HUSKY Maternity Bundle Payment Program

Provider Forum

July 6, 2023

Faulkner CONSULTING GROUP

Welcome to the HUSKY Maternity Bundle Provider Forum

Please see the meeting's ground rules below.

- As we value your time, the Provider Forum will start and end on time.
- This forum will be recorded and posted to the DSS Youtube channel for later viewing.
- If you are not speaking, please mute yourself.
- At the start of this meeting, please identify yourself by entering your name or organization as your participant name.
- Please use the chat to post questions anonymously; otherwise, please limit use of chat. We will answer questions during the designated Q&A period at the end of the presentation.
- This forum's meeting materials will be posted on the DSS Maternity Bundle website.

Today's Agenda

1. Key Elements of the Bundle Design

- Program Overview
- Building Blocks of the Bundle
- Bundle Services
- Payment & Pricing
- Quality Measures & Methodology
- Risk Adjustment

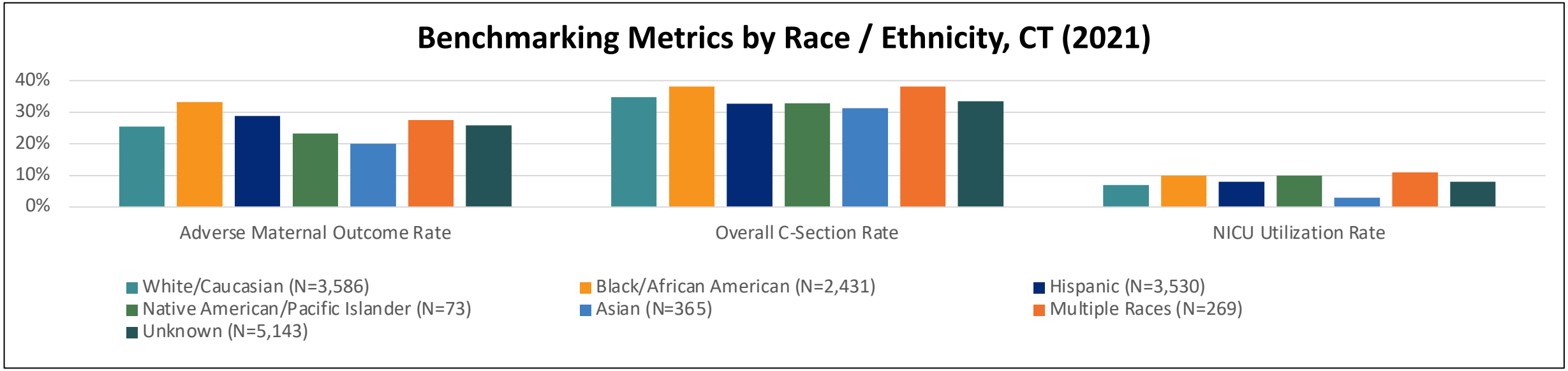
2. Upcoming Opportunities for Stakeholder Engagement

3. Questions

Connecticut's Starting Point in Maternal Health

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**.

- 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]



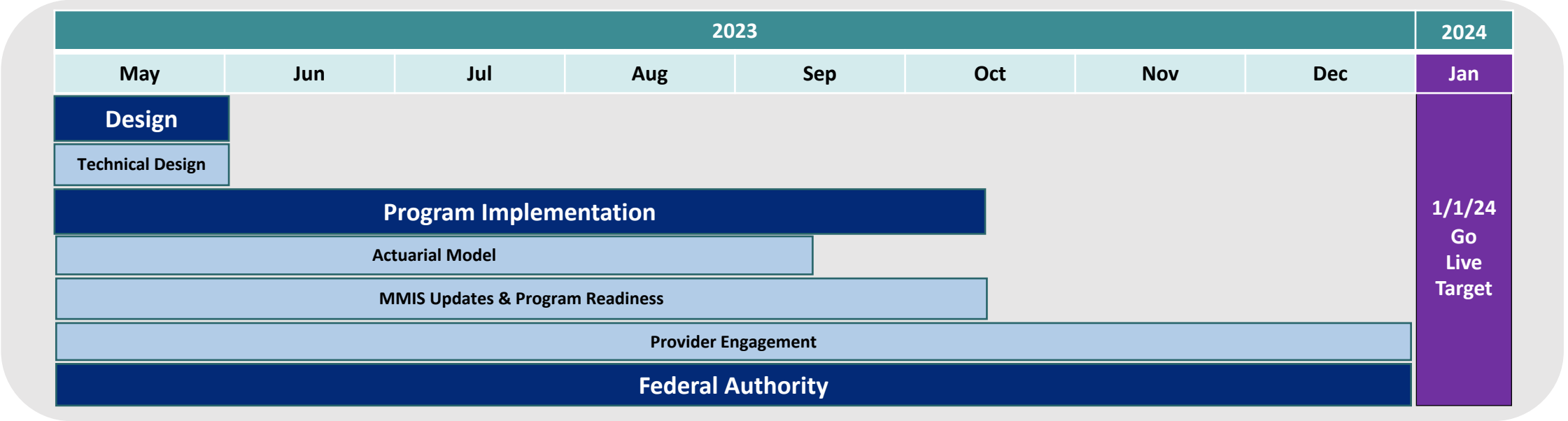
Data Source: CT DSS Data, provided by CHN

