# MAPOC

DEPARTMENT OF SOCIAL SERVICES

September 13, 2024

# Agenda

HUSKY Health Report – Invitation for Comments

- Summary of Statute
- Work to Date
- Next Steps and Opportunity for Comment

# HUSKY Health Report – Invitation for Comments

## Section 17 of Public Act 23-171 requires DSS to:

- Develop a strategy to improve health care **outcomes, community health and health equity**
  - Consult with the hospital association, hospitals, other providers and stakeholders to inform community-based prevention policies and wellness, care delivery and financing strategies

**Such strategy is to:**

- Address improved health **equity** by identifying **barriers and influences** that impact health and health care outcomes and articulate options to:
  1) Improve health care **access and outcomes**
  2) Increase adoption of interventions to support improved access to **preventive care** services
  3) Identify and address **social, economic and environmental drivers of health** to advance long-term preventive health and health care outcomes
  4) Explore innovative **financing reforms** that support high quality care, promote integration of primary, preventive and behavioral health care and address health-related social needs and long-term preventive outcomes
  5) Improve **collaboration and coordination** among health care providers and cross-sector community partners
  6) Improve **Medicaid reimbursement and performance** to achieve a sustainable health care delivery system and improve health care **affordability** for all.

- Include approaches designed to **improve performance in prevention measures, clinical outcomes, improved access to preventive services** and health equity measures recommended by the Advisory Board for Transparency on Medicaid Cost and Quality

Not later than January 1, 2025, DSS is to submit recommendations to MAPOC

# HUSKY Health Report – Invitation for Comments

- **Work to Date**
  - Internal analysis of recent and planned upcoming improvements to CT's Medicaid program across all areas of the program
  - Consultation with DSS staff, contractors, and HUSKY Health-involved state agencies
  - Identified areas for further analysis and additional organizations for consultation

- **Next Steps**
  - Consultation planned with provider groups and other relevant stakeholders per statute
  - Prepare report based on additional analysis and consultation

- **Opportunity for Comments:**
  - We want to hear from you and any other stakeholder interested in improving CT's Medicaid program
  - Feel free to send DSS brief written comments focused on one or more of the criteria set forth in Public Act 23-171, Section 17
  - Please put "Comment About HUSKY Health Report" in the Subject line
  - Comments due ***Friday, October 11, 2024***
  - *Send comments to:* **Public.Comment.DSS@ct.gov**

# Agenda

Operational Data Report

- Public Health Emergency (PHE) Unwinding
- HUSKY A Transition
- Application Processing Data
- Call Center Data

# Conclusion of Public Health Emergency (PHE) Unwinding

## Key Dates

- The PHE continuous enrollment provision ended on 3/31/2023 per federal legislation.
- Connecticut's PHE unwinding period officially began 4/1/2023 and continued through 3/31/2024.
- During this time, the state scheduled and processed renewals for the entire Medicaid and CHIP populations.
- On 4/1/2024, Connecticut's unwinding period officially ended (states are allowed two additional months for "clean up" work).

# National Data on Renewed Enrollment during Unwinding

National average of enrollees renewed: 55%  Connecticut: **75%** (ranked **3rd** nationwide and **1st** in Northeast)

| State | Total Due for Renewal March 2023-March 2024 | Total Renewed March 2023-March 2024 | Percent Renewed March 2023-March 2024 |
|---|---|---|---|
| AK | 143,754 | 54,352 | 37.8% |
| AL | 1,045,137 | 680,972 | 65.2% |
| AR | 906,169 | 497,338 | 54.9% |
| AZ | 2,400,877 | 1,866,188 | 77.7% |
| CA | 11,050,558 | 6,241,317 | 56.5% |
| CO | 1,534,369 | 740,505 | 48.3% |
| CT | 1,197,038 | 904,641 | 75.6% |
| DC | 277,382 | 176,923 | 63.8% |
| DE | 244,167 | 114,982 | 47.1% |
| FL | 4,971,937 | 2,763,003 | 55.6% |
| GA | 1,567,910 | 611,083 | 39.0% |
| HI | 291,019 | 189,673 | 65.2% |
| IA | 897,879 | 355,353 | 39.6% |
| ID | 370,309 | 165,358 | 44.7% |
| IL | 2,919,238 | 1,831,763 | 62.7% |
| IN | 1,785,104 | 935,600 | 52.4% |
| KS | 526,970 | 149,950 | 28.5% |
| KY | 960,259 | 557,239 | 58.0% |
| LA | 1,496,303 | 931,596 | 62.3% |
| MA | 1,377,547 | 788,242 | 57.2% |
| MD | 1,416,484 | 994,906 | 70.2% |
| ME | 402,561 | 180,332 | 44.8% |
| MI | 2,476,013 | 1,381,404 | 55.8% |
| MN | 1,157,546 | 673,436 | 58.2% |
| MO | 1,148,596 | 609,586 | 53.1% |
| MS | 603,665 | 296,124 | 49.1% |

| State | Total Due for Renewal March 2023-March 2024 | Total Renewed March 2023-March 2024 | Percent Renewed March 2023-March 2024 |
|---|---|---|---|
| MT | 295,549 | 86,895 | 29.4% |
| NC | 2,227,758 | 1,550,234 | 69.6% |
| ND | 129,837 | 67,449 | 51.9% |
| NE | 369,576 | 154,863 | 41.9% |
| NH | 195,693 | 122,896 | 62.8% |
| NJ | 1,639,215 | 441,496 | 26.9% |
| NM | 815,303 | 465,577 | 57.1% |
| NV | 820,236 | 489,928 | 59.7% |
| NY | 5,354,317 | 3,637,748 | 67.9% |
| OH | 3,442,168 | 2,403,897 | 69.8% |
| OK | 955,081 | 409,698 | 42.9% |
| OR | 1,100,436 | 933,415 | 84.8% |
| PA | 3,221,644 | 1,185,481 | 36.8% |
| RI | 258,235 | 167,116 | 64.7% |
| SC | 887,201 | 341,793 | 38.5% |
| SD | 125,106 | 51,653 | 41.3% |
| TN | 1,284,014 | 672,330 | 52.4% |
| TX | 4,640,566 | 1,477,765 | 31.8% |
| UT | 398,952 | 157,603 | 39.5% |
| VA | 1,925,681 | 1,219,407 | 63.3% |
| VT | 139,965 | 89,033 | 63.6% |
| WA | 1,611,475 | 1,148,967 | 71.3% |
| WI | 978,690 | 523,916 | 53.5% |
| WV | 515,971 | 290,699 | 56.3% |
| WY | 70,951 | 27,111 | 38.2% |

# National Data on Ex Parte (Passive) Enrollment during Unwinding

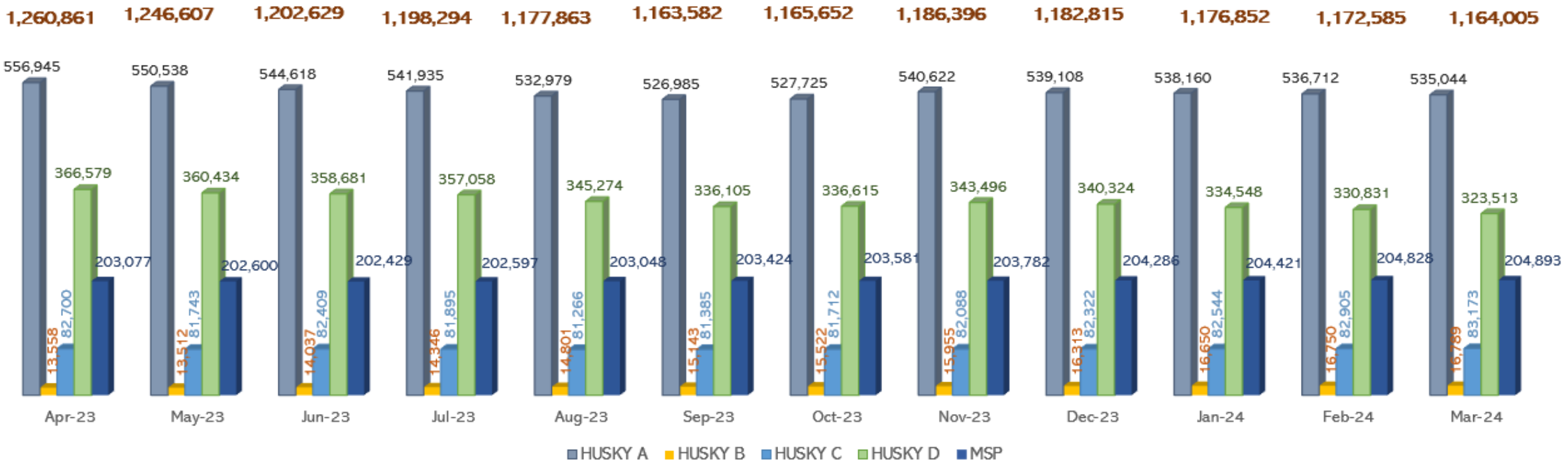
National average of enrollees renewed: 38.1%  Connecticut: **63.6%** (ranked **5th** nationwide and **1st** in Northeast)

| State | Total Due for Renewal March 2023-April 2024 | Total Renewed on an Ex Parte basis March 2023-April 2024 | Percent Renewed on an Ex Parte basis March 2023-April 2024 |
|---|---|---|---|
| USA | 82,846,657 | 31,602,420 | 38.1% |
| AK | 157,307 | 44,661 | 28.4% |
| AL | 1,126,710 | 406,789 | 36.1% |
| AR | 951,905 | 409,294 | 43.0% |
| AZ | 2,503,815 | 1,772,266 | 70.8% |
| CA | 12,168,615 | 5,759,144 | 47.3% |
| CO | 1,650,897 | 395,775 | 24.0% |
| CT | 1,266,867 | 806,254 | 63.6% |
| DC | 297,516 | 167,852 | 56.4% |
| DE | 285,970 | 81,829 | 28.6% |
| FL | 5,123,148 | 1,038,290 | 20.3% |
| GA | 1,901,679 | 640,833 | 33.7% |
| HI | 330,994 | 165,847 | 50.1% |
| IA | 948,929 | 217,274 | 22.9% |
| ID | 392,406 | 91,557 | 23.3% |
| IL | 3,200,980 | 1,562,775 | 48.8% |
| IN | 1,900,152 | 805,333 | 42.4% |
| KS | 567,951 | 116,862 | 20.6% |
| KY | 1,063,524 | 533,287 | 50.1% |
| LA | 1,689,363 | 859,170 | 50.9% |
| MA | 1,505,899 | 607,455 | 40.3% |
| MD | 1,520,023 | 829,896 | 54.6% |
| ME | 436,201 | 83,711 | 19.2% |
| MI | 2,727,084 | 965,935 | 35.4% |
| MN | 1,265,444 | 433,896 | 34.3% |
| MO | 1,257,115 | 557,353 | 44.3% |
| MS | 653,585 | 111,539 | 17.1% |

| State | Total Due for Renewal March 2023-April 2024 | Total Renewed on an Ex Parte basis March 2023-April 2024 | Percent Renewed on an Ex Parte basis March 2023-April 2024 |
|---|---|---|---|
| MT | 300,685 | 49,081 | 16.3% |
| NC | 2,478,072 | 1,711,119 | 69.1% |
| ND | 141,092 | 35,762 | 25.3% |
| NE | 396,797 | 112,767 | 28.4% |
| NH | 205,950 | 102,043 | 49.5% |
| NJ | 1,828,534 | 293,231 | 16.0% |
| NM | 854,166 | 356,820 | 41.8% |
| NV | 910,492 | 425,846 | 46.8% |
| NY | 5,908,532 | 2,082,253 | 35.2% |
| OH | 3,637,716 | 1,833,580 | 50.4% |
| OK | 991,962 | 157,108 | 15.8% |
| OR | 1,258,496 | 975,278 | 77.5% |
| PA | 3,396,287 | 170,879 | 5.0% |
| RI | 314,169 | 185,423 | 59.0% |
| SC | 1,032,418 | 354,839 | 34.4% |
| SD | 125,106 | 15,178 | 12.1% |
| TN | 1,412,224 | 559,226 | 39.6% |
| TX | 4,817,043 | 189,072 | 3.9% |
| UT | 424,516 | 90,805 | 21.4% |
| VA | 2,104,998 | 1,015,230 | 48.2% |
| VT | 158,571 | 80,437 | 50.7% |
| WA | 1,714,919 | 1,100,271 | 64.2% |
| WI | 1,095,458 | 233,703 | 21.3% |
| WV | 542,767 | 96,115 | 17.7% |
| WY | 75,069 | 15,059 | 20.1% |

