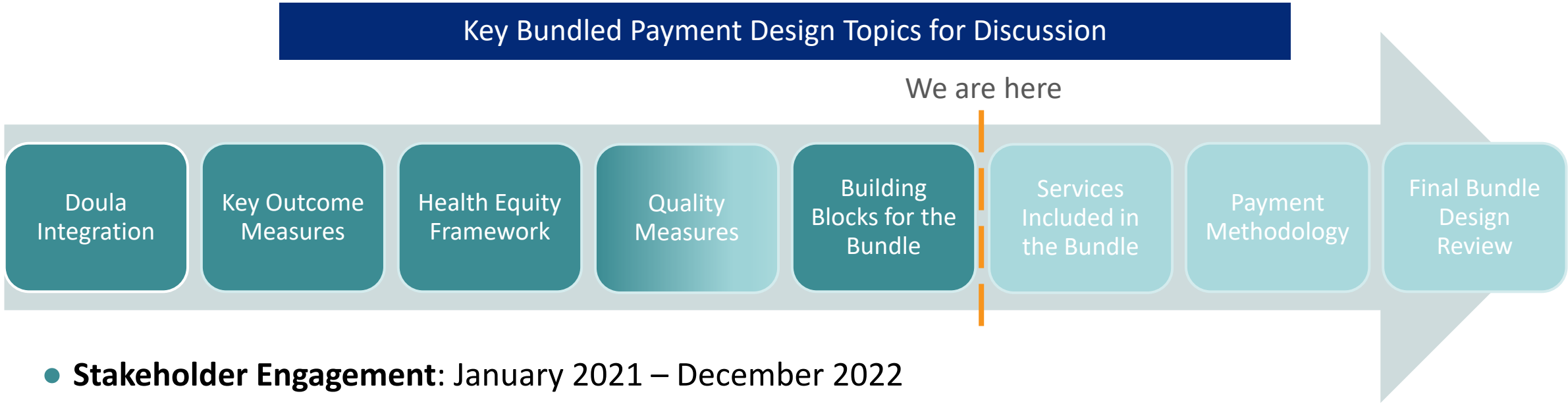
Section 3: Post-Implementation Evaluation of the Overall Program

- Completed for each element of design to evaluate whether the program goals are being met and to identify changes or updates that may be needed to the program design

Note: The current draft of the health equity framework is intended for feedback and discussion. All questions and comments pertaining to the tool are welcome.

FCG Faulkner CONSULTING GROUP

Maternity Bundle Roadmap – Process To Date



- **Stakeholder Engagement**: January 2021 – December 2022
- **Analysis & Design Detail**: January 2022 – December 2022
- **Preliminary Launch**: Q4 2022
  - Doula Integration
  - Improvements to Race/Ethnicity Data Collection
  - Baseline Data Reports
- **Full Launch**: 2023

Appendix

Faulkner CONSULTING GROUP

Maternity Bundle Key Design Elements (From 2021 Public Sessions)

This framework from 2021 offers high-level direction on each maternity bundle elements. Subsequent working sessions of this group will dive deeper into the specifics of each element within the context of the established framework (e.g. finalize services included in prospective vs retrospective bundle payment approach, finalize initial quality measures, and which ones would be pay for outcomes vs. pay for reporting, etc.)

	Design Element	Straw Recommendation
Episode definition and population	**Episode Definition** Bundle Inclusions/ Exclusions	Episode defined as a **Comprehensive Bundle** inclusive of services across all phases of maternal health (prenatal, labor and delivery, postpartum)
	Accountable/ Contracting Entity	All Obstetrics (**OB)/**Licensed **Midwife practices** in CT's Medicaid program, as well as Family Medicine providers who provide OB services
	Population Newborn care?	**Newborn care is initially excluded from the bundle**. • Over time, phase in newborn care
	Population Any exclusion criteria?	All Medicaid births, except those excluded for **administrative reasons** (e.g. non-continuous enrollment, death, etc). Evaluate using a **financial proxy** to define high-cost episodes to be excluded from the bundle. Identify **limited clinical risk exclusion criteria**, so key diagnoses such as SUD are not categorically excluded from the program
Services	**Services included in Bundle**	Included services: • **Prospective payment** – **routine pregnancy-**related visits that providers can impact • **Retrospective payments** – those **services that may not always be necessary** during pregnancy Excluded services: • Not included to ensure there is **not adverse fallout for needed services that may be more costly to providers**
Metrics	**Quality Metrics**	**Combination of State Employee Health Plan (SEHP) quality measures and Medicaid core maternity bundle measures**: 6 SEHP measures + ~4-6 additional measures including Vaginal Birth After Cesarean (VBAC), early elective delivery, prenatal timeliness of care, and postpartum care* **Stratify all measures by race/ethnicity** **Update measures & measure specifications as quality best practices evolve**

