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HUSKY Maternity Bundle Payment Program

Provider Forum Meeting

November 8, 2023

A business of Marsh McLennan

Welcome to the HUSKY Maternity Bundle Provider Forum

- 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.
- Please use the Chat to identify yourself by entering your name or organization.
- Otherwise, please limit use of the Chat for Zoom technical and audio issues only.
- Please Q&A feature to post questions anonymously.
- This forum’s meeting materials will be posted on the DSS Maternity Bundle website.

Agenda

1. Program Go Live Update
2. Maternity Bundle Overview
3. Provider Attribution
4. Target Price
5. Reconciliation
6. Quality Measures

Program Go Live 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.
- The decision to delay the launch was made after carefully considering several factors including the need for the Centers for Medicare & Medicaid Services' (CMS) approval, further programmatic development, and the need for further stakeholder engagement.

Next Steps

Current Priorities

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

Upcoming Work

- Provider FAQs
- Provider Bulletin of bundled payment policies and processes
- Program Testing (dry run of 2022 claims)
- 2022 Provider Historic Performance Reports
- Additional Provider Forums & Advisory Council Meetings

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Maternity Bundle Overview

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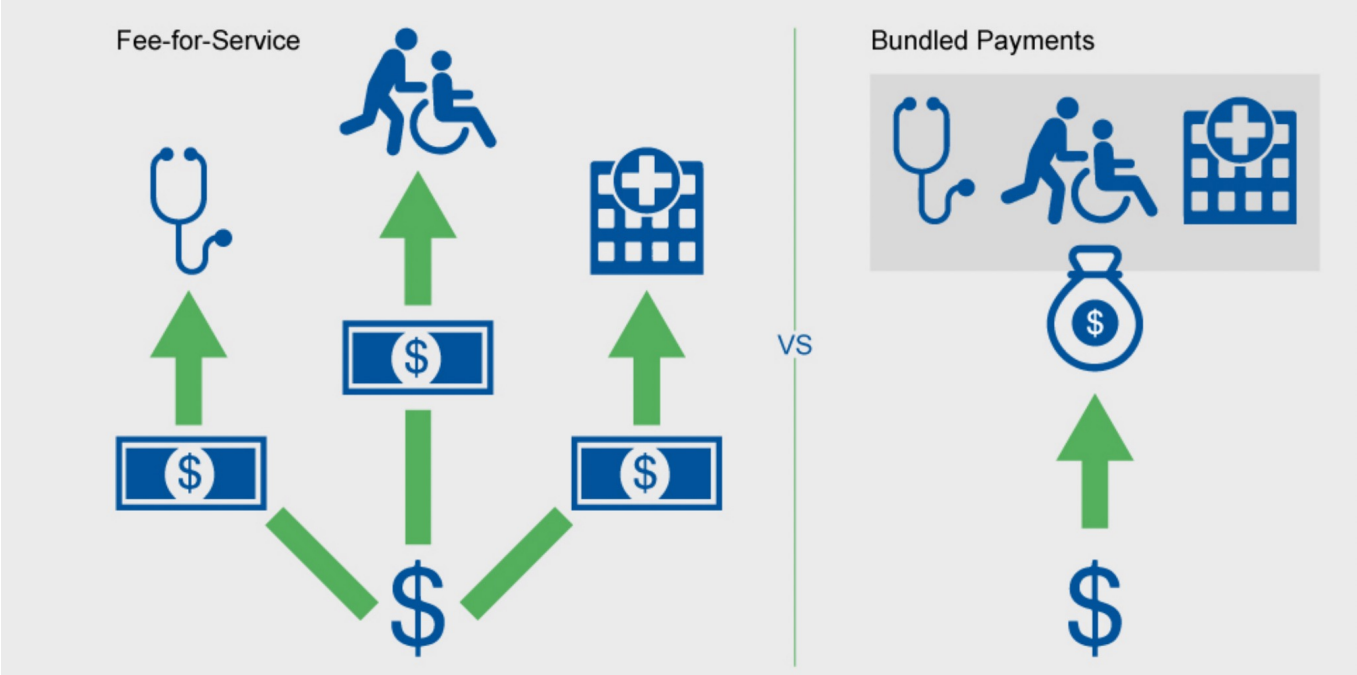
About Episode-Based Payments

In contrast to fee-for-service payments which incentivize a high volume of care, episode-based payments (or "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 episodes of care model is designed to:
  - encourage **greater efficiency and coordination** in the overall management of patients
  - **improve care quality and outcomes**
  - **reduce costs**
- Episode-based 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

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

Case rate payments triggered by first claim of 2nd trimester

FFS

Bundled "Case Rate" 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.

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 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.

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 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

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.