# HUSKY Total Enrollment During Unwinding

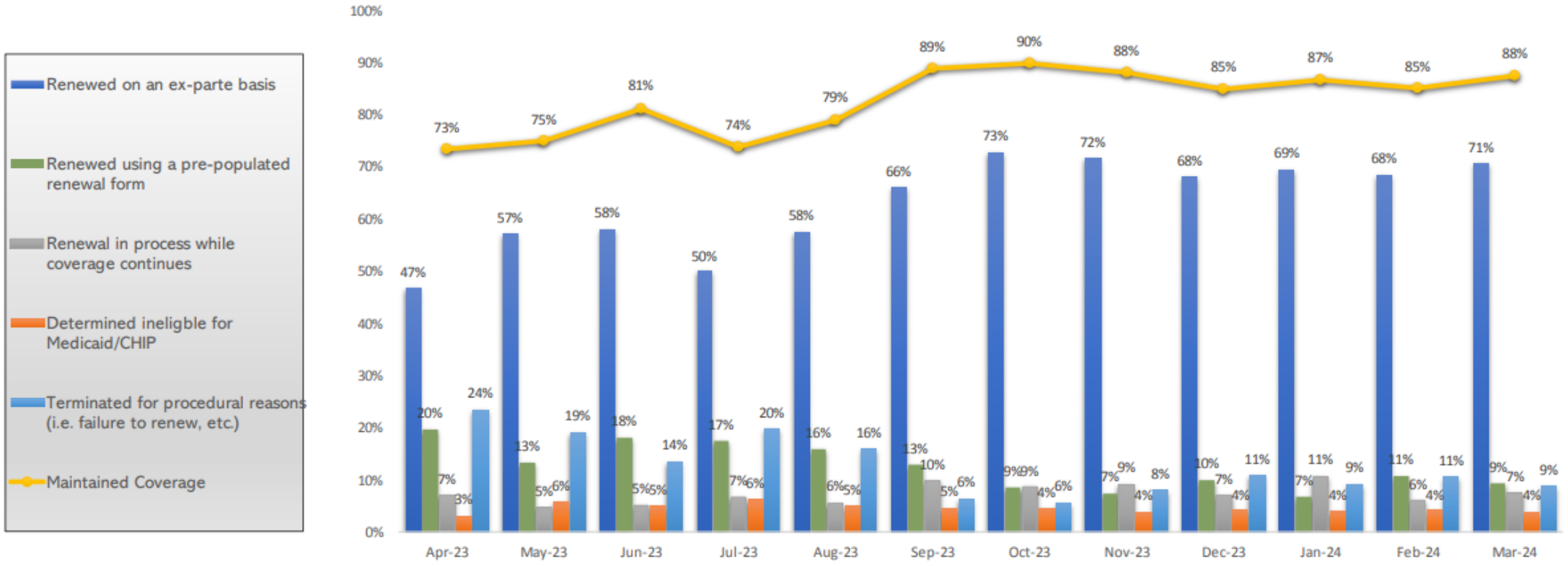
## April 2023 – March 2024




The top level numbers include all forms of HUSKY coverage, including some limited benefit coverage that has been excluded fro m the bars for readability. Notably, April and May 2023 include the HUSKY group for COVID-19 testing. This federal program had 60,000 enrollees when it sunset on 5/11/2023.

# HUSKY Enrollment Trends During Unwinding

## April 2023 – March 2024




An average of 83% of all individuals retained coverage at the end of each month. Those who disenrolled often re-enrolled after the month end.

# Cumulative Unwinding Medical Renewal Data

## April 2023 – March 2024

1,198,835 individuals went through renewal during unwinding

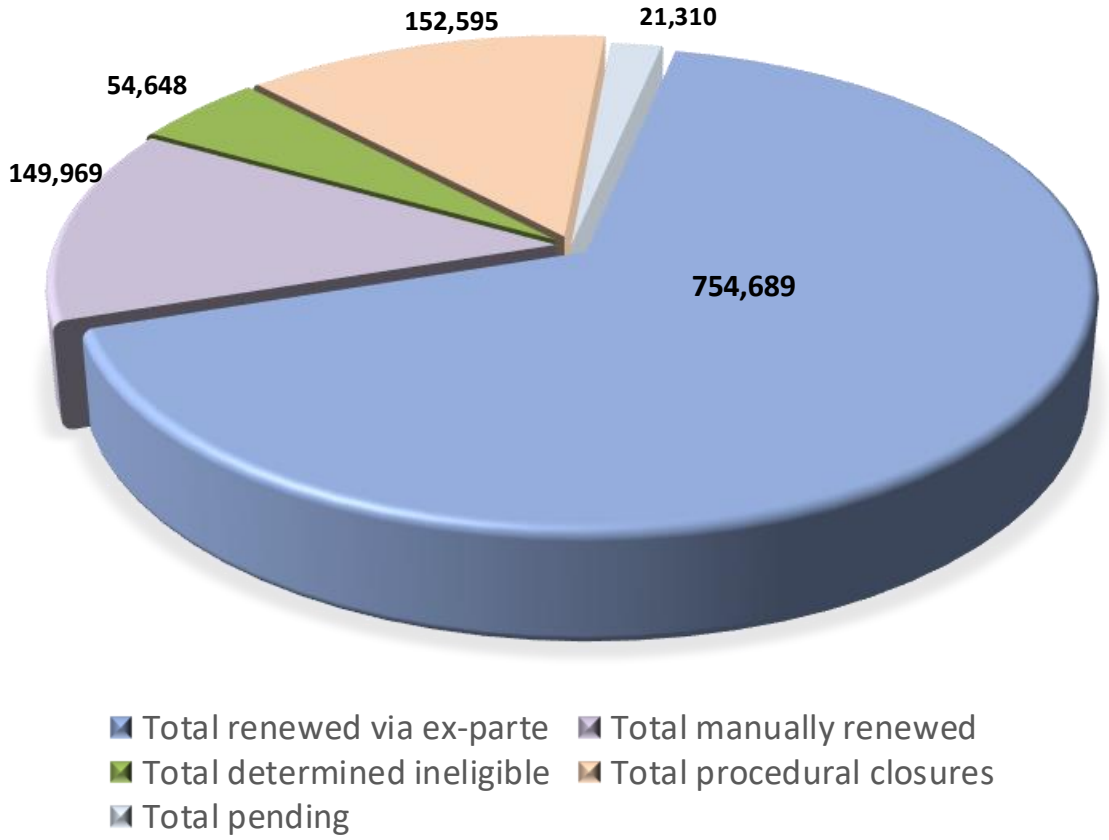
904,658 individuals* (75%) renewed & retained their Medicaid/CHIP coverage timely

- 754,689 individuals or 63% passively renewed
- 149,969 individuals or 12% manually renewed

207,243 individuals* or about 17% lost coverage

- 152,595 individuals or12.7% lost coverage for procedural reasons (i.e., failure to renew)
  - ~40% of the people (~60,000) who closed subsequently came back in and were enrolled
- 54,648 individuals or 4.6% were determined ineligible for eligibility reasons (i.e., over income)

21,310 individuals** remained pending final eligibility determination at the end of unwinding (March 2024)




* Cumulative from point in time data (at the end of each month)

** Pending as of March 2024; as of June 2024 the count was 10,914

# Improvements to Medical Renewal Processes

## During Unwinding…

- Implemented system update to correct logic in the Access Health CT (AHCT) HIX system and resolve the individual vs. household issue ongoing – high level of system automation facilitated success.
- Section 1902(e)(14)(A) of the Social Security Act allows CMS to waive certain income and eligibility rules when "necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries."
  - Granted (e)(14) waiver to leverage SNAP enrollment/income data to increase *ex parte* medical renewal rates.
    - ➢ Implemented system automation to add SNAP as an income data source in the *ex parte* renewal process hierarchy through June 2025.
    - ➢ Granted (e)(14) waiver to accept updated in-state enrollee contact information from the U.S. Postal Services (USPS) National Change of Address (NCOA) and USPS returned mail without additional confirmation from the individual.
  - Granted (e)(14) waiver to renew applications with zero income that had been verified prior to the PHE.

## Post Unwinding…

- CMS offered states the option to extend all temporary (e)(14) waivers through June 2025. CT has opted to extend the waivers.
  - ➢ DSS is in discussion with CMS about continuing SNAP *ex parte* processes beyond June 2025. Doing so will require separate authority and modifications to the temporary rules in use now. DSS is exploring an 1115 waiver option, as is done in MA, AL, and MD. CMS has also recently indicated that they may be making some of the (e)(14) options permanent.

