Agenda

HUSKY Maternity Bundle Payment Program

Follow up to Last Month's Meeting

Follow-up to Last Month's Meeting

At the September MAPOC meeting, we:

- Provided an overview of the Maternity Bundle Payment Program
- Provided an update on the program launch date and key program implementation priorities
- Reviewed recent stakeholder requests and DSS' approach to integrating stakeholder feedback

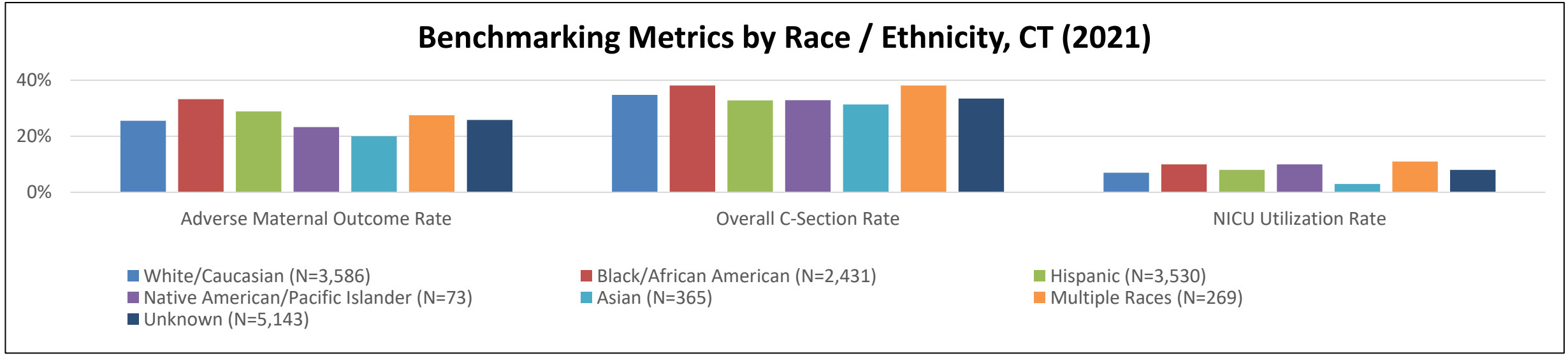
Today, we plan to provide more in-depth details about DSS' response to stakeholder requests raised at the last meeting – and answer any other questions this committee has about the program.

Connecticut's Starting Point in Maternal & Infant Health

Reminder

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

Reminder

- **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

Reminder

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

Program Status Update

Reminder

DSS will launch the Maternity Bundle Payment Program on January 1, 2025.

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

Current Priorities: Program Updates in Response to Feedback

Reminder

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.

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	Exclude Family Medicine providers to ensure primary care services are not included in case rate payments	**DSS accepted this request and 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)	Simplify billing processes for members with TPL - case rate billing will create administrative complexity for providers billing global code for members with TPL	**DSS accepted this request and 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	Exclude codes related to general preventive care	**DSS accepted this request and 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)*	Exclude MFM providers since they provide higher cost services to higher risk patients	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.
Program Appeal Rights*	Give practices the right to appeal their case rates	Similar to PCMH+, **DSS will provide practices with the option to request a desk review for incentive payments only.**

Requests raised at the last meeting, which we will provide more detail on today

Case Rate Reconciliation

Ensuring member access to affordable, high-quality care is a key value that underpins all HUSKY Health programs. As such, this payment model was designed to increase investment in maternity care providers.

DSS Work to Date

- DSS **rigorously developed the case rate payments** based on each practice's historic utilization and FFS billing. DSS also tested case rate payment through the program's **historic simulation** and a **separate fiscal impact analysis**.
- DSS anticipates that there will be an **opportunity for providers to earn additional revenue** through the case rate payment - this program is expected to add approximately $2.5 million in SFY 2025, $6.2 million in SFY 2026, and $6.3 million in SFY 2027.
- In addition, participating providers will also be eligible to receive **additive funding through lactation support add-on payments** ($7 per-member-per-month payments) and **upside only shared savings payments** for delivering high-quality, cost-effective services.

Case Rate Reconciliation

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 participating practices.