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 Go Live

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



Current Priorities

- CMS SPA Approval
- Actuarial Modeling
- Program Readiness

Upcoming Work

- Provider Bulletin of bundled payment policies and processes
- Program Testing (dry run of 2022 claims)
- 2022 Provider Historic Performance Reports
- Additional Provider Forums
- Doula Integration Policies

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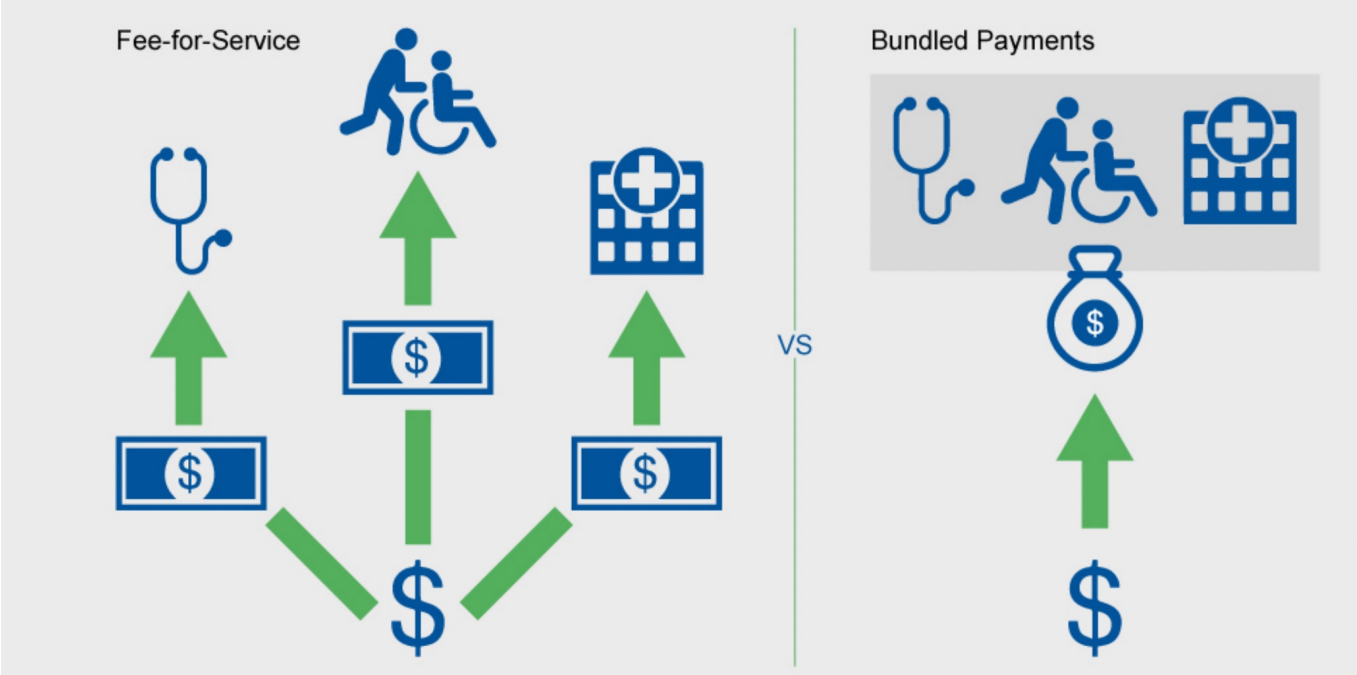
About Bundled Payments

In contrast to fee-for-service payments which incentivize a high volume of care, "bundled payments" create incentives to manage high-quality care and costs across a set of services in an episode of care, focusing on the provider with the greatest role in delivering these services.