Maternity Bundle Key Design Elements (From 2021 Public Sessions)

This framework from 2021 offers high-level direction on each maternity bundle element. Subsequent working sessions of this group will dive deeper into the specifics of each element within the context of the established framework (e.g. finalize services included in prospective vs retrospective bundle payment approach, finalize initial quality measures, and which ones would be pay for outcomes vs. pay for reporting, etc.)

Financial Model

Design Element	Straw Recommendation
Payment Flow	Hybrid financial model of **prospective payment** for services provided by OB + **retrospective reconciliation** for related services outside OB practice
Episode Timing	**40 weeks before birth/at least 60 days postpartum,** with plan to extend to longer postpartum time period
Episode Pricing	**Phased approach, such as:** Year 1: Upside Only Years 2-3: Asymmetric upside/downside (larger upside potential than downside exposure) Year 4: Symmetrical up/downside risk
Type and Level of Risk	Blended price using statewide and provider-specific utilization history (50/50 ratio in Phase 1), including single blended rate for C-sections and vaginal births. Also adjusted for any reimbursement rate changes. Risk-adjust based on clinical risk; consider adding social determinants
Impact of Quality Performance on Payment	Select key measures as pay for performance (P4P), with remaining reporting only (P4R). Move more measures from P4R to P4P over time. Use stratification of performance by race/ethnicity/language to incentivize improvements in quality disparities

Maternity Bundle Key Design Elements: Proposed Year 1 Quality Measures

Proposed Measure	SEHP	Core Measures/ Used in Other Medicaid Bundles*	Addresses Disparities in Quality and Outcomes
Low risk Cesarean rate: Number of women having a cesarean delivery with no predefined indications / Total number of deliveries	x	x	x
Low Birth Weight (LBW)/Premature babies in nursery level 1: Number of LBW/premature babies in nursery level 1/ Total number of LBW/premature babies	x	x	x
Incidence of Low Birth Weight/Premature babies: Number of LBW/Premature Babies / Total number of deliveries	x	x	x
Maternity Adverse Actionable Event (AAE): % of Deliveries with AAEs adjusted for case mix = # of Deliveries with AAE flags / Total number of Deliveries / Case Mix index	x	x	x
Missing Chlamydia, Group B Strep (GBS) and other Screening, Missing Vaccines: # of episodes missing a Screening and/or Vaccine/ Total number of deliveries	x	x	x
Missing Postpartum Depression Screening and Visits: # of episodes missing a Postpartum visit and or Depression screening / Total number of deliveries	x	x	x
Vaginal Births After Cesarean (VBAC): Vaginal births per 1,000 deliveries by patients with previous Cesarean deliveries			x
Early Elective Delivery: Inpatient (IP) hospitalizations for patients with elective deliveries by either medical induction of labor while not in labor prior to the procedure or Cesarean birth while not in labor and with no history of a prior uterine surgery / IP hospitalizations for patients delivering newborns with >= 37 and < 39 weeks of gestation completed			x
Prenatal Timeliness of Care: Percentage of deliveries that received a prenatal care visit in the first trimester (also consider if measure should relate to timeliness between first patient contact and first prenatal appt)		x	x
Postpartum Care: Percentage of deliveries that had a postpartum visit after delivery: Early postpartum visit – within 21 days after delivery. Late postpartum visit – within 22 – 84 days after delivery.		x	X
Consider adding: **Breastfeeding Support** – Offer rate of culturally competent breastfeeding resources/support, stratifying by race/ethnicity **Contraception/Interconception Counseling Measure** – either postpartum or longer time horizon **Doula Utilization or Process Measure** – Offer rate of doula services, stratifying by race/ethnicity **Patient Care Experience Measure**			

*Note – the specific methodology used to calculate the measure may differ between SEHP and those used in other bundled programs.