Policy Decision & Rationale

DSS does not plan to make upward or downward adjustments to reconcile case rate and FFS claims.

- If DSS were to implement the case rate true up, **federal authority and state budget constraints would require the state to conduct an upside and downside reconciliation**, which may create more **harm than benefit** to providers.

DSS Plan of Action

- **Case Rate Data:** In March, DSS provided draft provider-specific case rates to all participating providers along with detailed specifications documenting how rates were developed. To be responsive to requests for additional data, DSS distributed supplementary provider-specific data in August illustrating how the case rate was developed.
- **Program Monitoring:** DSS will also monitor changes in member access, practice revenue, and billing patterns after program implementation to ensure that the roll-out of case rate payments occurs as designed and to preserve HUSKY Health access to care.
- **Rate Rebasing:** DSS will rebase the case rates no more than once annually, based on risk adjustment and trend factors, to account for changes in risk mix or service delivery over time.

Program Appeal Rights

After rigorous rate development and testing, DSS has provided ample data to help practices understand how their case rate was developed.

Policy Decision & Rationale

DSS will not provide practices with the right to appeal their case rates.

- This decision is consistent with the context that there are generally not formal appeal rights for most non-institutional provider types, such as the Maternity Bundle's participating provider types (physicians, certified nurse midwives, advanced practice registered nurses, and physician assistants).

DSS Plan of Action

- **Similar to PCMH+, DSS has provided a desk review for incentive (shared savings) payments**, as outlined below:
  - At the end of each performance year, the Department shall provide each accountable provider with quality measure performance results and the details of their incentive payment calculation.
  - After receiving this information from the Department, the accountable provider may respond, in writing within 30 days of receipt of information, to any calculations, results, or decisions contained therein.

Maternal Fetal Medicine (MFM) Provider Inclusion

After careful consideration of potential operational and actuarial consequences, DSS has confirmed its decision to include MFM care within the Maternity Bundle for Year 1.

Policy Decision & Rationale

DSS will include MFM care to align with the following goals:

- To align incentives across OB provider specialties
- To ensure the inclusion of higher risk patients in the program
- To reduce complexities in program design and operations related to MFM billing and the impact of attribution changes

Provider Implications

- **In-house MFM services (i.e., provided within the Tax ID) will be reimbursed by the case rate.** Since MFM is an OBGYN subspecialty, MFM providers typically bill under the OBGYN billing provider specialty type, which qualifies in-house MFM providers to receive case rate payments.
- **External MFM services provided by a participating Maternity Bundle provider (i.e., provided under a different Tax ID than the OB practice) may receive the case rate payment** if a claim with trigger codes is submitted, and the service occurs in an office setting. As long as both providers bill with a trigger event, the OB and MFM may both receive case rate for the months that patient care is provided.

Attributing Costs to MFM Providers

DSS recognizes that accountable providers will need to determine how to allocate case rate revenue and will provide supplemental data to support this process.

Stakeholder Feedback

- MFMs typically provide higher cost services to higher risk patients. Accountable providers will need to determine how to allocate case rate revenue by practice and/or provider to ensure MFMs are adequately reimbursed for these services.

DSS Plan of Action

- **DSS will provide supplementary provider-specific data as part of 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.**
- DSS recognizes that accountable providers may need to modify their accounting practices to appropriately allocate case rate revenue by practice and/or provider; supplementary data is intended to support providers in operationalizing any accounting practice changes that need to occur.

Doula Care Add-on Payment Opt-Out

In response to provider feedback, DSS will give providers the option to opt-out of receiving doula care case rate add-on payments.

Policy Decision & Rationale

DSS will allow providers who do not intend to contract with doulas in Year 1 to opt-out of receiving the $14/month doula care case rate add-on payment.

- The doula care case rate add-on payment will be subject to a retrospective true-up process that identifies the actual amount of doula services accessed during the performance year.
- DSS is providing this opt-out to minimize administrative burden for providers who do not intend to contract with doulas in Year 1.

DSS Plan of Action

- Prior to the establishment of the Year 1 case rate, providers must report to DSS if they are opting out of receiving the add-on payment; no mid-year changes will be allowed.
- All providers received outreach from their CHNCT, Inc. Provider Engagement Services (PES) representative, and providers reported their case rate add-on payment opt-out decision to their PES representative by July 10, 2024.