# PHE Unwinding Outreach Efforts

Multimedia campaign to encourage address change reporting (ct.gov/UpdateUsDSS)

Dedicated informational website (ct.gov/phe)

## CHNCT Automated Emails:

Automated monthly emails to PHE unwinding households due for renewal averaged a 33% success rate for unique opens

Total emails sent: 111,861

## CHNCT Automated Calls (if email unsuccessful or unavailable):

Automated monthly calls to PHE unwinding households due for renewal averaged a 55% success rate for automated messages completely listened to

Total automated calls to date: 88,587

## Renewal Text Message:

Text message sent to households that must complete a manual renewal

Approximate Average Texts per Month: 20,000

## Renewal Reminder Text Message:

Text message sent to households that have not completed a manual renewal by the due date

Approximate Average Texts per Month: 9,000

## Reconsideration Text Messages:

Text message sent to households that did not complete a renewal during the reconsideration period, at 30, 60, 90 days after closure

Approximate Average Texts per Month: 15,000

# Takeaways

## Key Points

- CT was a national leader in number of retained eligible enrollees
- CT was a national leader in the most effective renewal process – *ex parte* renewals
- CT continued to be a national leader in timely medical application processing during unwinding – over 97% of all Medicaid applications are processed timely
- CT coordinated successful outreach and communication plans

## Durable Improvements to Customer Experience and Administrative Efficiency

- Developed new tools for outreach: texting and partner data sharing
- Developed expanded passive renewal methodologies
- Incorporated SNAP data into Medicaid eligibility processes
- Developed new interfaces for updating and verifying addresses

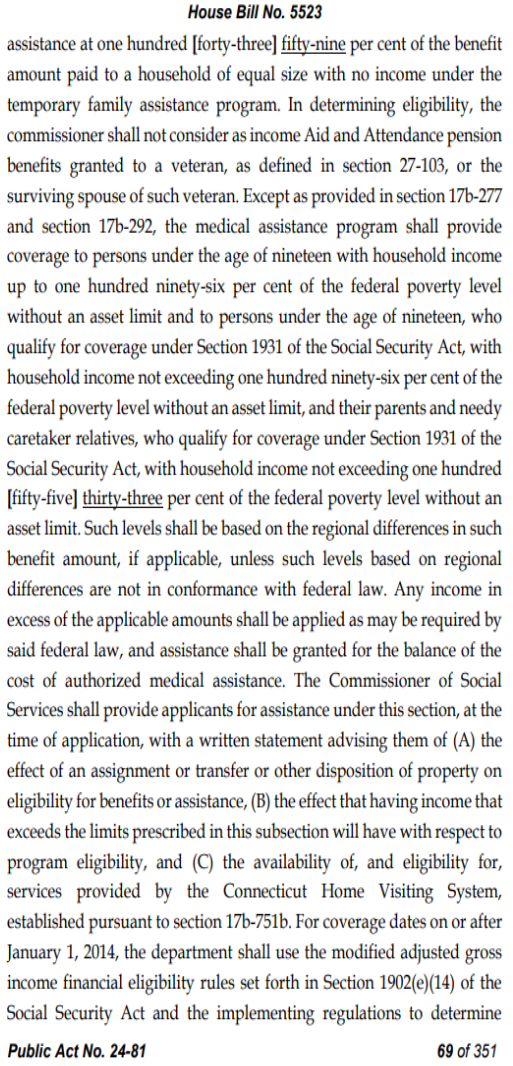
# Agenda

## HUSKY A Transition

- Public Health Unwinding
- HUSKY A Transition
- Application Processing Data
- Call Center Data

# HUSKY A Parent Transition

- Public Act 24-81
  - Reduces the HUSKY A income limit for parents & caretaker relatives from 155% of the Federal Poverty Level (FPL) to 133% FPL
  - Medicaid rules also require an income disregard of 5% FPL
  - The inclusion of the 5% income disregard results in an effective income limit of 138% FPL (reduced from 160% FPL)
  - Effective October 1, 2024
- Impacted Population (latest data)
  - 12,889 individuals in the HUSKY A Parent/Caretaker Relative coverage group
    - 10,490 had earned income or spousal support
      - These individuals will move to Transitional Medical Assistance (TMA), providing 12 months of additional Medicaid coverage
    - 2,399 had unearned income or no spousal support
      - These individuals are likely eligible for Covered CT, assuming their income has remained stable since last reported



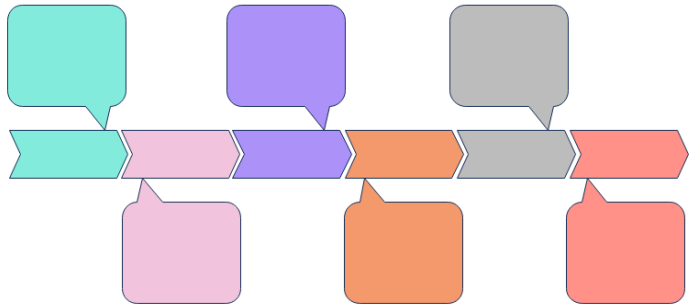
*House Bill No. 5523*

assistance at one hundred [forty-three] fifty-nine per cent of the benefit amount paid to a household of equal size with no income under the temporary family assistance program. In determining eligibility, the commissioner shall not consider as income Aid and Attendance pension benefits granted to a veteran, as defined in section 27-103, or the surviving spouse of such veteran. Except as provided in section 17b-277 and section 17b-292, the medical assistance program shall provide coverage to persons under the age of nineteen with household income up to one hundred ninety-six per cent of the federal poverty level without an asset limit and to persons under the age of nineteen, who qualify for coverage under Section 1931 of the Social Security Act, with household income not exceeding one hundred ninety-six per cent of the federal poverty level without an asset limit, and their parents and needy caretaker relatives, who qualify for coverage under Section 1931 of the Social Security Act, with household income not exceeding one hundred [fifty-five] thirty-three per cent of the federal poverty level without an asset limit. Such levels shall be based on the regional differences in such benefit amount, if applicable, unless such levels based on regional differences are not in conformance with federal law. Any income in excess of the applicable amounts shall be applied as may be required by said federal law, and assistance shall be granted for the balance of the cost of authorized medical assistance. The Commissioner of Social Services shall provide applicants for assistance under this section, at the time of application, with a written statement advising them of (A) the effect of an assignment or transfer or other disposition of property on eligibility for benefits or assistance, (B) the effect that having income that exceeds the limits prescribed in this subsection will have with respect to program eligibility, and (C) the availability of, and eligibility for, services provided by the Connecticut Home Visiting System, established pursuant to section 17b-751b. For coverage dates on or after January 1, 2014, the department shall use the modified adjusted gross income financial eligibility rules set forth in Section 1902(e)(14) of the Social Security Act and the implementing regulations to determine

*Public Act No. 24-81* *69 of 351*

# Timeline of Implementation Activities

- **8/5**: Started using the new 138% FPL threshold for individuals going through the renewal process for coverage starting 10/1
- **By 9/6**: Mailing of special notice to all impacted enrollees explaining change
- **9/11**: Text message to all impacted enrollees
- **9/20**: All HUSKY A Parent/Caretakers with data indicating income over 138% FPL will go through federal and state system data check to verify income. Notices will be generated to all individuals who no longer qualify. Those who are eligible for TMA will be automatically transitioned. All others will need to contact AHCT to complete enrollment in Covered CT or QHP coverage
- **10/1**: New 138% FPL threshold will be live for all new applications, reported changes, and ongoing renewals



## Outreach Efforts Underway:

- Special mailing to impacted enrollees
- Text messages to impacted enrollees
- Website updates (DSS webpage complete)
  - Homepage --> HUSKY Health --> Most Popular
- DSS staff communication (complete)
- AHCT/DSS call center communication (complete)
- Administrative services organization (ASO) communication
- Community partner newsletter
- Social media messages

# AHCT Support

**AHCT has offered to:**

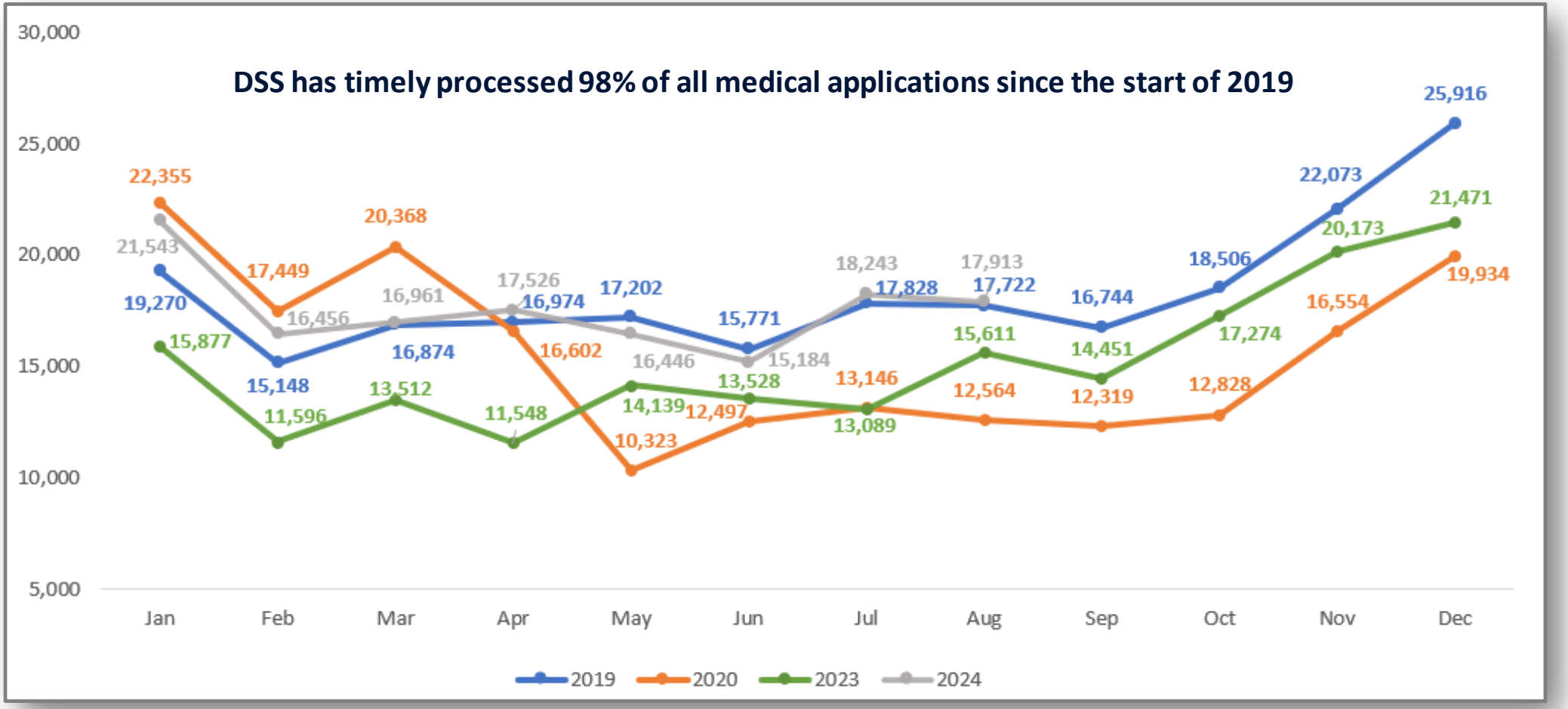
- Collaborate with DSS on cobranded direct mailer to affected customers (already completed).
- Provide data reporting about affected community (in progress).
- Train and properly staff the call center to respond to customer support needs.
- Share cobranded collateral at AHCT outreach events.
- Share cobranded collateral via our email distribution to brokers, certified application counselors, and community partners.
- Reshare social media posts.
- Link to any relevant information on the DSS website from the accesshealthct.com website.
- Provide direct-to-consumer marketing (direct mail, email and/or SMS) to affected consumers who may be eligible for Covered CT – much of this effort will be targeted for next fall because most affected customers will qualify for one year of Transitional Medical Assistance (TMA) before they become eligible for Covered CT.

