

HUSKY Maternity Bundle Payment Program

Provider Forum Meeting

February 14, 2024



Welcome to the HUSKY Maternity Bundle Provider Forum

Please see the meeting's ground rules below.

 This forum will be recorded and posted to the [DSS Youtube channel](#). Meeting materials will also be posted on the DSS [Maternity Bundle website](#).

 If you are not speaking, please mute yourself.

 Please limit use of the Chat for Zoom technical and audio issues only.

 Please Q&A feature to post questions anonymously.

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Program Overview



Program Status Update

DSS anticipates implementing the HUSKY Maternity Bundle Payment Program on **September 1, 2024**, pending federal approval.

- It is possible that DSS may be able to launch the bundle payment program earlier than this date but will not do so without giving a 3 month notice to providers if launching earlier than September 1, 2024.

Current Priorities

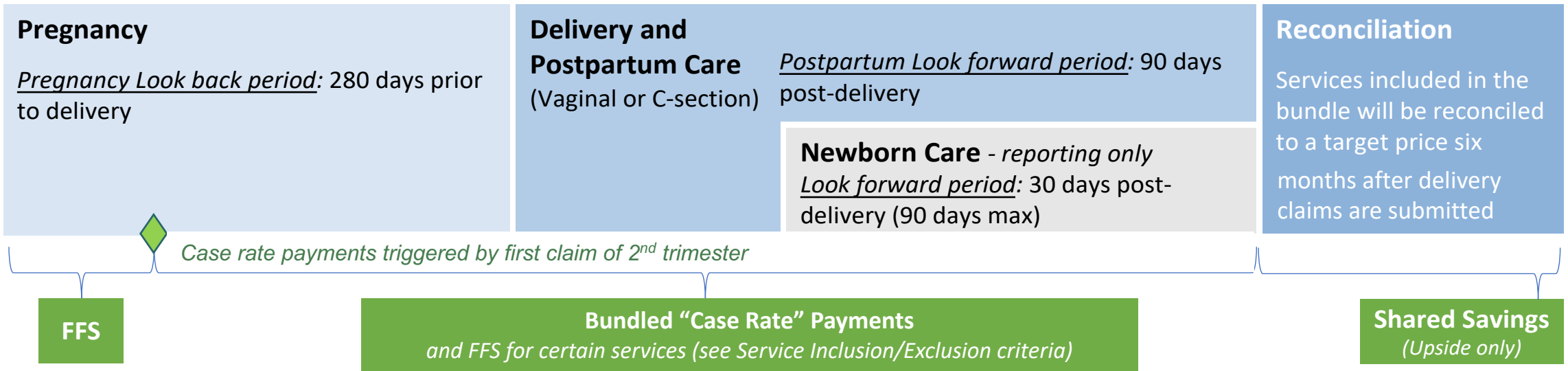
- CMS State Plan Amendment (SPA) Approval
- Actuarial Modeling & Program Testing (dry run of 2022 claims)
- Program Readiness

Upcoming Work

- Draft Provider-Specific Case Rates
- 2022 Provider Historic Performance Reports
- Provider Bulletin of payment policies and processes
- Additional Provider Forums & Advisory Council Meetings
- Provider FAQs
- Resources for Lactation Support & Other Services

Reminder: DSS Maternity Bundle Overview

An episode of care describes the total amount of care provided to a patient during a set timeframe. In this program, the “**Maternity Bundle**” episode includes services across all phases of the perinatal period (prenatal, labor & delivery, postpartum), spanning 280 days before birth and 90 days postpartum.



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

*To align with HUSKY’s expanded 12-month of postpartum coverage (effective April 1, 2022), DSS will conduct reporting on services provided within 365 days post-delivery to inform whether to include a 12-month postpartum period in the bundle’s financial reconciliation bundle after Year 1 or later.

The HUKSY Bundle Payment Program will automatically include all outpatient Obstetrics (OB), Licensed Midwife, and Family Medicine practices in CT's Medicaid program that meet the minimum volume criteria.

Type of provider

- **Episodes can be attributed to provider groups.** Providers are typically grouped under a Tax ID number.

Minimum episode volume

- Eligible providers must meet the minimum episode volume threshold: **30 episodes in the past 12 months.**
- Providers who are under the minimum episode volume will be excluded from the program and paid fee-for-service for all services rendered.

Bundle attribution

- Each episode is initially **attributed to the practice reporting a triggering diagnosis code** for the case rate payment.
- The attributed provider may change if another provider takes over care for the patient, as determined by another claim with a triggering diagnosis code from the new provider.
- For reconciliation, episodes will be attributed to the practice group that reported the most recent triggering diagnosis code, assuming that they were the provider throughout the remainder of prenatal care.
- Episodes with a change in care provider during the third trimester will be excluded from shared savings and cost calculations.
- Pregnancies for maternity providers that provide care during the prenatal period but do not perform the delivery are planned for inclusion.

Additional Building Block Design Components

Newborn Care: In Year 1, the program will include 30 days of newborn care (capped at 90 days postpartum for outlier cases) in provider reporting. Over time, DSS will phase in newborn care for financial accountability.

Postpartum Care: In Year 1, the program will include 90 days postpartum in the bundle for financial accountability, while reporting on the postpartum period for 365 days.

Multiple Births: The program will include multiple births in the case rate payment paid based on a singleton birth. For retrospective reconciliation, multiple births will be excluded from the target price and effectively paid at fee-for-service rates to make up the difference in costs between a singleton vs. multiple birth.

Newborn Care

- For the purposes of the maternity bundle, newborn care is defined as services for the newborn from birth to 30 days following discharge from the facility.
- Use Year 1 learnings to inform Year 2 and beyond
- Including newborn care will support tying the impact of prenatal care to post-birth outcomes, including NICU utilization
- DSS will work with CHN to better match baby's and birthing person's records (90+% match rate to date)

Postpartum Care

- Use Year 1 learnings to extend to longer postpartum time period (365 days) in Year 2 or beyond
- Important to standardize provider reporting during the postpartum period
- Need to define exclusion criteria to guardrail against non-maternity adverse health events
- 90 days provides more support for lactation counseling in the extended postpartum period

With the goal to connect members with doulas as soon as possible, DSS will utilize a dual approach to provide and fund doula access: (1) paying doulas through the maternity bundle and (2) paying doulas fee-for-service directly.