Family Medicine Exclusion

Stakeholder Feedback

- Primary care services delivered by Family Medicine providers to pregnant members will be included in case rate payments because these services are typically billed with qualifying case rate codes. This will result in the inclusion of non-maternal health care services in the case rate.

DSS Decision and Rationale

- **DSS will update the program design to exclude Family Medicine physicians and Family Nurse Practitioners.**
- The Maternity Bundle program is intended to focus on payment for maternal health care services.
- While Family Medicine providers can provide obstetrics care, additional actuarial analysis and discussion with providers suggests that few Family Medicine providers are providing obstetrics care in CT.
- By excluding Family Medicine providers, DSS aims to simplify billing processes for providers, and ensure non-maternal health care services delivered by Family Medicine providers are not unintentionally incorporated in the case rate.

Billing for Members with TPL Coverage

Stakeholder Feedback

- Providers are constrained by other payer requirements when billing for members with Medicaid as secondary coverage. It will be particularly challenging for providers to trigger case rate payments for members with TPL coverage when the primary payer uses global code billing.

DSS Decision and Rationale

- **DSS will pay claims with a TPL paid amount using standard FFS processes. Providers who currently bill global code for members with Medicaid as secondary coverage can continue billing for these members using global code instead of triggering case rate payments.**
- DSS recognizes the importance of multi-payer alignment and understands that providers are constrained by other payers' billing requirements when billing for members with TPL. To minimize disruption and simplify billing processes for providers, DSS will continue to pay claims with a TPL paid amount using standard FFS processes.

Stakeholder Feedback

- The inclusion of codes related to preventive pediatric and adult care (e.g., annual physical exams) are not aligned with the goals of inclusion.

DSS Decision and Rationale

- **DSS will exclude the comprehensive preventive medicine evaluation and management codes 99381-99397 from Case Rate development.**
- Codes for preventive medicine were removed to ensure non-maternal health care services are not unintentionally incorporated in the case rate.

Post Implementation Stakeholder Engagement

Stakeholder Engagement

- Stakeholder and provider engagement meetings will occur post implementation
- DSS is interested to hear from members related to access and their experience
- DSS is interested to hear from providers on all aspects of the model, including but not limited to:
  - Billing
  - Payment
  - Patient flow changes (if any)
  - Early process or patient improvement
  - Early challenges

Appendix:
Program Overview

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.