# Agenda

**Application Processing Data**

- Public Health Unwinding
- HUSKY A Transition
- Application Processing Data
- Call Center Data

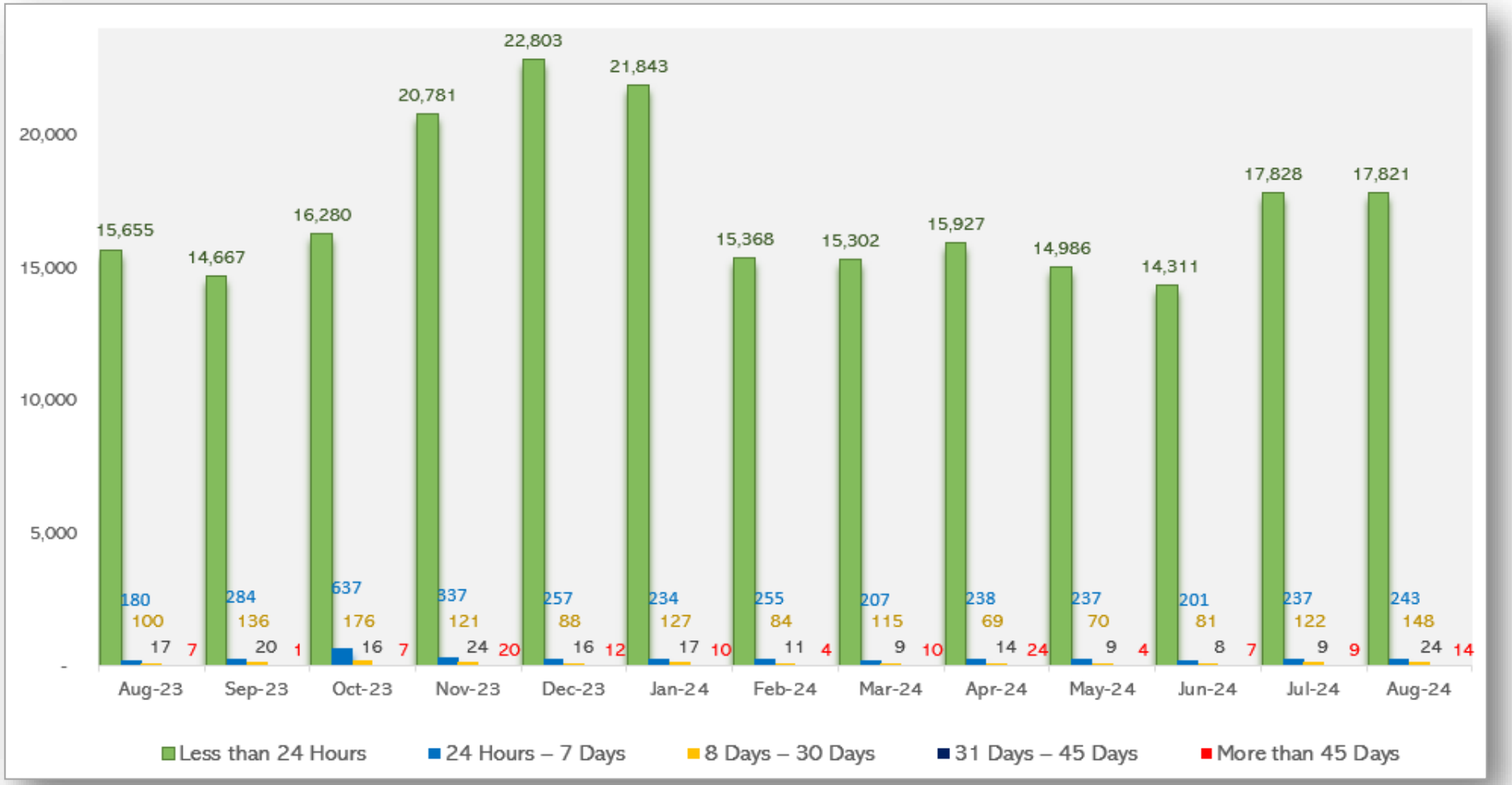
# Year-Over-Year New Medical Applications




Note: Calendar years 2021-2022 were omitted to ease crowding in the chart allowing better comparison of pre-pandemic data in 2019 and early 2020 with current trends.

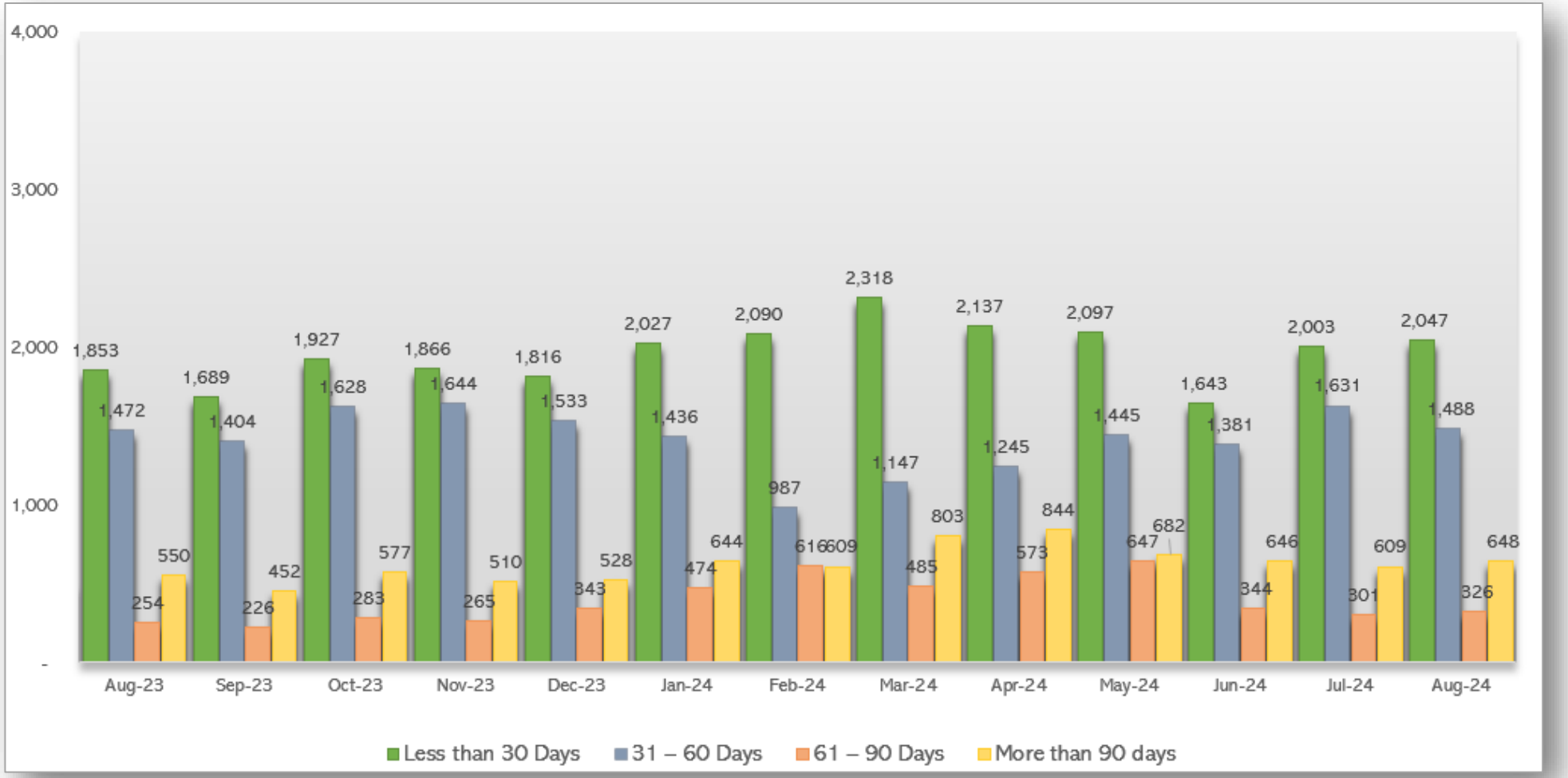
# MAGI Medicaid New Applications by Processing Time

- The standard of promptness for MAGI-based Medicaid (i.e., HUSKY A and HUSKY D) applications is 45 days from receipt
- Current median processing time in CT is less than 24 hours



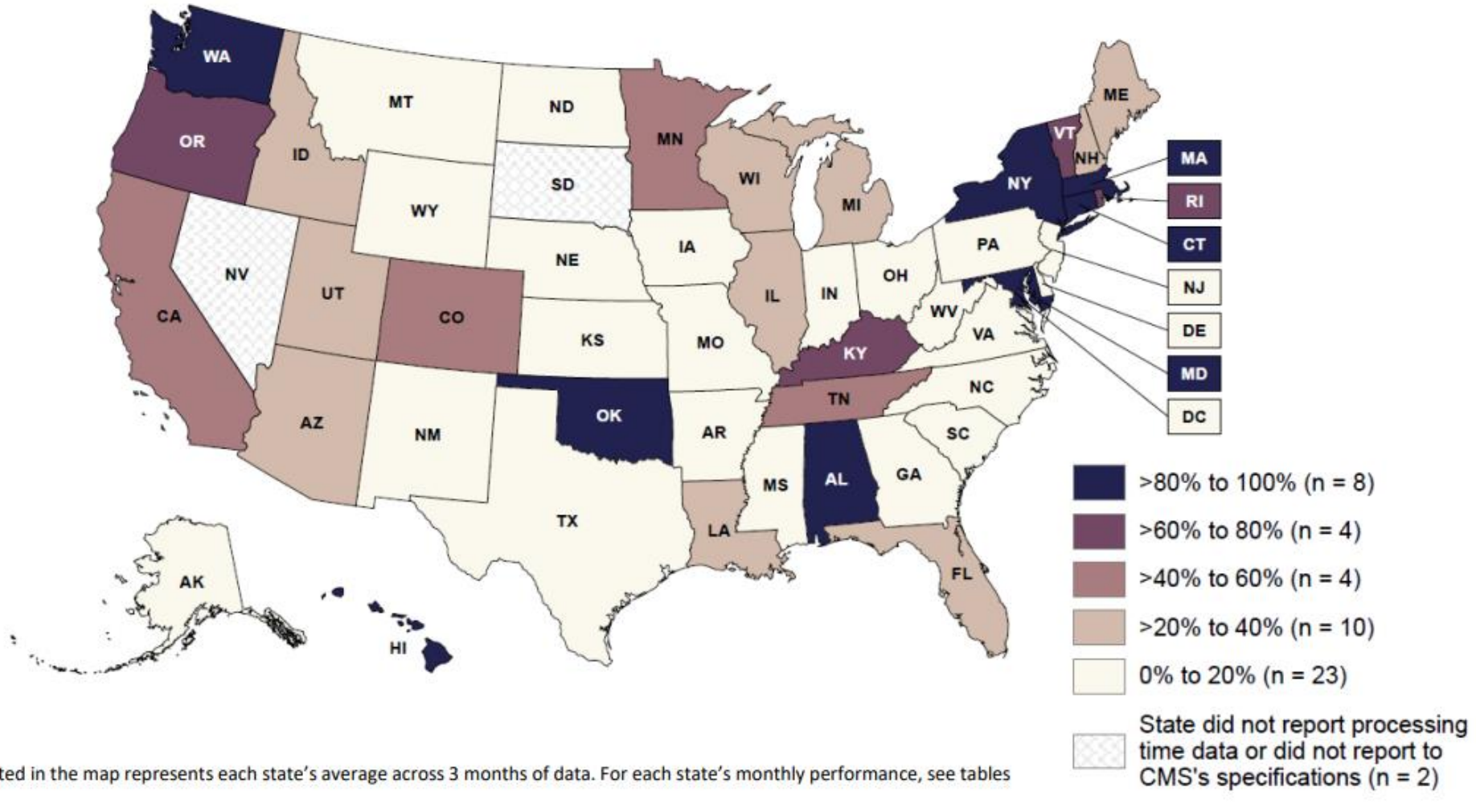
# Non-MAGI Medicaid New Applications by Processing Time

- The standard of promptness for most Medicaid applications is 45 days from receipt
- A longer period of up to 90 days is allowed for people with disabilities and applications for long-term services and supports (HUSKY C)
- Current median processing time is 32 days



# National Summary - New Applications by Processing Time

**CT processed 98% of all MAGI Medicaid & CHIP applications within 24 hours, ranking 3rd best nationwide**




Note: The data reflected in the map represents each state's average across 3 months of data. For each state's monthly performance, see tables below.