Doula Payment Approaches:

1. Paying through the bundle

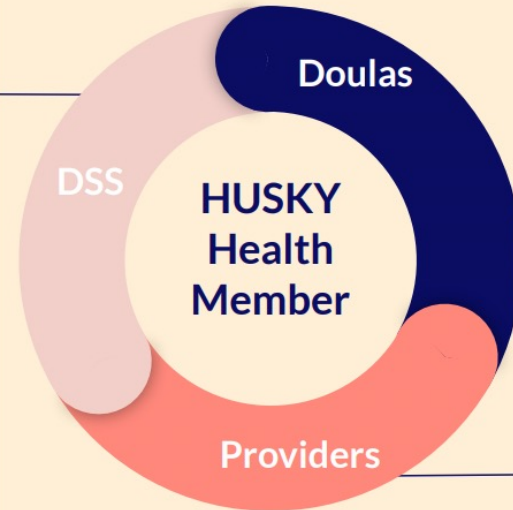
The picture to the right outlines envisioned roles and responsibilities for doulas to receive payment through the bundle.

2. Paying fee-for-service

DSS will initiate direct FFS payments to doulas on or after the launch of the maternity bundle, pending Department of Public Health’s doula certification, which is slated to begin in Fall 2023.

Integration Roles

- Pay a PMPM to providers
- Set bundle performance parameters
- Set reimbursement rate for doula services, paid to providers
- Provide draft supporting materials to facilitate provider + doula partnerships
- Pursuing parallel, direct FFS doula pathway pending DPH credentialing



- Engage with providers
- Meet DPH draft competencies
- Report visits + outcomes to providers
- Invoice provider for services

- Coordinate doula relationship
- Assist with member referrals
- Set practice doula rate + pay doulas
- Collect and report outcomes to DSS

Provider Attribution



Attribution Logic

Pre-Launch Attribution Logic: Three Stage Process

Stage 1: Global Codes

Episode attributing provider is determined by the billing provider of a maternal global CPT code:

- 59400
- 59510
- 59610
- 59618

Stage 2: E&M + Diagnosis

Otherwise, episodes are attributed under the following conditions:

- An E&M code was billed with a triggering second trimester diagnosis
- The patient has seen the provider at least one other time during the second or third trimester

Stage 3: E&M Volume

Else, episodes are attributed using the volume of prenatal and postpartum visits billed with an E&M code

Attribution eligibility is limited to a subset of provider specialties:

- Physician Family Medicine
- Physician Obstetrics and Gynecology
- Certified Nurse Midwife
- Nurse Midwife Group Certified Nurse Midwife
- Physician Group Family Medicine
- Physician Group Obstetrics and Gynecology
- Obstetric Nurse Practitioner
- Family Nurse Practitioner
- Women's Health Nurse Practitioner
- Obstetric Nurse Practitioner Group
- Family Nurse Practitioner Group
- Women's Health Nurse Practitioner Group

DSS anticipates future billing guidance for maternal care providers to specifically indicate episode responsibility.

Initial program attribution logic has been modified for the determination of eligible program providers and for historical experience needs.

Case Rate

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Case Rate

Prospective Payments

Prospective payments will be paid to attributed accountable provider based on historical second trimester, third trimester, and postpartum claim expense for historically attributed episodes.

- Case rate payments will begin for providers that indicate they are the primary maternal provider for the patient with a second or third-trimester claim. Payments will continue through 90 days postpartum (*Billing guidance TBD*)
- However, prospective payments will cease for a provider if/when a different provider indicates they are the primary maternal provider for the patient at a later point within the second or third trimester
- Case rate prospective payments are set to be the same for every episode per billing TIN, regardless of the current episode severity

Services to be Paid Prospectively

- OB/licensed midwife Professional Services
- **UPDATED:** OB/licensed midwife Professional-related hospitalization costs (Inpatient, Outpatient, and ED) **including professional delivery fees**, if performed by the eligible accountable provider
- OB/licensed midwife Professional-related Behavioral Health Evals, including screening for depression and substance use
- In-house OB/licensed midwife imaging
- In-house labs and diagnostics
- Screenings (general pregnancy screenings, chlamydia and cervical cancer, and screenings for IPV and anxiety)
- Doulas
- Lactation support (breastfeeding support is included with a broad spectrum of provider types, not limited to CHWs)
- Prenatal group visits
- Child education services
- Care coordination activities
- Any of the above services provided via telehealth

Case Rate

As part of the ongoing Actuarial Modeling & Program Testing (dry run of 2022 claims), DSS anticipates publishing provider-specific Case Rates before the end of Q1 2024.

- As noted in the previous slide, the provider-specific payment amount is based on historical second trimester, third trimester, and postpartum claim expenses and include delivery costs.
- An additional add-on payment of \$21/month will be provided to fund doula services and lactation supports.
 - Add-on payments for doula care and lactation supports will not impact opportunity for incentive payment earnings to encourage uptake of the new benefits.
 - Doula services and lactation supports will be excluded from incentive payment calculations, and doula services will be subject to a retrospective true up.

Draft Case Rate Distribution Plan

1. Case Rates Finalization

- DSS is currently completing the dry run's draft case rate calculation

2. Case Rates Publication

- DSS and CHN will mail providers their provider-specific case rate amount

3. Provider Engagement

- DSS, CHN, and Mercer will host a Provider Forum to answer your case rate questions

Target Price

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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.