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



Sources:
"What Are Bundled Payments?", New England Journal of Medicine Catalyst, February 28, 2018. https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0247
"Innovation in Health Care Delivery: Bundled Payments for High-Value Care", Robin Wang and Dr. Amol Navathe. https://ldi.upenn.edu/sites/default/files/sumr_docs/WangRobin_InnovationinHealthCareDelivery.pdf

Program Goals

With an emphasis on addressing racial health disparities, **DSS will utilize six key outcome measures to evaluate the progress and success of the overall bundled payment program.** DSS aims to cut racial disparities in Connecticut Medicaid's maternal and child health outcomes in half by 2027 and to eliminate them by 2032 for each key outcome measure.

Goals for Maternity & Infant Health Outcomes

Improve overall rates and reduce disparities for the following key outcome measures:

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

Program Objectives to Achieve Goals

- Provide access to community peer supports, such as doulas and lactation supports
- Incentivize greater care coordination throughout the perinatal period
- Enhance flexibility for providers to deliver high-quality care, specific to the needs of their members
- Encourage the establishment of regular relationships between pregnant individuals and their providers

Notes:

- Initial rounds of stakeholder discussions identified six key outcome measures to evaluate success of the overall bundled payment program
- Additional measures will be included in the quality measure slate for provider accountability and performance incentives
- As a key goal is to improve patient experience of care, DSS is also striving to include validated patient experience metrics that span the birthing person's full perinatal period

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

Pregnancy Look back period: 280 days prior to delivery

Delivery and Postpartum Care (Vaginal or C-section)

Postpartum Look forward period: 90 days post-delivery

Newborn Care - *reporting only*
Look forward period: 30 days post-delivery (90 days max)

Reconciliation

Services included in the bundle will be reconciled to a target price six months after delivery claims are submitted

Prospective payment triggered by first claim of 2nd trimester

FFS

Prospective Payments
and FFS for certain services (see Service Inclusion/Exclusion criteria)

Shared Savings
(Upside only)

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.

Payment Flow

Payment Approach

Hybrid Payment Approach: Prospective payment to outpatient providers for a subset of services provided by the accountable OB/certified midwife practice & Retrospective settlement of total costs of maternity bundle services provided, including services rendered outside the accountable practice.

Prospective Payment	Shared Savings/Shared Risk via Reconciliation
Accountable outpatient providers will be paid a set amount of money for certain services that an expecting individual will need	Reconciliation will give accountable providers the opportunity to be eligible for incentive (e.g., shared savings) payments based on maternity-related care provided during the perinatal period and for certain predetermined outcomes. Quality measures will impact how much shared savings providers are able to receive.

- **Rationale:** Prospective payment model supports providers with needed capital for practice transformation activities to achieve DSS' goals, while hybrid approach enables accountability for providers without setting up systems to pay external providers/hospitals.

Accountable Provider

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 prospective 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.

Member Inclusion/Exclusion Criteria

All pregnant and birthing Medicaid members in Connecticut will be eligible for the Bundled Payment Program for reconciliation with certain rare exceptions (below).

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

- Age <12 or >55
- Mother left hospital against medical advice (AMA) 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
  - Members who initially qualify for program inclusion (e.g., trigger prospective payments) but later meet exclusion criteria (i.e., someone who has a stillborn) will be excluded from reconciliation

The pregnancy, delivery, or newborn components of the maternity bundle can be excluded in the retrospective reconciliation for the following reasons below. Note that payment will remain through the PMPM 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

Multiple Births, Newborn Care, and Postpartum Care

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 prospective 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

Principles for Payment Designation

The following criteria was used to define the suggested list for which services would be paid prospectively, which would be reconciled retrospectively, and which would be excluded from the bundle and paid fee-for-service (FFS).