For Reference: Husky Health P4P Metrics

- Timely completion (within 14 days) of online obstetrics prenatal and post-partum notification forms
- A first obstetric visit with 14 days of confirmation of pregnancy
- A prescription for low-dose aspirin between 12 & 28 weeks of gestation
- At least one postpartum visit within 21 days after delivers
- Full-term, vaginal delivery (39 weeks gestation)

Key Outcomes Measures on Program Success

Initial rounds of stakeholder discussions identified six key outcome measures to evaluate success of the overall bundled payment program with an emphasis on addressing racial disparities

Goal - Reduce overall rates as well as disparities for the following key outcome measures:

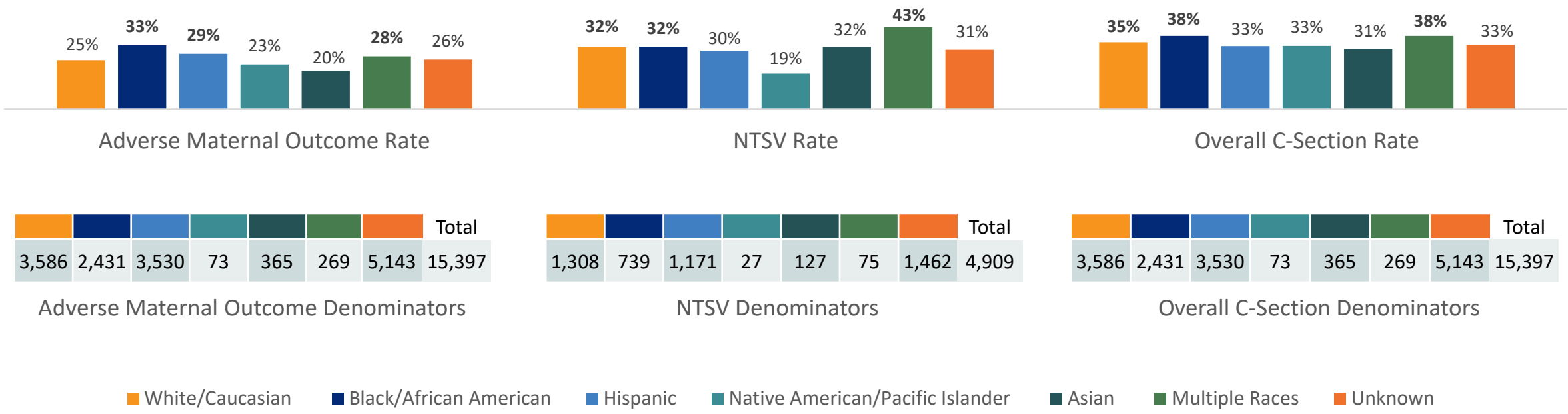
- NICU Utilization
- Overall Neonatal Abstinence Syndrome (NAS)
- Neonatal Opioid Withdrawal Syndrome (NOWS)
- Adverse maternal outcomes
- NTSV C-section
- Overall C-section

Notes:

- Additional measures will also be included in the quality measure slate for provider accountability and performance incentives
- As a key goal is to improve patient experience of care, DSS is also striving to include a validated patient experience metric that spans the birthing person's full perinatal period