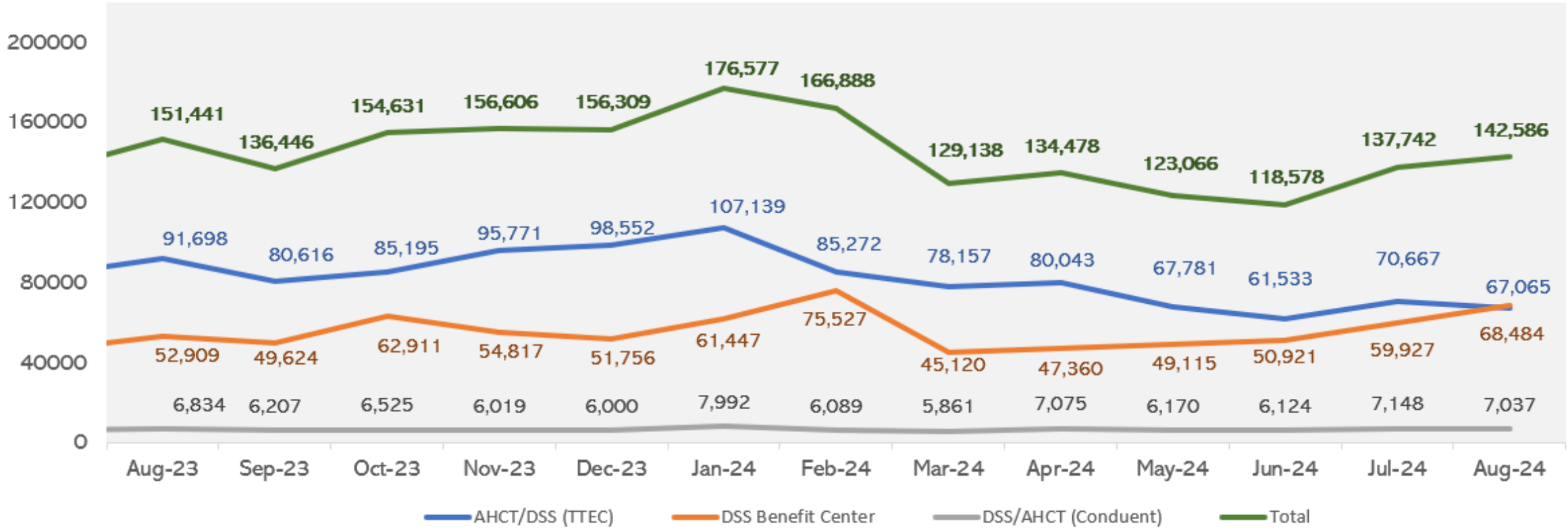
[MAGI Application Processing Time Snapshot Report: January 2024 – March 2024 (medicaid.gov)]

# Agenda

## Call Center Data

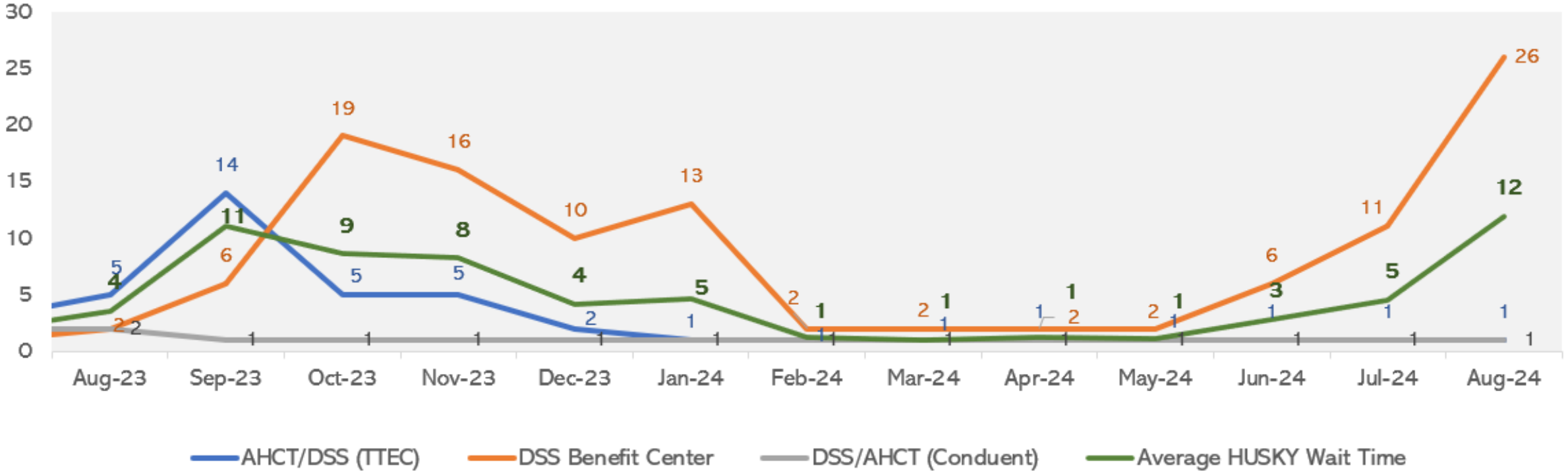
- Public Health Unwinding
- HUSKY A Transition
- Application Processing Data
- Call Center Data

# HUSKY Call Volume By Call Center



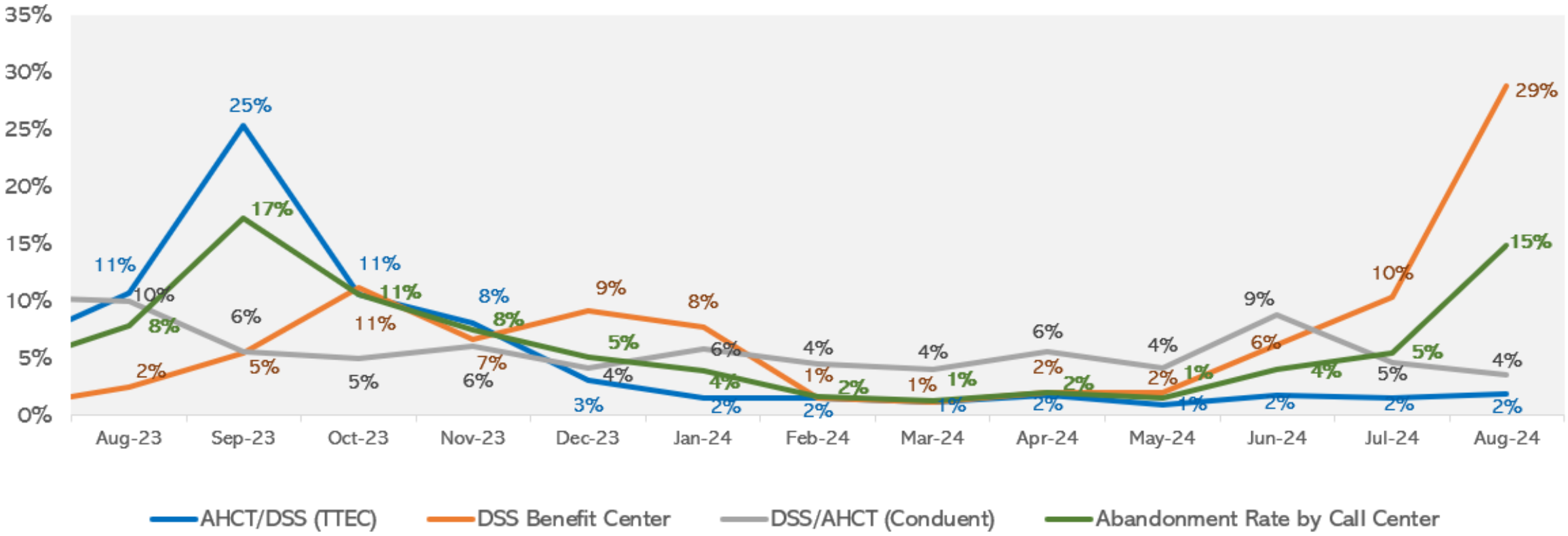

Per CMS requirements, data represents only Medicaid/CHIP calls. Calls for other programs are excluded. The DSS Benefit Center handles 30% of Medicaid/CHIP calls. Total call volume for the Benefit Center in August was 244,585.

# HUSKY Average Wait Time By Call Center (minutes)




Per CMS requirements, data represents only Medicaid/CHIP calls. Calls for other programs are excluded. Wait times are measured from the time a caller selects the option to speak with an agent to the moment the caller is connected to one.

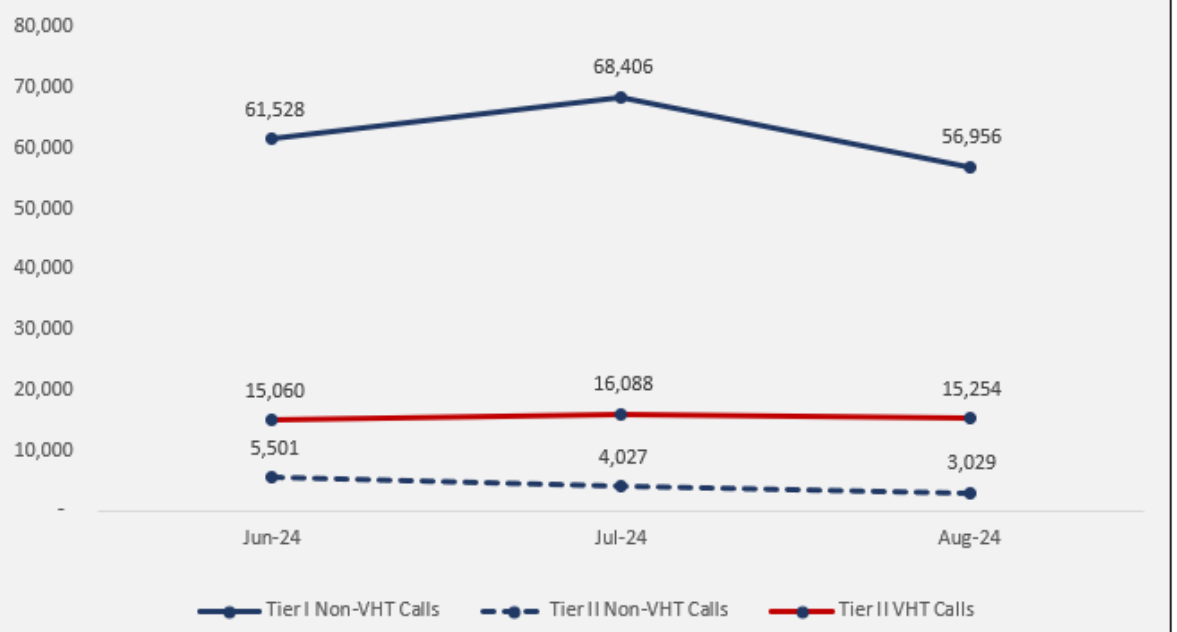
# HUSKY Abandonment Rate By Call Center




Per CMS requirements, data represents only Medicaid/CHIP calls. Calls for other programs are excluded.