Services Included in the Target Price:

- OB/Licensed Midwife Professional Services
- **UPDATED:** OB/Licensed Midwife Professional-related hospitalization costs (Inpatient, Outpatient, and emergency department), **including professional delivery fees**, if performed by the eligible accountable provider
- OB/Licensed Midwife Professional-Related Behavioral Health Evaluations, including screening for depression and substance use
- OB/Licensed Midwife imaging, labs and diagnostics
- Screenings (general pregnancy screenings, chlamydia and cervical cancer, and screenings for intrapulmonary percussive ventilator and anxiety)
- Birth Centers and hospital costs related to maternity care
- Specialist/Professional Services related to maternity (e.g., anesthesia)
- General Pharmacy related to maternity
- Prenatal group visits
- Child education services
- Care coordination activities
- Any of the above services provided via telehealth

Time Frame	Target Price
Pregnancy	Yes
Delivery	Yes
Postpartum	Yes
Newborn	Reporting only at program launch

Target Price

Case Inclusion/Exclusion Criteria

All beneficiaries are included unless they meet one or more of the following exclusion criteria:

- Age <12 or >55
- Mother left the hospital against medical advice prior to discharge
- Any substantial gap in enrollment or eligibility during the delivery episode
- Missing a facility claim in the episode (i.e., “orphan” episode)
- Baby is stillborn
- Miscarriage or abortion

The pregnancy, delivery, or newborn components of the maternity bundle can be excluded from the cases for target price and retrospective reconciliation for the following reasons. Note that payment will remain through the prospective payment for these cases.

- Pregnancy:
 - There were no claims incurred during the first two trimesters of the pregnancy (prospective payments may still be paid for the third trimester, but the pregnancy would be excluded from the retrospective reconciliation)
- Newborn (for reporting purposes only):
 - Baby was born with a serious congenital anomaly
 - Baby could not be linked with the delivery episode

Target Price

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 the institutional knowledge from CT Department of Social Services, such as fee schedule changes.

* Standardization includes applying average fee by diagnosis related group and severity level across providers. This process will be used for inpatient hospitals and some other services.

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%)

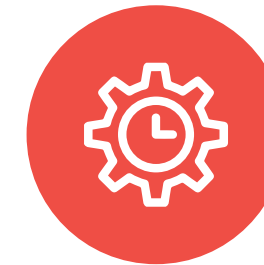
Risk-neutral historical price by provider TIN