2021 Maternal Health Outcomes by Race & Ethnicity

Maternity Benchmarking Metrics by Race / Ethnicity, CT, 2021

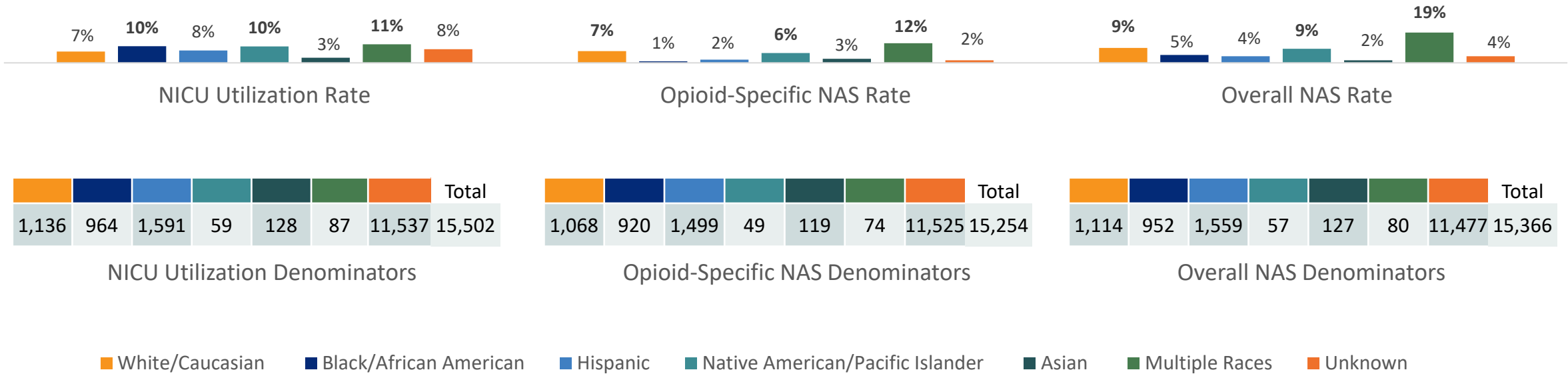


Source: CT DSS Provided Data, provided by CHN

About the Metrics: ***Adverse Maternal Outcome*** – Race based on mother's member record. Current outcomes defined as Adverse Maternal Outcomes: Acute Myocardial Infarction, Cerebral Infarction, Disseminated Intravascular Coagulation, Eclampsia, HELLP Syndrome, Hemorrhage, Maternal Death within 1 year, Peripartum Cardiomyopathy, Placenta Accreta, Placenta Increta, Placenta Infarction, Placenta Percreta, Placenta Previa, Preeclampsia, Premature Separation of Placenta, Stillborn, Thrombosis Embolism. ***NTSV*** – Race based on mother's member record. ***Overall C-Section*** – Race based on mother's member record. Determined by match in the C-Section value set.

2021 Infant Health Outcomes by Race & Ethnicity

Maternity Benchmarking Metrics by Race / Ethnicity, CT, 2021



Source: CT DSS Provided Data, provided by CHN

About the Metrics: ***NICU*** – Race based on baby's member record. Defined by a stay under revenue codes 0174 or 0203 prior to baby turning 29 days old. ***Opioid-Specific NAS*** – Race based on baby's member record. Determined by diagnosis code P96.1 on baby's birth claim. ***Overall NAS*** - Race based on baby's member record. Determined by presence of one of the following diagnosis codes on baby's birth claim: P96.1, P04.42, P04.1A, P04.14, P04.40, P04.41, P04.81, P04.49, and P04.16.

Health Equity Framework Summary

This slide provides a summary of the Health Equity framework. The Advisory Council has worked through detailed analysis of each component through an equity lens.

	Overall	Doula Integration	Payment Methodology	Building Blocks for the Bundle (Who?)	Services Included in the Bundle	Quality Measures
Design Element Goals	Reduce rates and close racial disparities for key outcome measures	Invest in doula infrastructure and capacity building to improve access to doula care, which improves maternal and infant health outcomes	Structure payment methodologies to improve equity across program outcomes, such as factoring social determinants of health into risk adjustment methodology	Define program parameters to maximize scope of program impact, such as inclusion of higher risk pregnancies	Designate services to create incentives that improve quality of care, including access to community-based services that are not traditionally covered by Medicaid (e.g., doulas, CHWs, breastfeeding support, contraception counseling)	Prioritize metrics for provider accountability based on impact on equity
Community Context	• Promote culturally responsive care and improve the overall patient experience of birthing members • Include access to community-based supports, like doulas, CHWs, etc., to strengthen a workforce that is reflective of the community being served • Continuously review and monitor impact of payment methodology on outcomes to make mid-course adjustments as needed					
Community Engagement	• The Advisory Committee includes two members who have lived birthing experience through HUSKY Health • Smaller focused discussions will be scheduled for some of the design elements where appropriate to allow for additional time for design discussions					
Data Analysis & Measurement	• Advisory Council input will be sought for (1) quality slate and process measures and (2) methods for data tracking, reporting, and communication of the metrics • Performance data will be stratified by race/ethnicity, while DSS continues to explore strategies that improve race/ethnicity data collection • DSS will monitor outcomes to inform necessary updates to the program design					

Section 1: Design Readiness Checklist

Complete this section once prior to conducting the detailed design of a program. As needed, revisit and update this section as additional information is gathered.

Overview

Program/Alternative Payment Model:

Description:

Department/Team:

Lead Contacts:

Goals

- What does this program aim to achieve? What problem(s) does it solve?
- What are the explicit health equity goals for this program?