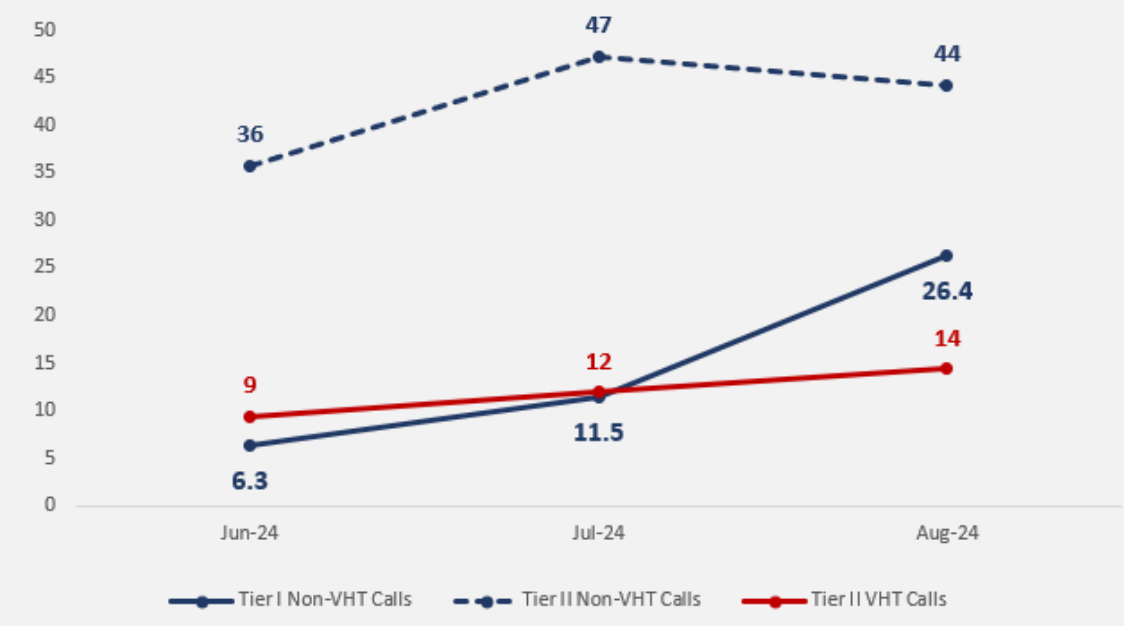
# DSS Benefit Center Data

## Tier I and Tier II Calls Answered (ACD Calls) by Month - VHT and Non-VHT



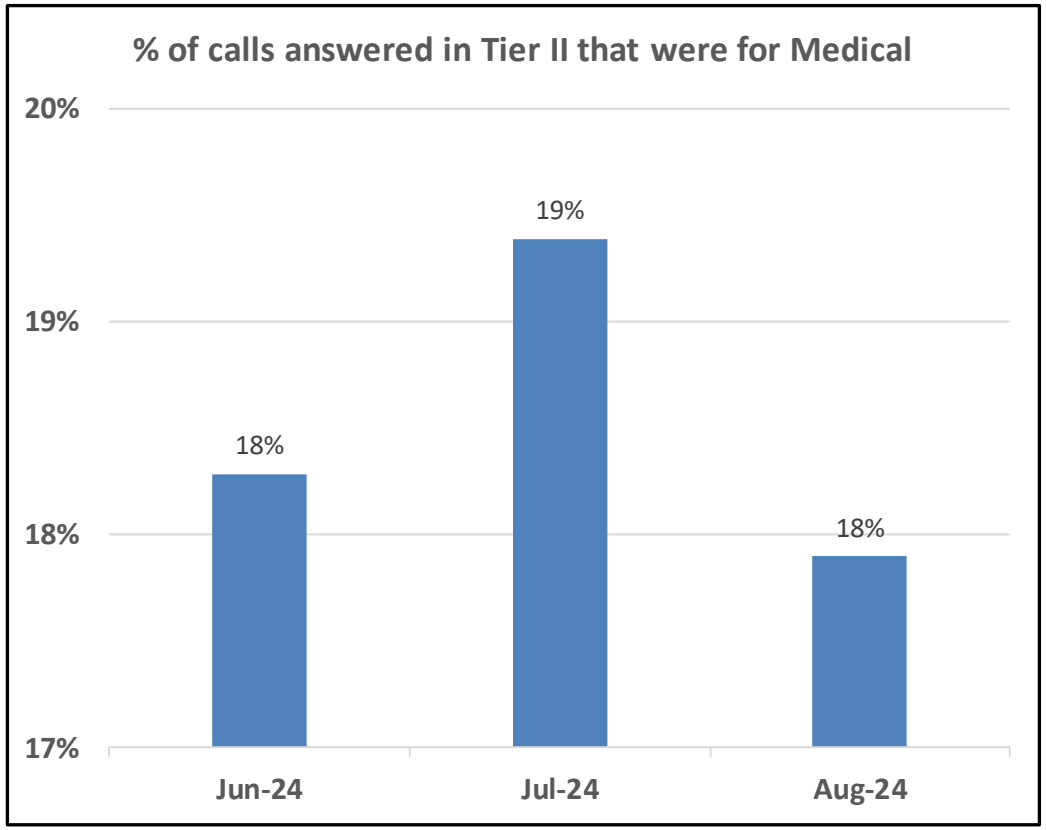

*Note: VHT (Virtual Hold Technology) option not offered for Tier I Calls*

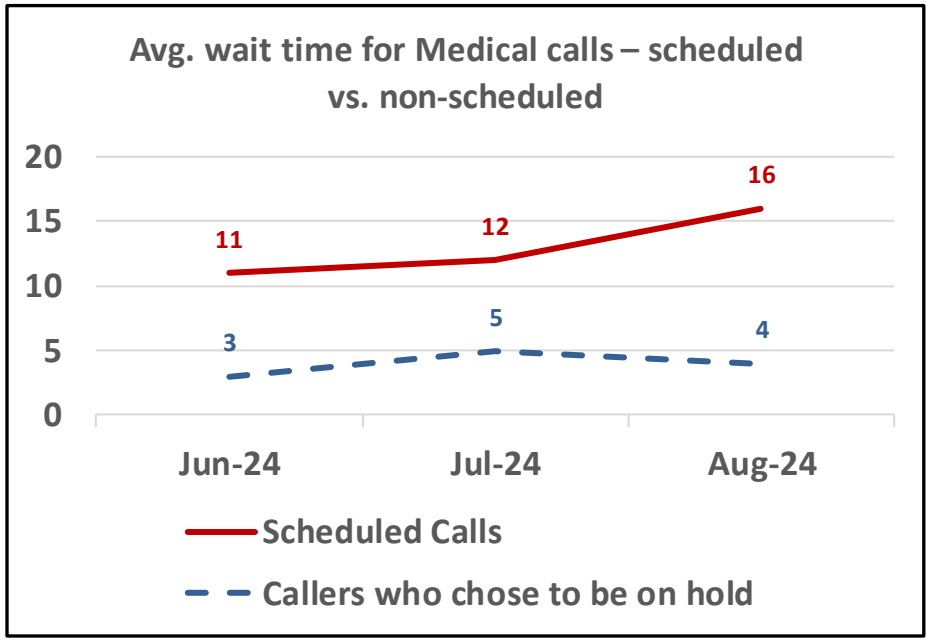
## Tier I and Tier II Average Wait Times (minutes) by Month - VHT and Non-VHT




*Note: VHT (Virtual Hold Technology) option not offered for Tier I Calls*

# Metrics for Calls Answered by Tier II DSS Eligibility Staff that were Medical




**74%** of Medical calls answered in Tier II on average were scheduled calls

**For August:**

- Out of 18,283 calls answered in Tier II
  - 3,272 were medical-related, as identified by Tier 1 staff who spoke with the caller

# Activities Underway to Improve Efficiency

- **IVR replacement** - The current telephony system was implemented in 2012 on the Avaya platform. It lacks modern access capabilities for our vulnerable populations where phone is the primary channel.
  - Upon implementation, the new system will reduce call wait and handle times due to increased capability of self-service options, omni-channel functionality (i.e., SMS texting and emails), knowledge management tool for staff, added functionality for effective management and tracking of calls.
- **Staffing** - Over 100 vacancies at present, even with refill of ~220 vacancies between October 2022 and June 2023. Vacancies have impacted the department's ability to meet the service demand. The eligibility role begins as an entry level position, and the division faces staffing challenges as entry-level staff are extensively trained and have ample promotional opportunities to other divisions within the agency and beyond.
  - Significant efforts are being pursued to address this by focusing on hiring dedicated, skilled staff, fostering a supportive work environment to improve retention, and by moving towards a recruitment plan to be able to refill and train continuously.
  - Postings have been published for eligibility positions.
- **Developing sustainable operational model** - During PHE unwinding, because of anticipated increases in demand and with the availability of associated funding sources, the agency piloted a new service delivery model by implementing a tiered model for the contact center for eligibility operations. This helped streamline routing of routine inquiries and the more complex calls regarding benefits updates and/or changes. The tiered model has been successful in reducing call wait times.
  - As federal PHE unwinding funds have begun to phase out, the agency has begun scaling back on vendor call center staffing supports, which has contributed to the increase in call wait times.
  - DSS has maintained efforts to mitigate this challenge while continuing to explore the appropriate operational investments to address the increasing demands on eligibility operations.
- **Automation to improve interface between AHCT's HIX and DSS' ImpaCT system** – Varied efforts to minimize duplicative manual data entry through process automation.
  - Automation efforts are in progress and will be completed this year. This will improve staff efficiency.