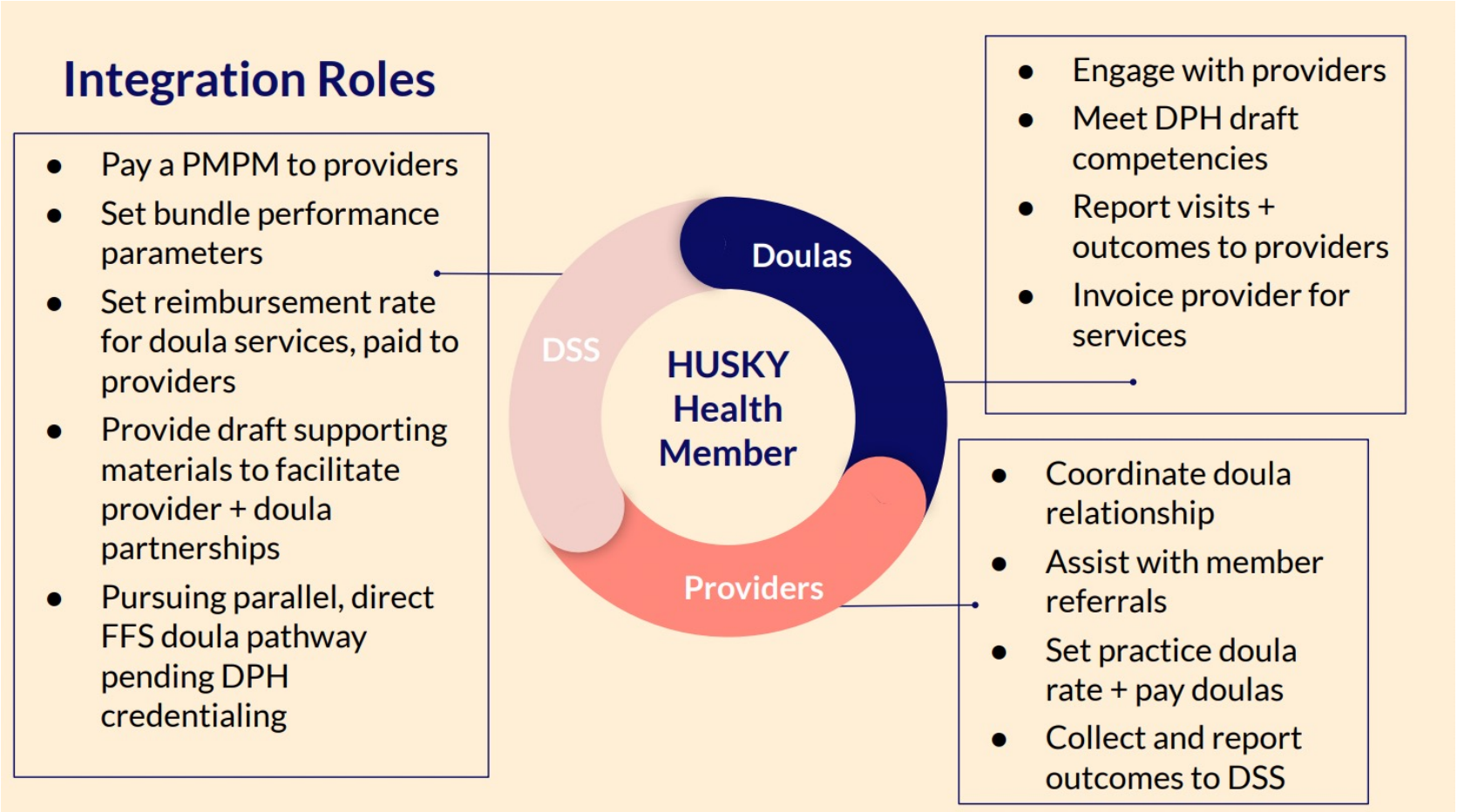
Doula Services

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.