Base Price by Provider



Base Price by Provider



Performance Year Risk Factor

Risk adjustment factor of the performance year



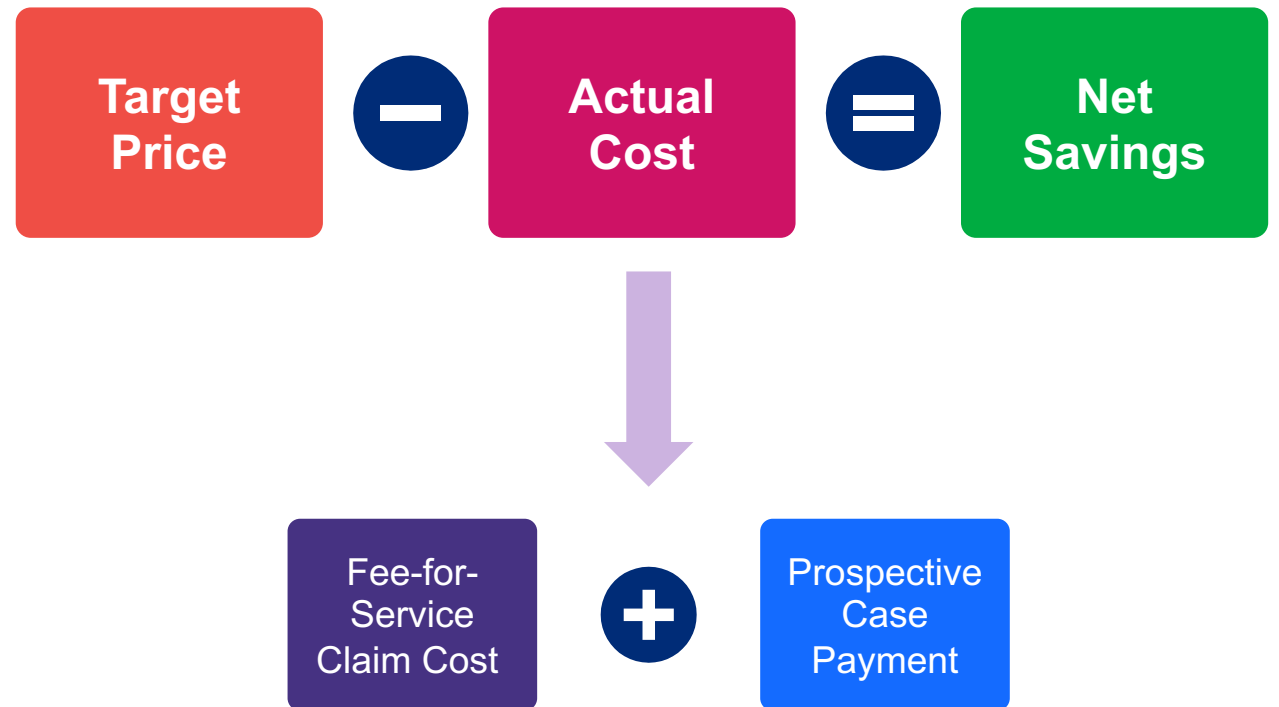
Target Price by Provider

Reconciliation

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Reconciliation

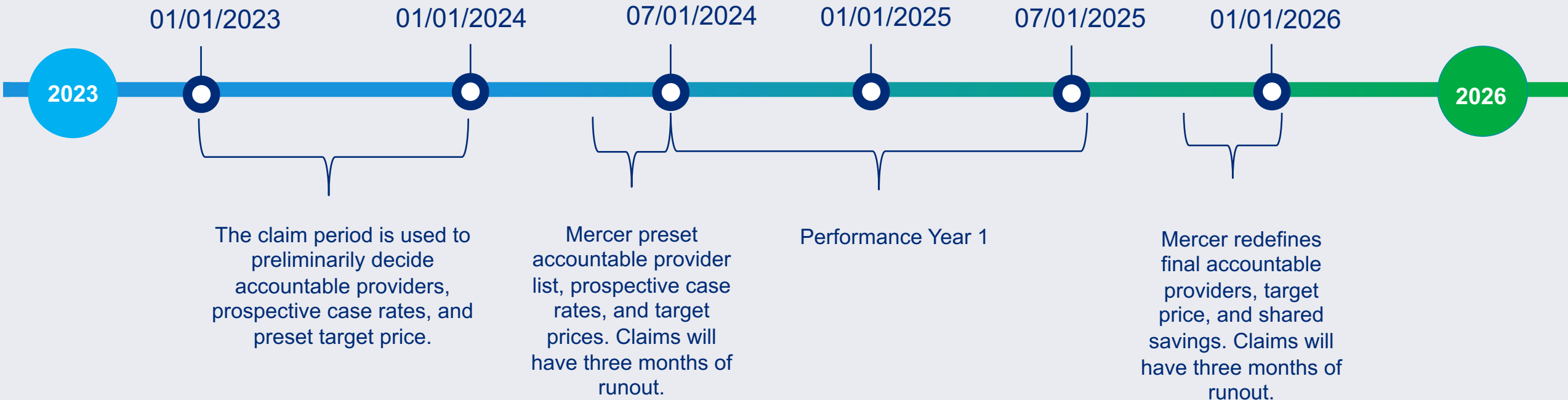
- Occurs no later than six months after the performance period ends.
- The total cost of care for services provided under the bundle will be compared to the target price.
- Bundles will be reconciled once per year with the provision of quarterly provider data reports.
- For year one, providers will not be responsible for losses, but will share a portion of savings based on their quality measure performance.



Reconciliation Timeline

Assuming Performance Year 1–July 1, 2024, to June 30, 2025

This timeline reflects an assumption of a July 2024 go live, however, should the final go-live date shift to September 2024 everything will shift by three months.

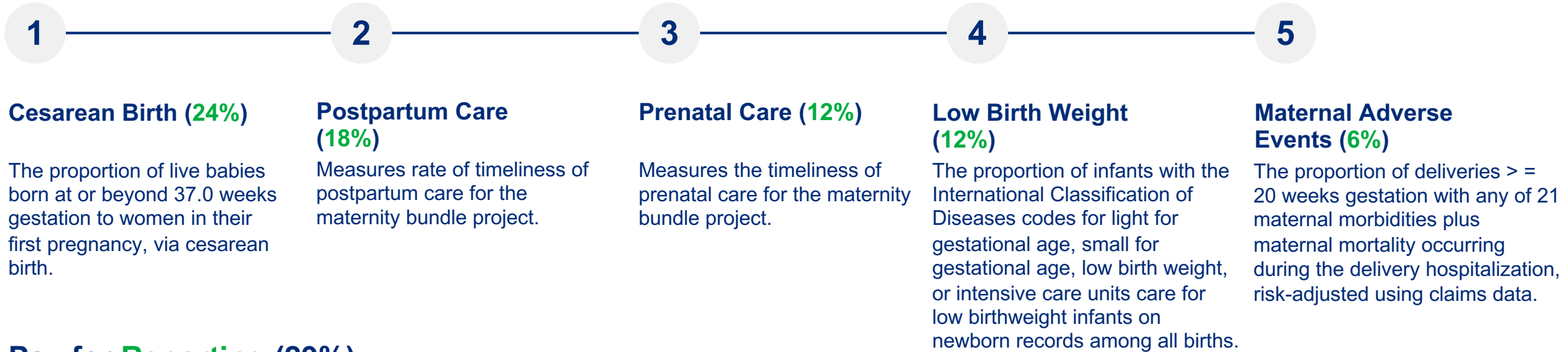


Quality Measure

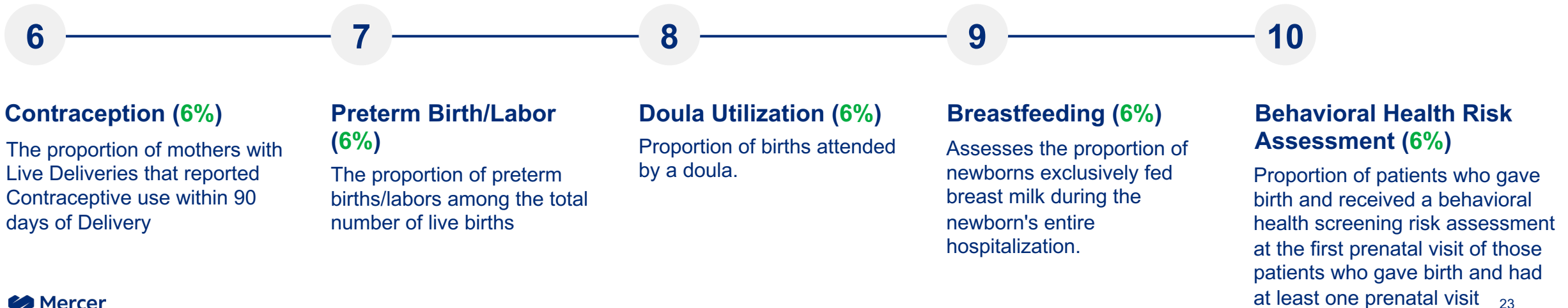
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Quality Measures and Weights

Pay for Performance (71% Total)



Pay for Reporting (29%)



Illustrative Methodology Example — Draft

Performance Tier Calculation

Improvement Tier Calculation

Raw Data is normalized such that the scores can range between 0% (low performance relative to the historical year) and 100% (high performance relative to the historical year) for each of the 10 metrics

The Performance Tier Score is developed using **ALL** quality measures

The Improvement Tier Score is developed using **ONLY** pay for performance measures

Performance Score
of 90%

Improvement Score
of 80%

The Final Score is the **MAX**
of Performance Score and
Improvement Score
90%

Methodology and Assumptions Overview — Draft

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.