# Activities Underway to Improve Efficiency

- **Leveraging SNAP data for Medicaid *ex parte* renewals**
  - Connecticut has taken advantage of federal authorities to incorporate SNAP income data into our *ex parte* (passive) renewal process
  - When an individual has recently verified their gross income through SNAP, the system will use that data when assessing whether the individual can be automatically renewed for Medicaid
  - When more individuals are renewed automatically, it frees up operational capacity to support other workstreams and improves overall operational efficiency
  - This is a temporary authority that runs through June 2025; DSS is in conversations with CMS about ways that the state may be able to make this a permanent feature of the eligibility process

- **Ongoing use of Medicaid (e)(14) waiver authority to streamline renewal processes for eligible households**
  - In addition to the SNAP income data authority, CMS has given Connecticut permission to automatically renew individuals who have reported having zero income and there are no data sources with reported income
  - CMS has also permitted Connecticut to continue using the National Change of Address (NCOA) database to help ensure updated contact information when communicating with enrollees by mail

# Agenda

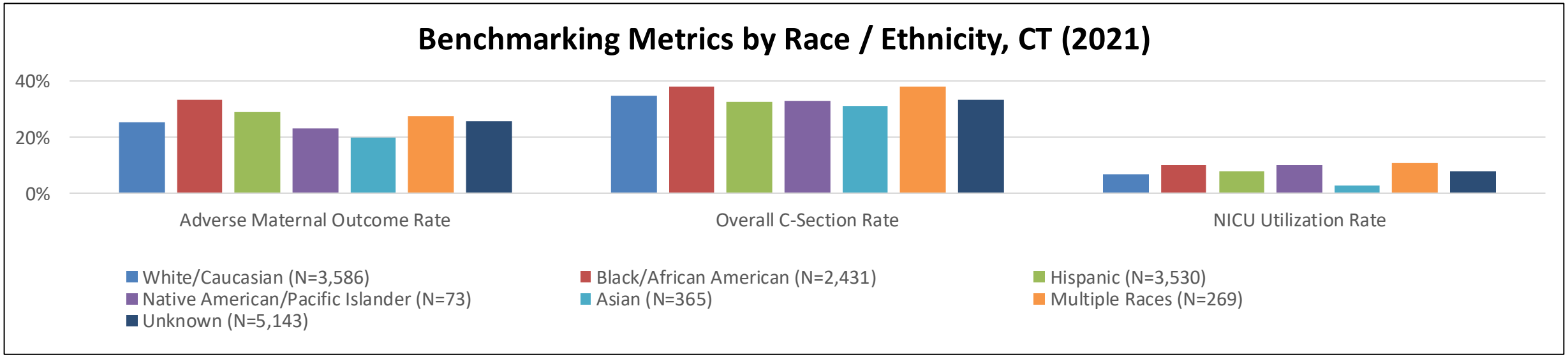
HUSKY Maternity Bundle Payment Program

- Reminder: Overview of Maternity Bundle Program
- Update: Launch Date and Current Priorities

# Connecticut's Starting Point in Maternal and Infant Health

Since 2021, DSS has been working with a diverse group of stakeholders to address **disparities of access, utilization and outcomes for pregnant individuals**, with an **emphasis on birthing people of color**, through development and implementation of a **Medicaid maternity bundle** program.

- 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]




**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 (Sept 2020)

# Program Goals

- **Strengthen maternal health** in Connecticut Medicaid through improved quality of care
- **Promote health equity** through program design and health disparity reduction targets
- **Improve health outcomes** with enhanced flexibility to deliver person-centered care
- **Incentivize high quality care** through performance-linked quality measures
- **Increase patient satisfaction** with new coverage of community-based, peer resources
- **Reduce unnecessary costs** through greater efficiency and care coordination

# Program Overview

**Program Start Date:** January 1, 2025

**Eligible Providers:** Maternity practices who deliver 30 or more births per year

**Key Design Components:**

- Provider-specific **"case rate" payments** to encourage flexibility in care delivery
- Episode cost calculated through **retrospective reconciliation**
- **Quality measures** to ensure high-quality care and improvements in care
- **Social and clinical risk adjustment** to reward providers who care for Medicaid members with greater social and health needs

**Program Highlights:**

- New coverage of **doula and lactation support** services
- Opportunity for **"incentive" payments** (shared savings) without downside risk

# Revised Launch Date

In response to stakeholder feedback, DSS is revising the launch date for the HUSKY Maternity Bundle Payment Program to **January 1, 2025.**

- This new payment model aims to strengthen maternal health and improve health outcomes for HUSKY Health members through improved quality of care and access, with an emphasis on reducing health disparities and improving the patient's care experience.
- To enable program success, DSS values providers as critical partners in this initiative and has aimed to incorporate and be responsive to stakeholder feedback throughout the design and implementation process.
- After careful consideration, DSS has decided to update the launch date of the program to enable consideration of program refinements and provide additional provider resources and guidance in response to stakeholder feedback.

# Program Status Update

With the revised launch date, DSS will continue to engage stakeholders throughout this period, providing additional information and opportunities for providers to ask questions and share feedback.

## Recently Accomplished

- ✓ Actuarial Modeling & Program Testing
- ✓ Draft Case Rates
- ✓ Historic Performance Reports
- ✓ Provider Resources: Video Guides and FAQs

## Current Priorities

- ✓ Consideration of Program Refinements
- ✓ Updated FAQ
- ✓ Quality Measures Reference Guide
- ✓ Billing Example
- ❑ CMS State Plan Amendment (SPA) Approval

## Upcoming

- ❑ Provider Bulletin of Payment Policies and Processes
- ❑ Final Performance Year Case Rates
- ❑ Performance Year Provider Reports

More information about the HUSKY Maternity Bundle can be found at this website: [https://portal.ct.gov/DSS/Health-And-Home-Care/HUSKY-Maternity-Bundle](https://portal.ct.gov/DSS/Health-And-Home-Care/HUSKY-Maternity-Bundle)

# Program Status Update

DSS has aimed to be responsive to stakeholder input throughout the program's design process and looks forward to continuing close engagement with all stakeholders during the upcoming program launch and implementation.

| Month | Stakeholder Meeting | Communications Materials |
|---|---|---|
| **January** | Maternity Bundle Advisory Council | |
| **February** | Provider Forum | |
| **March** | Provider Office Hours | Historic Draft Case Rate Letter, Maternity Bundle Overview & Glossary Document, Case Rate Video Guide |
| **April** | Provider Office Hours | Program Overview Video Guide |
| **May** | | Case Rate FAQs |
| **June** | Provider Forums (2) | Historic Provider Performance Reports, Historic Performance Report Video Guide, Doula Add-On Payment Opt-Out Form |
| **July** | Individual Practice Meetings | Program FAQs |
| **August** | Provider Office Hours (2) | Revised Launch Date Announcement, Supplemental Case Rate Data Letters |
| **September** | MAPOC, Provider Forums (2) | Updated Program FAQs, Updated Code List, Quality Measures Guide, Billing Example |

# Current Priorities: Program Updates in Response to Feedback

In June and July, various providers raised valuable questions and requests for program refinements, as well as additional provider resources.

- **DSS has carefully considered all stakeholder requests** – from less substantive technical adjustments to more substantive programmatic changes – and has determined an approach to integrating stakeholder feedback on each request.
- Throughout this process, DSS has aimed to be responsive to provider feedback while balancing the integrity of the program's goals and recognizing the Department's operational capabilities.
- **Today, we will review key feedback and highlight program updates DSS is making** in response to stakeholder feedback.

# Provider Requested Program Refinements

Fully Responsive

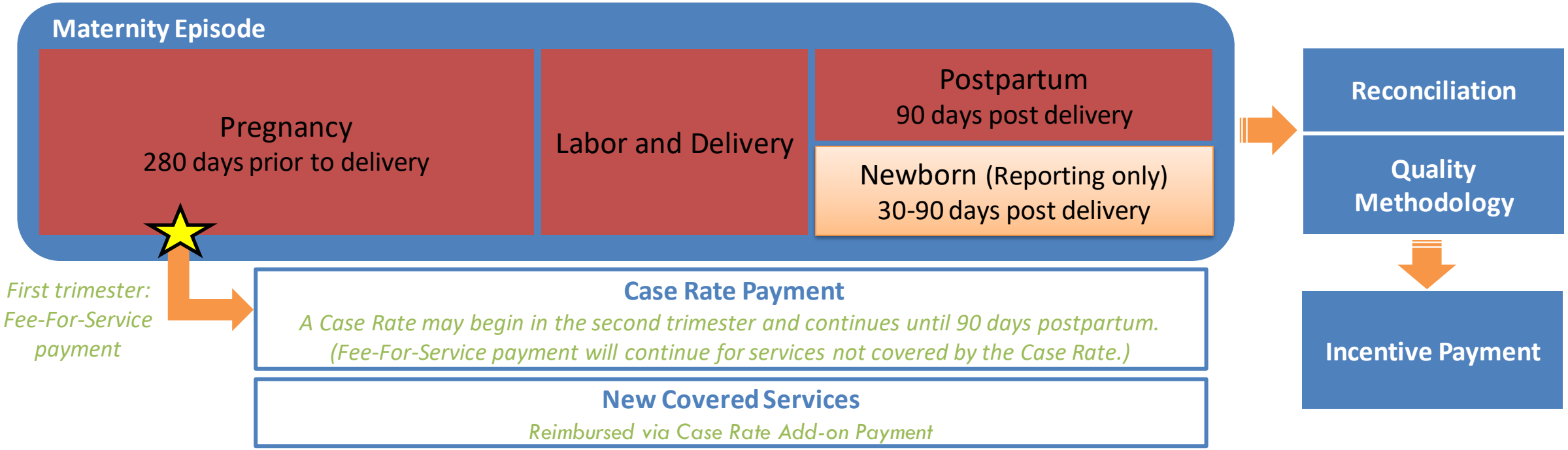
Partially Responsive

| Topic | Provider Feedback | DSS Update |
|---|---|---|
| **Doula Add-On Payment** | Allow practices to opt out of the doula add-on payment | **DSS accepted this request and enabled providers to opt out** of receiving the doula add-on payment this summer. |
| **Family Medicine** | Primary care services delivered by Family Medicine providers may be included in case rate payments | **DSS will exclude Family Medicine physicians and Family Nurse Practitioners** to ensure that non-maternal health care services delivered by Family Medicine providers are not unintentionally incorporated in the case rate. |
| **Third Party Liability (TPL)** | Commercial global billing & DSS case rate billing conflict for members with TPL | **DSS will pay claims with a TPL paid amount using standard fee-for-service (FFS) processes** (e.g., the program will exclude members with TPL) to minimize disruption and streamline billing processes for providers. |
| **Case Rate Services** | The inclusion of codes related to general preventive care are not aligned with the goals of inclusion. | **DSS will exclude the comprehensive preventive medicine E&M codes** 99381-99397 from case rate development to ensure non-maternal health care services are not unintentionally incorporated in the case rate. |
| **Maternal Fetal Medicine (MFM)** | Since MFMs provide higher cost services to higher risk patients, Accountable Providers will need to determine how to allocate case rate revenue for MFM care. | DSS will include MFM providers to ensure the program's inclusion of higher risk patients, and **DSS will provide supplementary provider-specific data** in the PY 1 case rate refresh report to support providers in understanding what portion of the case rate is associated with services delivered by an MFM within their TIN. |
| **Case Rate Reconciliation** | Reconcile Year 1 case rates if case rate revenue is less than FFS revenue | If DSS accepted this request, federal authority and state budget constraints would require the state to conduct an upside and downside reconciliation, which would create more harm than benefit to providers. **DSS will monitor changes in member access, practice revenue, and billing patterns** to preserve HUSKY Health access to care and to ensure financial stability for practice. |

# Appendix: Program Overview

# Maternity Episode

An episode of care describes the total amount of care provided to a patient during a set timeframe. In this program, the maternity episode includes services across all phases of the perinatal period, spanning 280 days before birth to 90 days postpartum.