	Principles
Covered services included for prospective payment (Per-member-per-month payment)	• Specific services provided in-house or directly by the accountable OB/licensed midwife • Services that predictably happen during the course of pregnancy or that should happen during the course of pregnancy • High-value services, including doulas and breastfeeding support
Covered services included for retrospective payment (Paid FFS)	• Services provided outside of the accountable OB/licensed midwife practice • Services that predictably happen during the course of pregnancy
Covered services excluded from the bundle (Paid FFS)	• Specific services provided by either an accountable OB/licensed midwife or another provider • Services that are uncommon during the course of pregnancy

Note:
- Awaiting technical verification of this approach to identify and evaluate potential limitations
- Under the maternity bundle program, HUSKY Health members will retain full coverage to all Medicaid-covered services and benefits *and* gain new benefits, including access to doula care, breastfeeding support, and group prenatal visits.
- DSS will maintain FFS payments for specific services (see "Services Included in the Bundle" slide) where a higher volume of delivery should be encouraged (e.g., vaccines) or where there are operational challenges for inclusion under the prospective payment (e.g., behavioral health services)
- Services "excluded from the bundle" will not have its associated costs of care factored into bundle payment pricing or reconciliation

Bundle Services

Services Included in the Bundle

Design Element	DSS Approach			Rationale
For each covered service: **(A) Include in bundle** **1. Pay prospectively** **2. Settle retrospectively** **(B) Exclude from the bundle (Pay FFS)**	**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.**			• 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 1. Pay Prospectively	**A) Include in Bundle** 2. Settle retrospectively	**B) Exclude from Bundle** Pay Fee-for-Service	
	• 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 (breastfeeding support is included with 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	• 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	• 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.