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.**

Improvement Tier Score Calculation

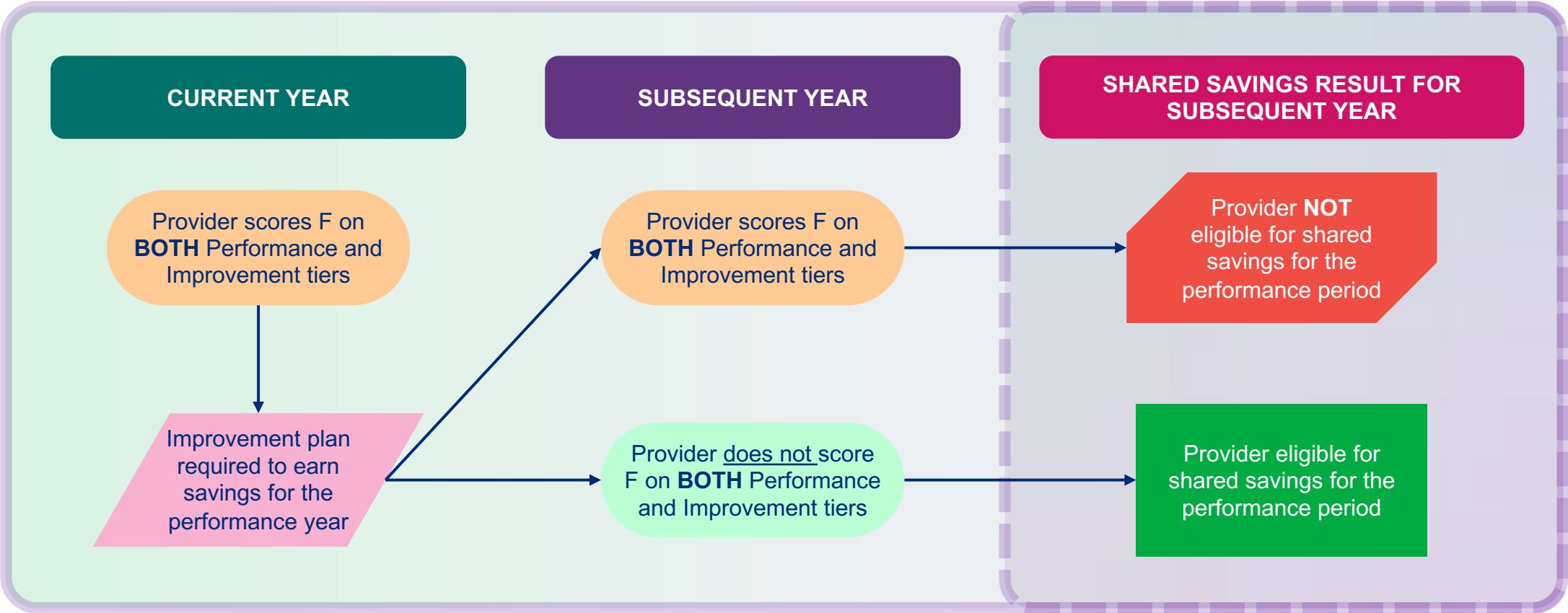
There are three additional steps to calculate the Improvement Tier Score:

- **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.

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

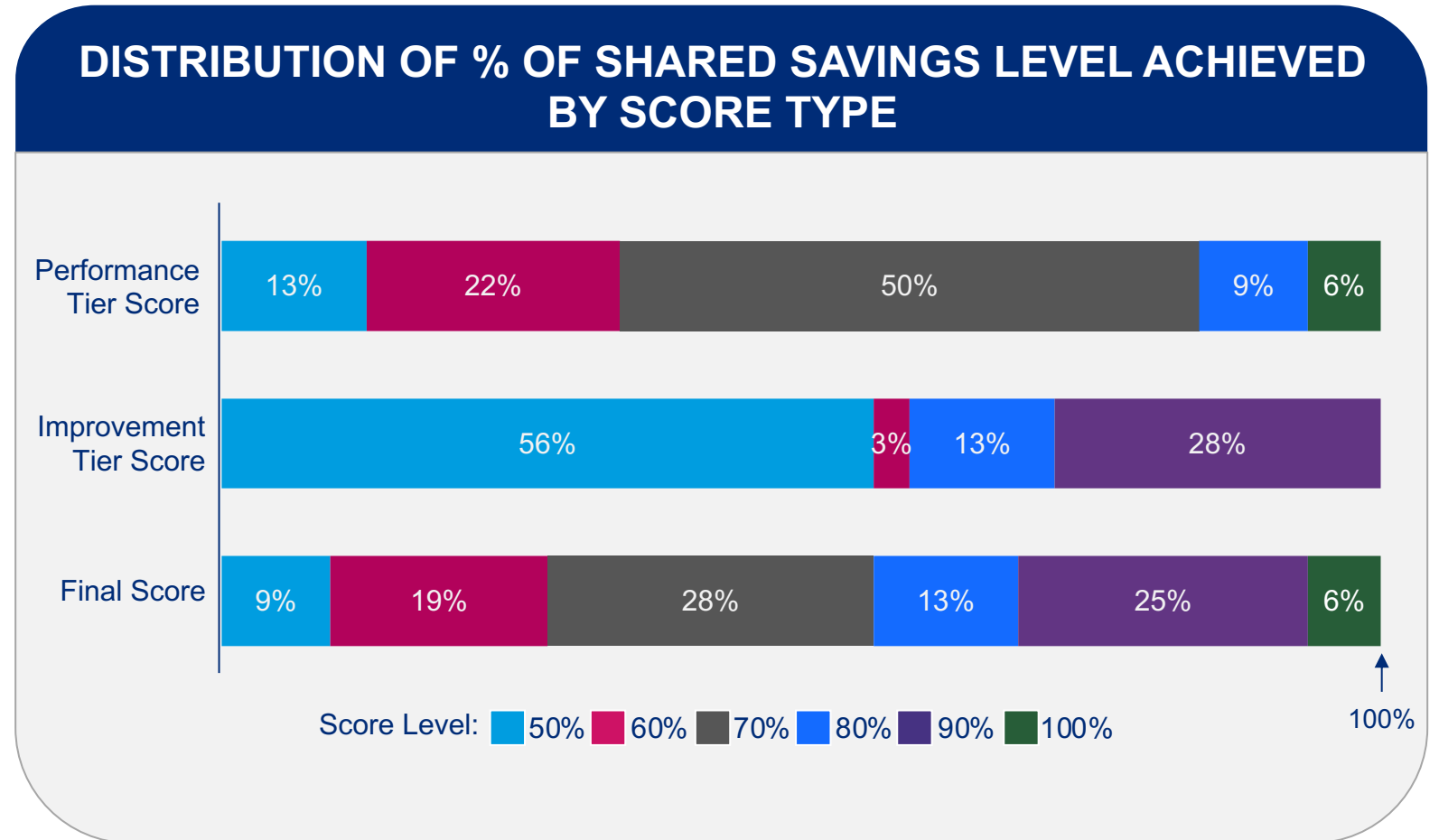
Improvement Tier Score		
Improvement	Improvement Earnings Tier	Improvement: % Shared Savings
<0%	F	50%
0–3%	D	60%
3–5%	C	70%
5–10%	B	80%
10%+	A	90%