## Maternity Episode Services

See the full list on the following slide.

**Pregnancy**

- Monthly prenatal visits
- Routine ultrasound
- Blood testing
- Diabetes testing
- Genetic testing
- Doulas
- Care navigators
- Group education meetings
- Birth education classes
- Preventive screenings (chlamydia, cervical cancer, etc.)

**Labor & Delivery**

- Vaginal delivery
- C-section delivery

**Postpartum**

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

# Case Rate Payments

Accountable providers will receive monthly case rate payments for a subset of prenatal and postpartum services.

- **What?** For a subset of services, DSS will make monthly "case rate" payments for the majority of prenatal and postpartum care that a birthing person receives.
  - Each provider's initial case rate is based on historical second trimester, third trimester, delivery (if performed by the accountable provider), and postpartum claim expense for historically attributed episodes.
  - The rates will be rebased, not more frequently than once every 12 months.
  - A case rate may begin in the 2nd trimester. Claims submitted in the first trimester will be paid fee-for-service.
  - If/when a different provider takes over the patient's case within the second or third trimester, the case rate for the original accountable provider will cease.
- **Who?** Case rate payments will be paid to the accountable provider to which the birth is attributed.
- **Why?** DSS designed the maternity bundle's case rate payment to give providers greater flexibility in how they deliver care.

# Maternity Episode Services

| Included Services | Excluded Services |
|---|---|
| ➢ OB/licensed midwife Professional Services<br>➢ ***In-house*** OB/licensed midwife Professional-related hospitalization costs (Inpatient, Outpatient, and ED) including professional delivery fees<br>➢ OB/licensed midwife Professional-related Behavioral Health Evals, including screening for depression and substance use<br>➢ Screenings (general pregnancy, chlamydia, cervical cancer, intimate partner violence, anxiety)<br>➢ ***In-house*** OB/licensed midwife imaging<br>➢ ***In-house*** labs and diagnostics<br>➢ Prenatal group visits<br>➢ Birth education services<br>➢ Care coordination activities<br>➢ Any of the above services provided via telehealth<br>• *If performed outside the participating Accountable Provider:* OB/licensed midwife imaging & labs<br>• Birth Centers and hospital costs related to maternity care<br>• Specialist/Professional Services related to maternity (e.g., anesthesia)<br>• General Pharmacy related to maternity | • Pediatric Professional Services<br>• Neonatal Intensive Care Unit (NICU)<br>• Behavioral Health & Substance Use services<br>• Long-acting reversible contraception (LARC)<br>• Sterilizations<br>• DME (e.g., blood pressure monitors, breast pumps)<br>• High-cost medications (specifically, HIV drugs and brexanolone)<br>• Hospital costs unrelated to maternity (e.g., appendicitis)<br>• Other Care, including Nutrition, Respiratory Care, Home Care, etc.<br>• Maternal Oral Health services |

**Key:** ➢ Services reimbursed and included in the Case Rate.
• Services reimbursed Fee-For-Service

# Target Price

The provider-specific target price is the expected total cost of care for the maternity episode based on a blend of the statewide average cost for maternity care and the provider's historical cost.

## Historical Price

- Calculate the average standardized* episode cost of all services by provider TIN.
- Winsorize outliers — set the total episode cost thresholds between the fifth and 99th percentile.
- Trending — utilize DSS' institutional knowledge regarding fee schedule changes, etc..

** Standardization includes applying standard fee schedule by diagnosis related group and severity level. This process will be used for inpatient hospitals and some other services, if applicable.*

## Risk Adjustment Factor

The historical year's risk adjustment factor, integrated with the Area Deprivation Index (an area-level measure of socioeconomic factor) will be used to risk adjust the historical price.

**State-wide Historical Price (50%)**

**Risk Adjusted Historical Price (50%)**

*Risk-neutral historical price by provider TIN*

**Base Price by Provider**

**Base Price by Provider**

**Performance Year Risk Factor**

*Risk adjustment factor of the performance year*

**Target Price by Provider**

# Quality Measures and Weights

This program has ten quality measures: five are pay-for-performance measures and five are pay-for-reporting measures.

## Pay-for-Performance (71% Total)

### 1 Cesarean Birth (24%)

The proportion of live babies born at or beyond 37.0 weeks gestation to women in their first pregnancy, via cesarean birth.

### 2 Postpartum Care (18%)

Measures rate of timeliness of postpartum care for the maternity bundle project.

### 3 Prenatal Care (12%)

Measures the timeliness of prenatal care for the maternity bundle project.

### 4 Low Birth Weight (12%)

The proportion of infants with the International Classification of Diseases codes for light for gestational age, small for gestational age, low birth weight, or intensive care units care for low birthweight infants on newborn records among all births.

### 5 Maternal Adverse Events (6%)

The proportion of deliveries > = 20 weeks gestation with any of 21 maternal morbidities plus maternal mortality occurring during the delivery hospitalization, risk-adjusted using claims data.

## Pay-for-Reporting (29%)

### 6 Contraception (6%)

The proportion of mothers with Live Deliveries that reported Contraceptive use within 90 days of Delivery

### 7 Preterm Birth/Labor (6%)

The proportion of preterm births/labors among the total number of live births

### 8 Doula Utilization (6%)

Proportion of births attended by a doula.

### 9 Breastfeeding (6%)

Assesses the proportion of newborns exclusively fed breast milk during the newborn's entire hospitalization.

### 10 Behavioral Health Risk Assessment (6%)

Proportion of patients who gave birth and received a behavioral health screening risk assessment at the first prenatal visit of those patients who gave birth and had at least one prenatal visit

# Quality Methodology and Scoring

## Performance Tier Score Calculation

**There are four steps to calculating the Performance Tier Score:**

- **Step 1:** Normalize each Pay-for-Performance Metric against the Historical year minimum and maximum values.
  - Pay-for-Reporting Metrics are assigned a value of 1 if data for the metric is present otherwise 0 if no data is present.
- **Step 2:** Invert the appropriate metrics such that a higher score is better.
- **Step 3:** Ensure that the metrics are within the boundaries of 0 and 1.
- **Step 4:** Utilize the metric weights to calculate a final composite, metric-weighted Performance Score.

## Improvement Tier Score Calculation

**There are three additional steps to calculate the Improvement Tier Score:**

- **Step 1:** The improvement tier score is calculated with the same steps as the Performance Tier Score, but from the Pay for Performance Metrics only.
- **Step 2:** Take the difference in the Current (2022) Pay-for-Performance Score from the Historical (2021) Pay-for-Performance Score.
- **Step 3:** Divide the difference between the Current (2022) and Historical (2021) scores to get the Improvement Tier Score.

## Percentage of Shared Savings Earned

- The Performance Tier Score and Improvement Tier Score are each cross-walked to a Percentage of Shared Savings Earned. **The maximum Percentage of Shared Savings Earned between the two scores is selected as the final Percentage of Shared Earning Earned**.

## Performance Tier Score

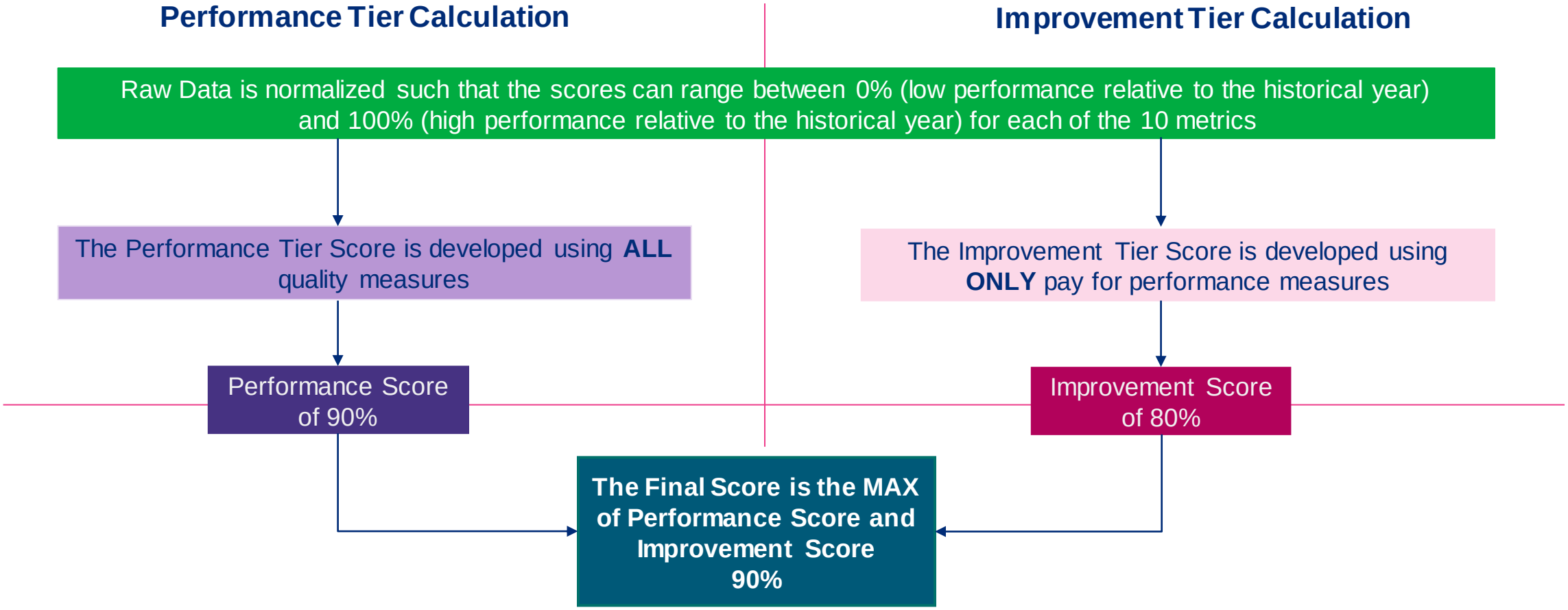
| Overall Performance | Performance Earnings Tier | Performance: % Shared Savings |
|---|---|---|
| < 55th Percentile of peer group | F | 50% |
| 55–60th Percentile of peer group | D | 60% |
| 60–70th Percentile of peer group | C | 70% |
| 70–75th Percentile of peer group | B | 80% |
| 75–80th Percentile of peer group | A | 90% |
| > 80th Percentile of peer group | S | 100% |

## Improvement Tier Score

| Improvement | Improvement Earnings Tier | Improvement: % Shared Savings |
|---|---|---|
| <0% | F | 50% |
| 0–3% | D | 60% |
| 3–5% | C | 70% |
| 5–10% | B | 80% |
| 10%+ | A | 90% |

# Quality Methodology Example

The distribution of incentive payments will be adjusted based on the accountable provider's quality performance. The example below illustrates how DSS will produce the final quality score.



# Quality Gate Check

- Accountable providers who fall into Tier F for both the Performance Earnings Tier and the Improvement Earnings Tier will be required to submit a quality improvement plan in order to earn incentive payments.
- In the subsequent year, if an accountable provider consecutively maintains quality performance in Tier F for both tiers, the provider will be ineligible for the incentive payment that year.