Intended Populations for Impact

- What is the target population or subpopulations? *Think about who will be most impacted (neighborhoods, regions, racial/ethnic groups, income groups) by the program, and consider whether the design will benefit different population groups the same, less so, or more so (e.g: Will Latino populations benefit more or less than Black populations? If yes, why?).*
- How is the design intended to improve health outcomes for the targeted population?

Community Context

- Identify the history and current reality of structural barriers that negatively impact the affected communities. *Examples include unequal social determinants of health in education, income, neighborhood characteristics, housing, access to care, safety, and food stability and manifestations of systemic racism, such as redlining, mass incarceration, the racial pay gap, etc.*
- What does the data tell us about the current context? (e.g. current health disparities data)
- What are the potential barriers, challenges, or risks that may limit the ability of this program to achieve its intended outcomes for the target population? What specific design elements have been incorporated to mitigate these challenges?

Community Engagement

- How are those most affected actively involved in defining the problem and shaping the solution? Who is missing and how can they be engaged?
- Feedback loop: What mechanism is in place to provide and receive timely feedback as issues arise?

Data Analysis & Measurement

- How is data related to health disparities collected for this program? What are future plans for collecting this data?
- Can the measures be stratified by race/ethnicity, language, disability (RELD) and other demographics? What barriers to effective stratified data collection do you anticipate for this program and how have they been addressed?

Health Equity Framework Section 2: "The Equity Yardstick" for Design & Implementation Principles

Complete this section to guide design and implementation of each element of a program to ensure health equity focus – e.g. risk adjustment, quality metrics, member and/or provider eligibility, etc

Goals

- Proposal
  - What are the expected results and outcomes of the design element?
- Equity Alignment
  - How does the proposed design element impact existing inequities?
  - How does the proposed design element align with the project's overall equity goals?

Community Context

- What are the potential barriers, challenges, or risks that may limit the ability of this program to achieve its intended outcomes for the target population? What specific design elements have been incorporated to mitigate these challenges?

Community Engagement

- How was community voice considered for this design element? *Ensure community members, especially those who are most impacted by the program, have been informed, meaningfully involved, and authentically represented in the development of the program or initiative.*

Data Analysis & Measurement

- What measures will be used to assess effectiveness of design? What are the success indicators and progress benchmarks? Do these measures reflect the equity goal(s)?
- What methods will be used for data tracking, reporting, and communication of the metrics selected?

Faulkner CONSULTING GROUP

Note: The current draft of the health equity framework is intended for feedback and discussion. All questions and comments pertaining to the tool are welcome.

Health Equity Framework Section 3: Post-Implementation Evaluation of the Overall Program

Complete this section after the program has been implemented to evaluate program impact and alignment of its health equity goals.

Goals

- What were the initial goals of the program?
- What were the outcomes of the program implementation?
- Identify whether program goals were met. What changes are needed to achieve the desired outcomes and/or to align with health equity goals?

Intended Populations for Impact

- Based on the outcomes, who has benefited so far? Are there additional populations or subgroups that can or should be targeted further to receive greater program benefit?
- What has changed (improved/declined) for the targeted population?

Community Engagement

- What feedback have impacted communities provided about the program? Do they believe the program is having its intended impact?
- What barriers or challenges have been identified that limit the ability of this program to achieve its intended impact and/or to achieve its health equity goals?

Data Analysis & Measurement

- Are the data providing the appropriate detail to evaluate whether metrics have been met?
- Are the design metrics providing the appropriate detail to evaluate program success?

Note: The current draft of the health equity framework is intended for feedback and discussion. All questions and comments pertaining to the tool are welcome.

Upcoming Maternity Bundle Advisory Meetings

- Feedback will be gathered in the monthly advisory meetings with ad hoc sessions, scheduled as needed to offer more focused discussions on specific topics
- The process will be iterative with opportunity to share feedback to drafted design elements

Advisory

Focused Discussions

Date	Meetings	Agenda Topic
9/20	Maternity Bundle Advisory	Solicit feedback on services included in the bundle
9/27	*Focus: Provider Payment*	*Preview financial risk (including retrospective reconciliation against bundle benchmark), provider and member inclusion/exclusion criteria, and provider-specific benchmarks for performance*
10/18	Maternity Bundle Advisory	Solicit feedback on financial risk, provider/member inclusion criteria, and provider-specific target prices for initial feedback
10/25	*Focus: Provider Payment*	*Input on proposed hybrid prospective & retrospective payment methodology; quality measure technical specs*
11/22	Maternity Bundle Advisory	Review final bundle design