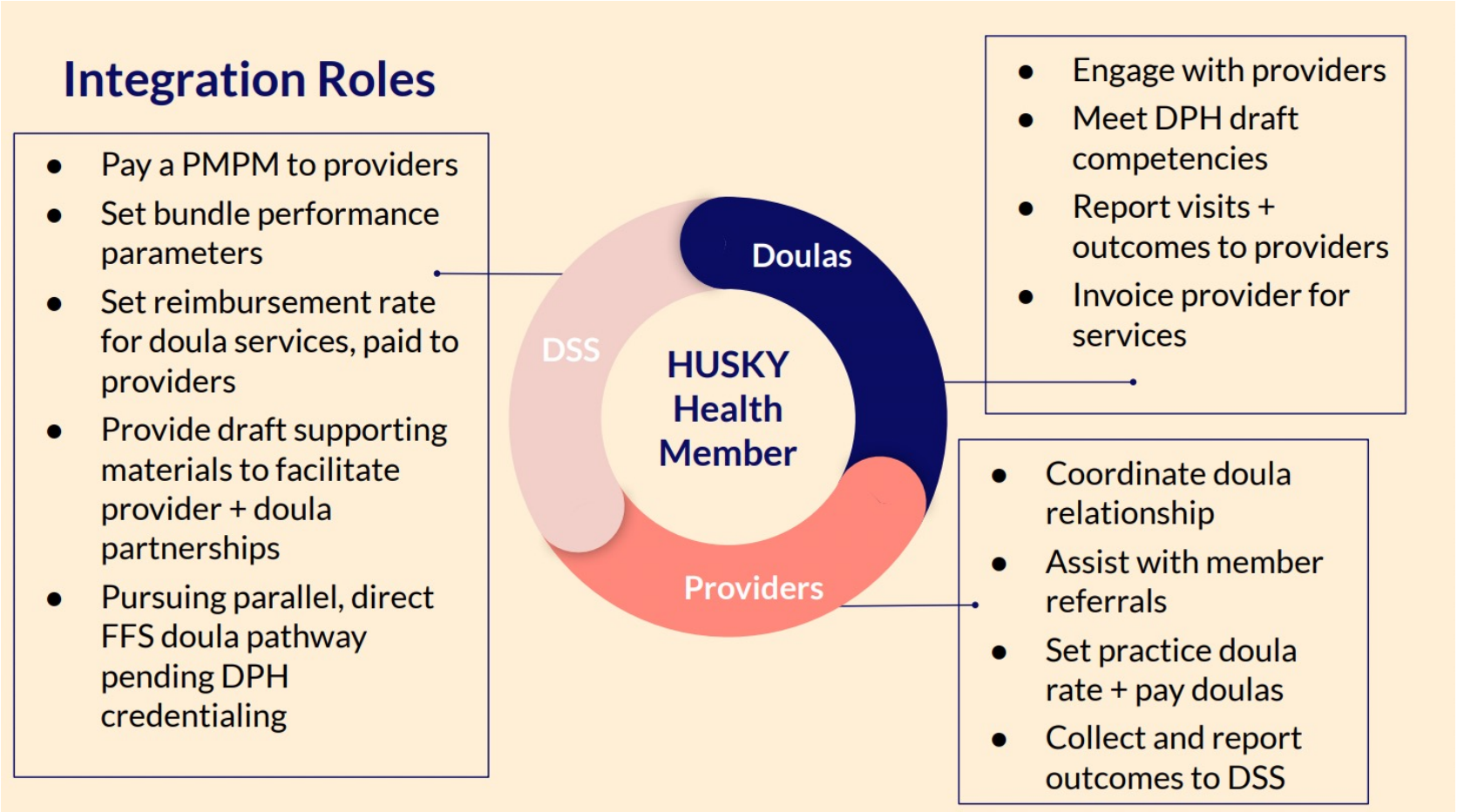
Doula Services

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.

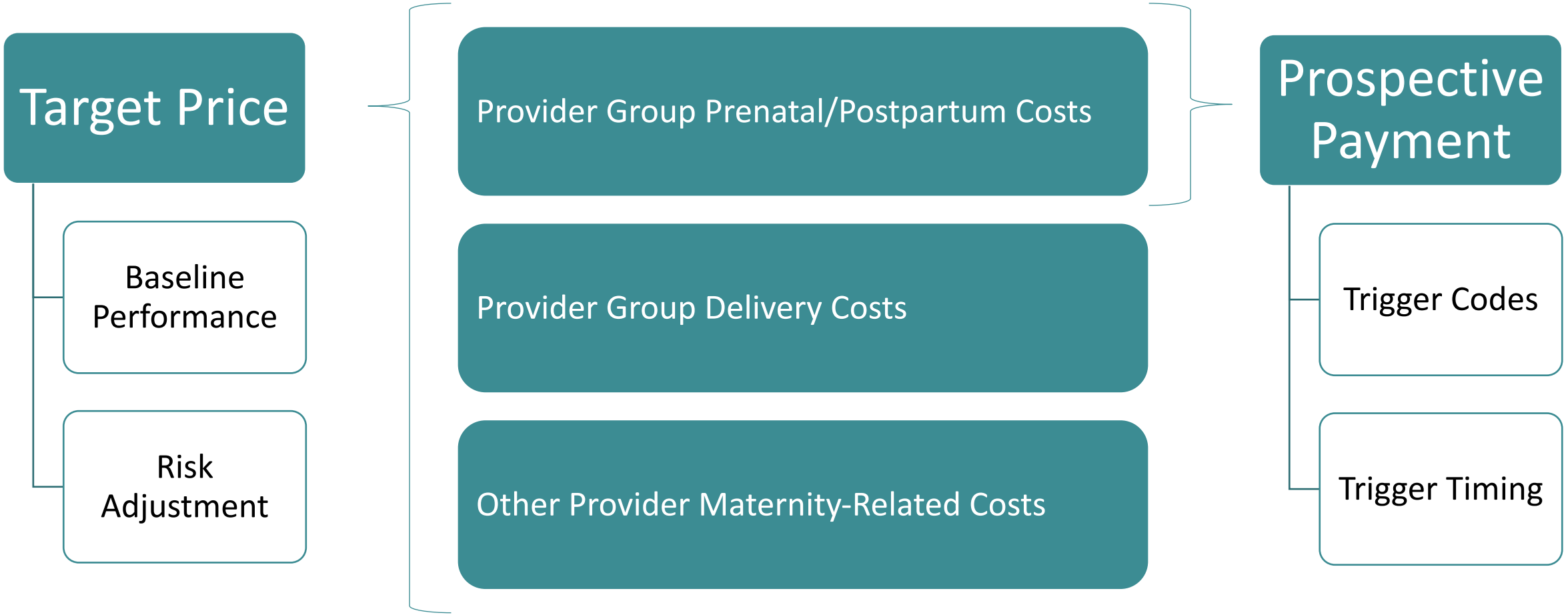
Doula Payment Approaches:

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.