Quality Gate Check — Draft



Model Results Observations — Draft

- 59% of providers would earn 70% to 80% of the Shared Savings using the Performance Tier score..
 - 59% of Providers did not improve or did worse than the prior year.
- The distribution of shared savings is well-balanced.
 - The average Earned Shared Savings is 74%, almost exactly at the center point.
 - There is now a wider arrangement of Shared Earnings ranging from 50%–100% compared to only 70%–100%
 - 6% of Providers Obtained 100% of Shared Earnings.
- 50% of Shared Earnings is the lowest level of savings possible under this methodological approach.
 - 9% of Providers scored at 50% of Shared Earnings

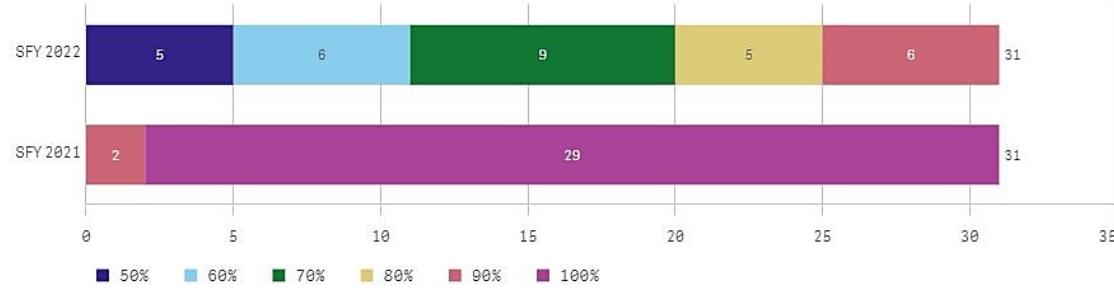


Sample Dashboard of Shared Savings

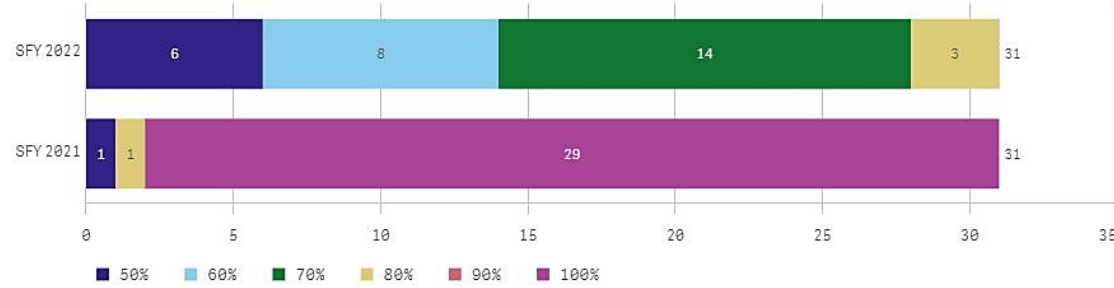
Pending Final Approval

Mercer % Earned Shared Savings

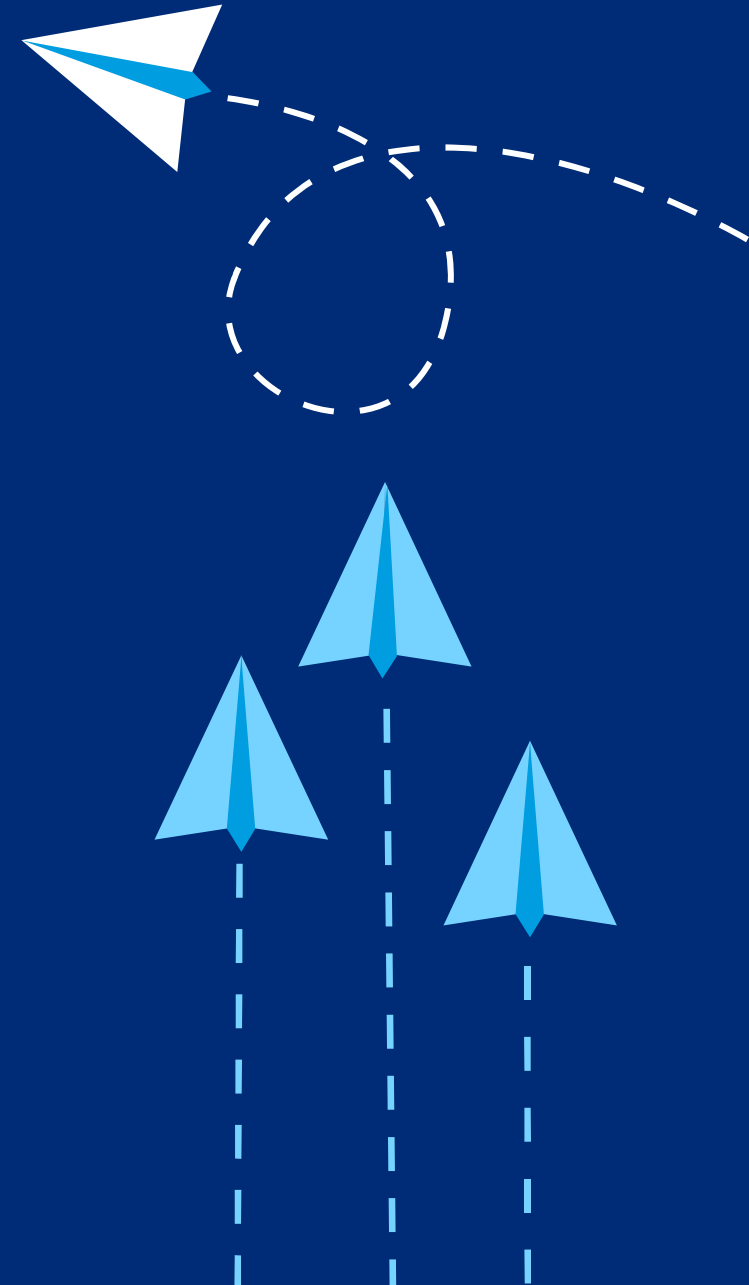
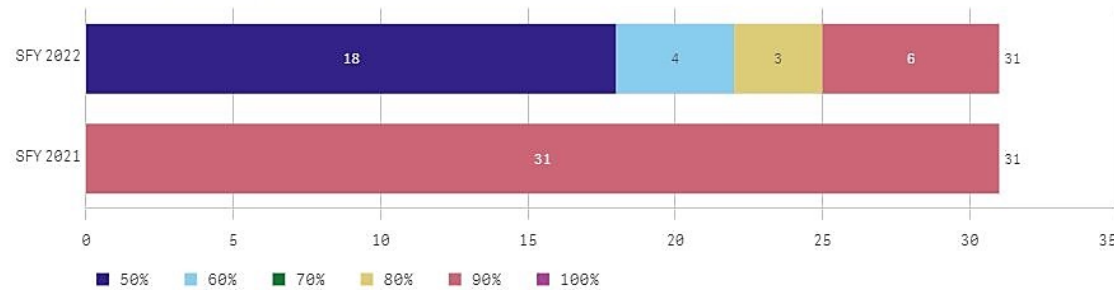
% Earned Shared Savings - Final