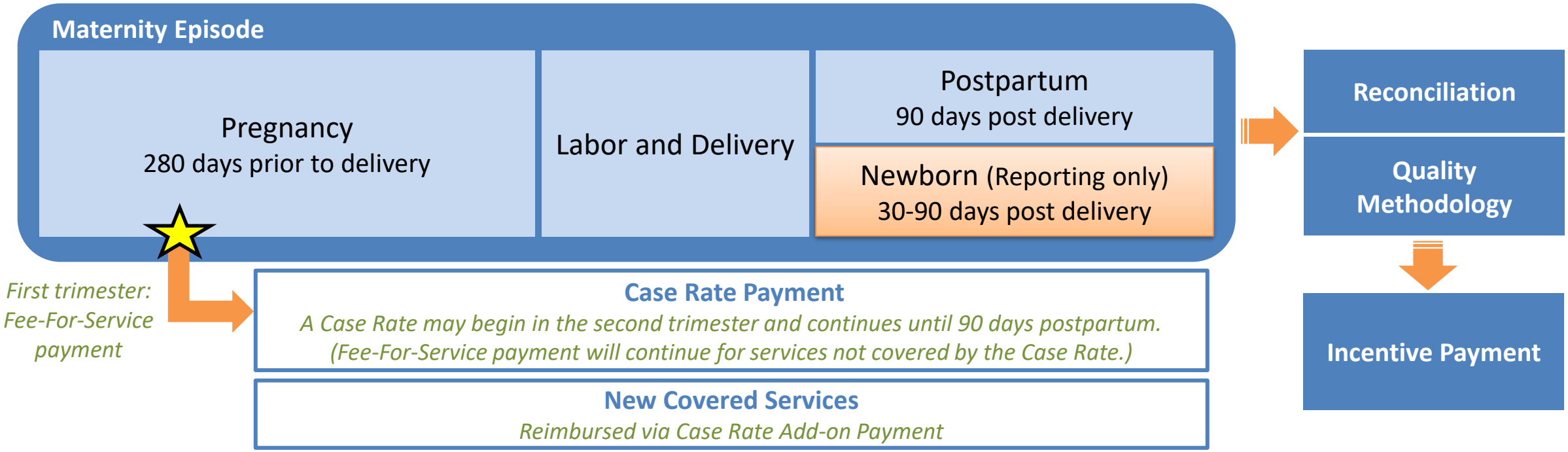
Stakeholder Engagement to Date

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

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

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

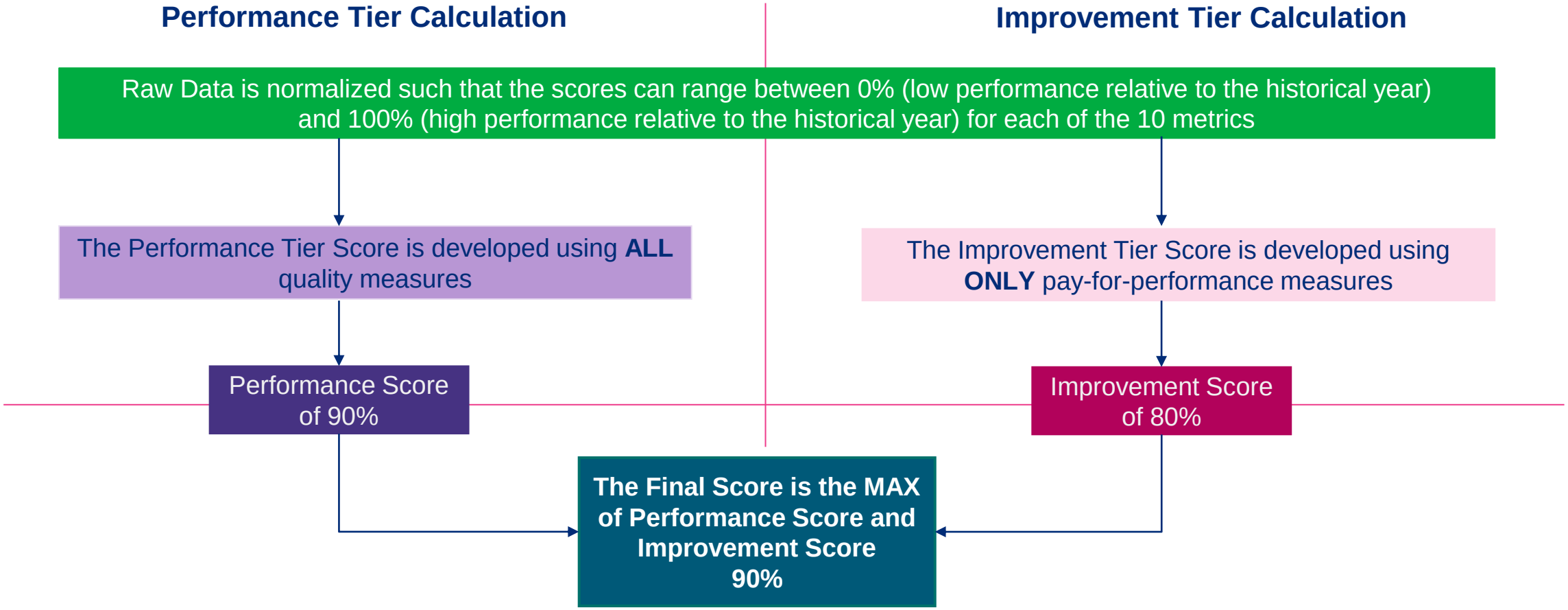
Overall Performance	Performance Earnings Tier	Performance: % Shared Savings
< 55th Percentile of peer group	F	50%
55–60th Percentile of peer group	D	60%
60–70th Percentile of peer group	C	70%
70–75th Percentile of peer group	B	80%
75–80th Percentile of peer group	A	90%
> 80th Percentile of peer group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