Payment and Price Structure



Prospective Payment Methodology

Goals for Prospective Payments

DSS designed the maternity bundle's prospective payment, to give providers upfront capital to encourage greater flexibility in how they deliver care, including:

- Incorporate doula services payment.
- Changing payment methodology should result in greater changes in provider behavior to increase impact on overall bundle outcomes by increasing provider accountability and flexibility.

Principles for Services Included in Prospective Payment

- In-house by the accountable provider (OB/licensed midwife/family medicine provider)
- Predictably happen during pregnancy OR that should happen during pregnancy
- High-value services (Doulas and breastfeeding supports)

Of all services included, a portion will be paid prospectively. All services included (including those paid prospectively) would be reconciled retrospectively:

Timeframe	Prospective Payment	Retrospective Reconciliation
Pregnancy	Yes, for a subset of services in accordance with principles	Yes
Delivery	No	Yes
Postpartum	Yes, for a subset of services in accordance with principles	Yes
Newborn	No	Reporting only at program launch

Prospective Payments

Trigger	Claims submitted in the first trimester will be paid fee-for-service. (Note that add-on doula payments are, therefore, not provided in the first trimester)
	Prospective payments will be triggered with a Z34, Z3A, or O09 diagnosis code and procedure codes indicating a pregnancy on the earliest single encounter in the second trimester.
Timing	Prospective payments will be made monthly.
	After initiated, the triggering claim and all subsequent claims meeting the services included in the prospective payment criteria will have no payment.
	At program launch, providers will continue to bill all claims as usual to demonstrate services provided to the beneficiary.
Termination Rules	If a claim is submitted carrying a code indicating the pregnancy was miscarried/terminated
	At 90 days postpartum

Prospective Payment Amount

- The prospective payment will be paid during the prenatal and postpartum periods.
- The payments will be based on each provider's historically provided services during the prenatal and postpartum periods and exclude delivery costs.
- An additional add-on PMPM will be provided for doula care and breastfeeding support.

Provider Specific Target Prices

- Target prices include the overall costs of the pregnancy and delivery for all providers.
- Provider-specific targets will initially reflect a 50/50 blend of statewide and provider-specific data.
- Inpatient costs will be adjusted based on hospital base prices to mitigate cost differences between hospitals.
- Prices for specific services may be adjusted for pricing differences between providers.

Provider Specific Target Prices Cont'd

- The calculation of the practice specific payment rates will reflect clinical and social risk adjustment.
- To ensure reasonable trends and program stability, target prices may be adjusted for:
  - AAE (Actionable Adverse Event) costs
  - C-Section rate (percentage of blend)
  - Other factors
- Any variations in amounts paid prospectively will be counterbalanced through the reconciliation process.

Retrospective Reconciliation

- Happens at the end of the attribution period.
- The total cost of care for the services provided under the bundle will be compared to the benchmark price.
- Gives accountable providers the opportunity to be eligible for shared savings (upside only in Year 1) based on maternity-related care provided from 280 days prior to delivery through 90 days postpartum, when combined with quality performance.
- Bundles will be reconciled once per year with the provision of quarterly provider data reports.