% Earned Shared Savings - Performance



% Earned Shared Savings - Improvement




Sample of Quality Measure Dashboard

Pending Final Approval

Mercer Reporting Measure Rate Overview

Measure Descriptions

Measures 	Measure Description	Category	Excluded Membership
BH Risk Assessments	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.	Pay for Reporting Metrics	-
Breastfeeding	Assesses the proportion of newborns exclusively fed breast milk during the newborn's entire hospitalization.	Pay for Reporting Metrics	-
Cesarean Birth NTSV	The proportion of live babies born at or beyond 37.0 weeks gestation to women in their first pregnancy, via cesarean birth.	Pay for Performance Metrics	Dual-Eligible, Limited Benefit & Medicare/Medicaid Members
Doula Utilization	Proportion of births attended by doula.	Pay for Reporting Metrics	-
LARC Within 90 Days	Proportion of mothers with Live Deliveries that reported Contraceptive use within 90 days of Delivery.	Pay for Reporting Metrics	Dual Eligible Members and Limited Benefit
Low Birth Weight	Proportion of infants with ICD codes for light for gestational age, small for gestational age, low birthweight, or ICU care for low birthweight infant on newborn record among all births.	Pay for Performance Metrics	Dual-eligible Medicare/Medicaid members
Postpartum Care	Measures rate of timeliness of postpartum care for the maternity bundle project.	Pay for Performance Metrics	Non-live births, Dual Eligible Medicare/Medicaid, Deceased Members, Hospice
Prenatal Care	Measures the timeliness of prenatal care for the maternity bundle project.	Pay for Performance Metrics	Non-live births, Dual Eligible Medicare/Medicaid, Deceased Members, Hospice
Preterm Birth/Labor	Proportion of preterm births/labors among the total number of live births.	Pay for Reporting Metrics	Limited Benefit, Dual-Eligible & Medicare/Medicaid Members
Risk SOC - Maternal Adverse Events	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 Performance Metrics	-