Quality

Quality Measure Set for Year 1

	Quality Measure	Description	Measure Source	Data Source
Pay for Performance	Maternal Adverse Events	Proportion of deliveries >= 20 weeks gestation with any of 21 maternal morbidities plus maternal mortality occurring during the delivery hospitalization, using claims information for risk adjustment (34 risk variables).	NQF #3687e ePC-07	Claims based. Maternal delivery hospitalization.
	Cesarean Birth	Proportion of cesarean deliveries among NTSV deliveries.	NQF #0471e ePC-02	Claims based. Maternal delivery hospitalization.
	Low Birth Weight (LBW)	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.	Existing DSS Measure	Claims based. Newborn delivery hospitalization.
	Prenatal Care	Proportion of pregnancies where first prenatal care visit occurred in first trimester.	NCQA #1517 (Admin only)	Shadow claim (all prenatal care claims) or encounter form.
	Postpartum Care	Proportion of deliveries with at least two postpartum visits within 7-90 days after delivery.	NCQA #1517 (Admin only)	Shadow claim (all postpartum claims up to 90 days after delivery) or encounter form
Pay for Reporting	Doula Utilization	Proportion of births attended by doula.	Custom Measure	Encounter form
	Breastfeeding	Assesses the number of newborns exclusively fed breast milk during the newborn's entire hospitalization.	NQF #0480 PC-05, NQF #0480e PC-05	Encounter form
	Behavioral Health Risk Assessments	Percentage of patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: screening for depression, alcohol use, tobacco use, drug use, and intimate partner violence screening.	NQF# MC-3	Encounter form
	Preterm Birth/Preterm Labor	Number of LBW/Premature Babies among the total number of deliveries.	Revised SEHP Measure	Claims based. Maternal and newborn delivery hospitalization.
	Contraception	Proportion of persons with a CPT, HCPCS, ICD-10 DX or PCS, or NDC code for LARC in postpartum period.	NQF #2902	Claims-based (postpartum maternal claims).

Pay for Performance (P4P) & Pay for Reporting (P4R)

Weights

- Maternal Adverse Events and Cesarean Births will be weighted with highest priority (3)
- Pay for Reporting measures will be weighted lowest (1)
- All other Pay for Performance measures will be weighted between them (2)

Reporting

- The five Pay for Reporting measures will require encounter form data submissions, similar to the OBP4P program
- DSS will release billing and encounter form guidance prior to program launch

	P4P or P4R	Metric %	Metric Weights
Maternal Adverse Events	P	18%	3
Cesarean Births	P	18%	3
Postpartum Care	P	12%	2
Prenatal Care	P	12%	2
Low Birth Weight	P	12%	2
Preterm Birth/ Preterm Labor	R	6%	1
Breastfeeding	R	6%	1
Contraception	R	6%	1
Doula Utilization	R	6%	1
BH Risk Assessments	R	6%	1
Total		100%	

Quality Score Methodology

Quality scorecards use provider baseline data to set quality performance targets against which performance during the live program is measured. DSS anticipates shifting to statewide target rates for quality measures in subsequent years as needed.

Quality Score Methodology

- **Step 1 – Normalization:** (Rate - baseline Min Rate) / (baseline Max Rate - baseline Min Rate)) * 100
- **Step 2A – Inversion** (if needed so that higher rates = better performance): Individual Metric Score = 100 - Normalized Rate
- **Step 2B – Guardrail Check:** Ensure inverted scores are within the 0%-100% range
- **Step 2C – Performance Quality Score:** Combined Metrics Score of all measures = Sum (individual metric score * metric weight)
- **Step 2D – Pay for Performance (P4P) Combined Score:** Combined Metrics Score of P4P measures only = sum (individual metric score * metric weight)
- **Step 3 – P4P Change of Baseline:** Change from baseline = Performance period combined score - baseline performance target combined score
- **Step 4 – Improvement Quality Score:** Percent Change for P4P measures only = Performance period combined score - baseline combined score) / baseline combined score * 100

Context: *Example illustrates quality score calculations for a provider with the criteria below.*

(1) Demonstrates high quality of care performance across most quality measures compared to the peer group in Year 0 (see Historical Baseline Performance Period)

(2) Maintains and improves high quality of care performance in Year 1 (see Year 1 Performance Period)

(3) Reports on 4 of 5 measures, including reporting measures

Example Scenario

Historical Baseline Performance Period (P4P measure rates only)

Metric 1	Metric 2	Metric 3	Metric 4	Metric 5	Combined Metrics
6.7%	77.3%	70.6%	28.5%	25.2%	52.2%

Year 1 Performance Period (P4P & P4R measure rates)

Metric 1	Metric 2	Metric 3	Metric 4	Metric 5	P4R
5.4%	77.5%	75.4%	27.9%	24.2%	Yes for 4 of 5 metrics

Minimum & Maximum Rates of Peer Group (P4P measures only)

	Metric 1	Metric 2	Metric 3	Metric 4	Metric 5	P4R Metrics
Minimum	5.5%	72.2%	70.6%	28.5%	24.7%	N/A
Maximum	10.0%	78.6%	76.4%	36.2%	32.9%	

Step 2A (Inversion) and 2B (Guardrail Check)

Metric 1	Metric 2	Metric 3	Metric 4	Metric 5	P4R Metrics
100.0%	82.8%	82.8%	100.0%	100.0%	N/A

Step 2C - Performance Quality Score - Combined Metrics (All Measures)	Step 2D: Combined Metrics (P4P Only)	Step 3: Change from Baseline (P4P Only)	Step 4: - Improvement Quality Score - % Change from Baseline (P4P Only)
90.1%	66.5%	14.3%	27.4%

Risk Adjustment

Risk factors are tested and clinically validated to capture the clinical risk of the individual patient and the effect on the episode of care cost.

- Health risk scores will be applied to each episode.
- The risk adjustment will use maternity-related health factors and social factors as the independent variables and per-delivery costs as the dependent variable.
- The health factors and their weights form the health portion of the risk score, and the social factors (namely ADI deciles) and their weights form the social portion of the risk score.
- The risk score is the estimated impact on cost that a person's health or social factors have.
- Episodes of care with a risk score greater than 1 are expected to cost more than average, and episodes with a risk score less than 1 are expected to cost less than average.

Social Risk Adjustment

- Year 1 Proposal: Area Deprivation Index (ADI) will be used for social risk adjustment.
- The ADI is a measure for ranking relative income, education, employment, and housing quality between neighborhoods. A low ADI score indicates affluence, and a high ADI score indicates high levels of deprivation.
- The specifics of how ADI will be used are still being determined, but factors such as hospital cost differences will be removed to not influence the adjustment.
- Risk adjustment will be applied in a budget neutral manner. Risk adjustment will pay providers with higher risk patients more compared to providers who serve lower risk patients.
- For future years, other adjustments may be used as further data becomes available.

Underutilization Plan

Risk Mitigation

- Clinical and social risk adjustment to prevent risk-based patient selection ("cherry picking")
- Carve out specific services to prevent a reduction in the utilization of specific services
  - Examples: Vaccines, DMEs, Mental health/SUD services, and LARCs
- Quality Measures to drive improved outcome and increase perinatal services that monitor/encourage service utilization or that are impacted by the lack of prenatal care
  - Adverse Maternal Events, Prenatal Care, Postnatal Care, C-section rate, Low birth weight
- Timeframe of the bundle
  - Increases provider accountability in the preterm and postpartum

Monitoring and Oversight

- Ongoing claims monitoring similar to PCMH+, but specific to the MB program
- Identify individuals who are financially expensive for providers from historical FFS data and monitor patients that either transition between providers more frequently and/or use not get into care early
- Consideration of other strategies to support the assessment of the member experience

Upcoming Stakeholder Engagement

Stakeholder Engagement	Objective	Target Month
Summer		
Provider Webinar	Educate about the benefits of doulas, the role of doulas in the Maternity Bundle Program, and how providers can meaningfully engage with doulas	June
Doula Webinar	Educate doulas about their participation in the Maternity Bundle Program	June
Provider Forum	Educate and answer questions about the Maternity Bundled Payment Program	July
Fall		
Provider Guidance	Provide technical details of the program's bundled payment policies and processes	August/September
Service Guidance/FAQs	Provide recommendations/guidance on new bundle benefits, including lactation supports, prenatal group visits, mental health supports, and doula services	August/September
Historic Performance Reports	Share previews of each provider's prospective payment rate and anticipated performance in the Maternity Bundle Program based on 2022 claims data	October
Provider Forum	Discuss and review the historic performance reports and share best practices	October
Ongoing		
Advisory Council Meetings	Continue to convene the Advisory Council to solicit feedback on design elements and future updates to the Maternity Bundle Program	As needed

Note: Communication materials for HUSKY members, providers, and community health workers will also be disseminated closer to program launch.

Questions?

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