Sample of Quality Measure Dashboard

Pending Final Approval

Mercer Reporting Measure Rate Overview

Last Update: 01/17/2024

Measure Descriptions

Fiscal Year

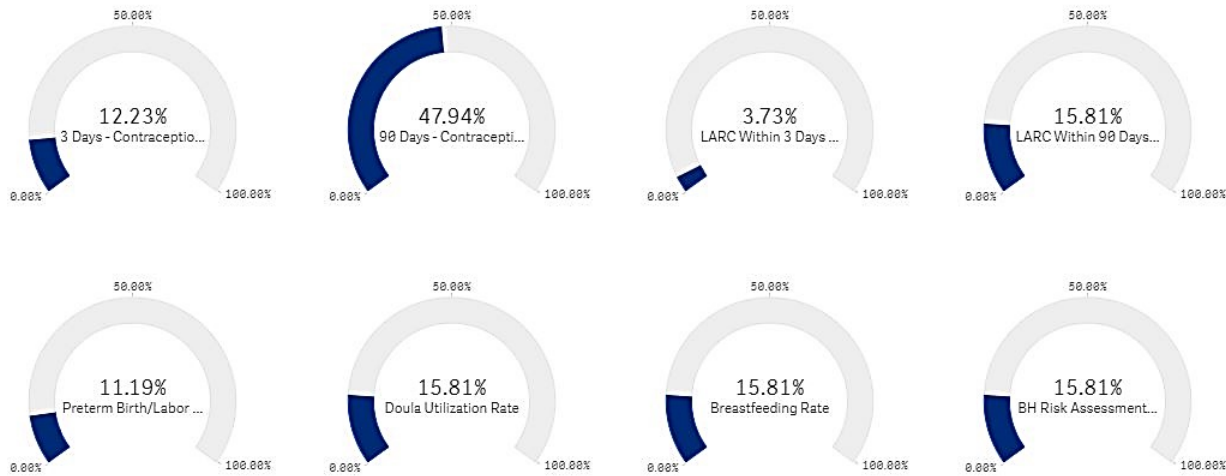
Measure

Measure Group

TIN

Provider Name

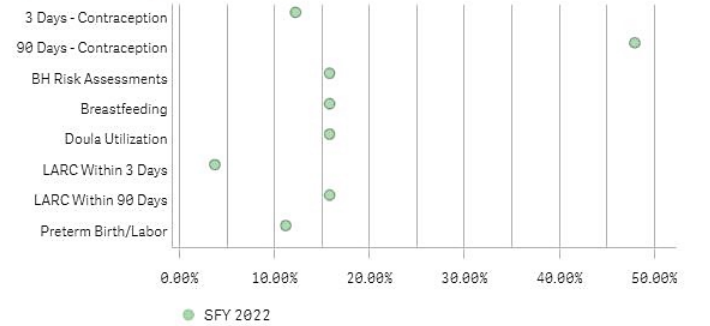
Included Providers



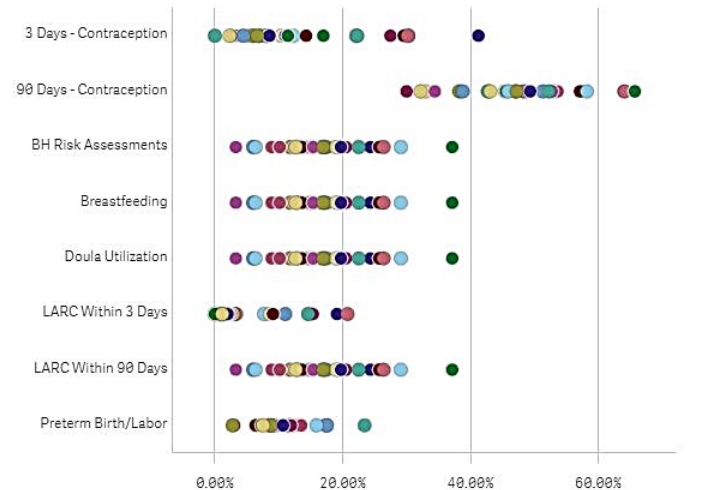
Measure Rate Detail



Rate Distribution by Measure & Fiscal Year



Provider Distribution By Rate & Reporting Measures



Next Steps



Next Steps

Current Priorities

- CMS CMS State Plan Amendment (SPA) Approval
- Actuarial Modeling & Program Testing
- Program Readiness



Upcoming Work

- Draft Provider-Specific Case Rates
- 2022 Provider Historic Performance Reports
- Provider Bulletin of bundled payment policies and processes
- Additional Provider Forums & Advisory Council Meetings

Provider Resources	Objective	Target for Release
Doula Resources	Provide doula service guidance for providers and for doulas	See DSS Doula Integration webpage
Draft Case Rates	Share previews of each provider's draft case rate payment amount	Q1 2024
Provider Bulletin	Provide technical details of the program's payment/billing policies and processes	Q2 2024
2022 Provider Historic Performance Reports	Share previews of each provider's anticipated performance in the HUSKY Maternity Bundle Program based on 2022 claims data	Q2 2024
Provider Forums	Discuss and review the historic performance reports and share best practices	Q1-Q3 2024 Next Scheduled: Feb. 14th 2-3:30pm
Lactation Support Resources & Other Service Guidance	Provide recommendations/guidance on new bundle benefits, including lactation supports, prenatal group visits, and mental health supports	Q2 2024

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>

Questions



Appendix: Clarification of Stakeholder Concerns

“The program will require bundle payment for all maternity services from 280 days before birth to 90 days postpartum.”

- As shown in the subsequent Services Included slide, the Case Rate payment only reimburses a select set of services included in bundle.

“The program will require physicians to provide and reimburse doula services and lactation support specialists.”

- As part of this program, DSS is proud to provide new Medicaid coverage of doula services and lactation supports, which are high-value services with evidence of improving health outcomes, health disparities, and patient birthing experiences. With the goal to connect members with doulas as soon as possible, DSS will utilize a dual approach to provide and fund doula access: (1) paying doulas through the maternity bundle and (2) paying doulas fee-for-service directly.
- Participating providers have the non-mandatory option to provide doula services or lactation supports through the bundle payment’s add-on payment. To encourage utilization of these high-value services, doula services and lactation supports will be excluded from incentive payment calculations.

“The program will tie reimbursement to outcomes outside of the physician’s control such as Doula utilization, exclusive breastfeeding during the newborn’s entire hospitalization, and the proportion of live babies born at or beyond 37.0 weeks gestation to women in their first pregnancy, via caesarean.”

- DSS will provide opportunity for providers to receive upside-only shared savings payments, based on quality performance for a combination of Pay for Performance measures (e.g., caesarean births) and Pay for Reporting measures (e.g., doula utilization and breastfeeding).

Appendix: Services Included in the Bundle

Design Element	DSS Approach			Rationale
For each covered service:	Hybrid model: Pay prospectively for a select set of services included in bundle, with retrospective settlement of other services. Defined list of services excluded from the bundle and paid fee-for-service.			<ul style="list-style-type: none"> Included services support DSS' goals and create appropriate incentives for providers to improve quality of care and reduce costs. Tie quality metrics to screenings, care coordination activities, and use of high-value support services to align clinical and financial incentives.
(A) Include in bundle	A) Include in Bundle 1. Pay Prospectively	A) Include in Bundle 2. Settle retrospectively	B) Exclude from Bundle Pay Fee-for-Service	
1. Pay prospectively 2. Settle retrospectively (B) Exclude from the bundle (Pay FFS)	<ul style="list-style-type: none"> OB/licensed midwife Professional Services OB/licensed midwife Professional-related hospitalization costs (Inpatient, Outpatient, & ED) if performed by the attributed provider OB/licensed midwife Professional-related Behavioral Health Evals, including screening for depression & substance use In-house OB/licensed midwife imaging In-house labs & diagnostics Screenings (general pregnancy screenings, chlamydia and cervical cancer, and screenings for IPV and anxiety) Doulas Breastfeeding support <small>(breastfeeding support is included with broad spectrum of provider types, not limited to CHWs)</small> Prenatal group visits Child education services Care coordination activities Any of the above services provided via telehealth 	<ul style="list-style-type: none"> Birth Centers and hospital costs related to maternity care Specialist/Professional Services related to maternity (e.g., anesthesia) General Pharmacy related to maternity OB/licensed midwife imaging & labs outside of OB/licensed midwife practice 	<ul style="list-style-type: none"> 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 	

Note: Under the maternity bundle program, HUSKY Health members will retain full coverage to all Medicaid-covered services and benefits *and* gain new benefits, including doula care, breastfeeding support, and group prenatal visits. Services “excluded from the bundle” will not have its associated costs of care factored into bundle payment pricing or reconciliation.