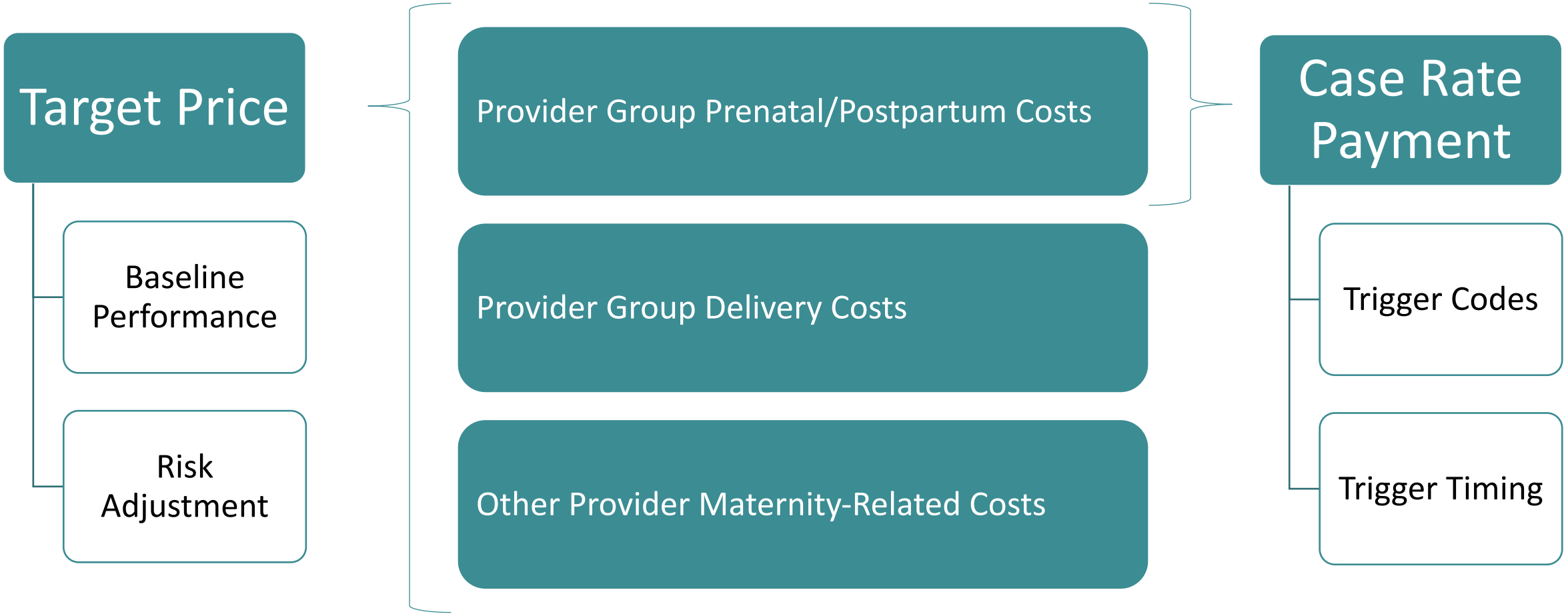
Doula Payment Approaches:

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



Case Rate Payment Methodology

Goals for Case Rate Payments

DSS designed the maternity bundle's case rate 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 Case Rate 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 through case rate payments. All services included (including those paid through the case rate) would be reconciled retrospectively:

Timeframe	Case Rate 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

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Provider Attribution

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Attribution Logic

Attribution Principles

- Attribute members to their core OB/licensed midwife
- Keep as many episodes as possible with accountable providers
- Design attribution to appropriately address co-managed episodes
- Remove accountability from OB/licensed midwife where the episode has left the care of the accountable provider
- Make accountable providers whole, via the case rate, for non-delivery services

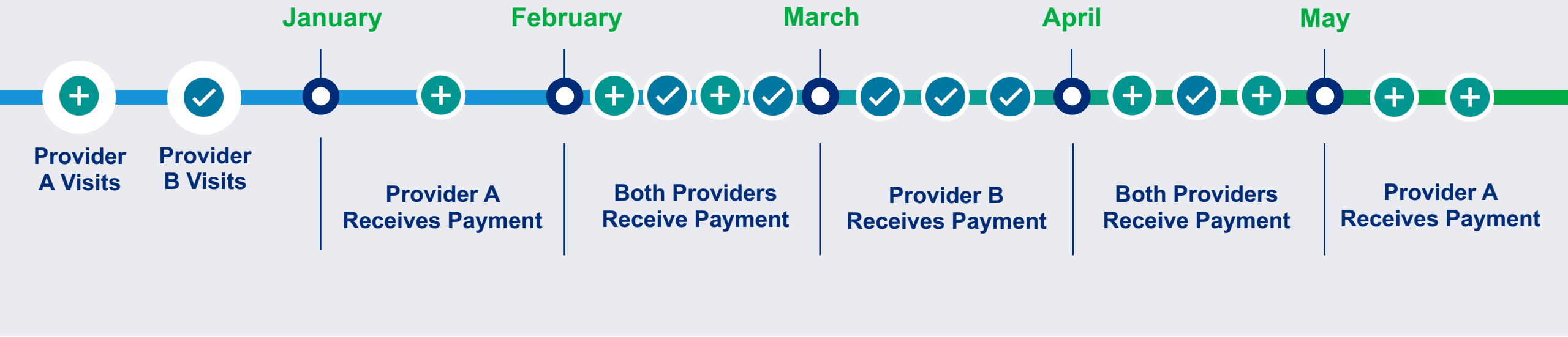
Attribution Rules

- Last, in the chain, second-trimester provider in most instances will be the accountable provider
- Attribution screens for a second service to affirm care with the accountable provider

Attribution Removal

- Provider-specific attribution changes when an affirmative move to a different provider is identified

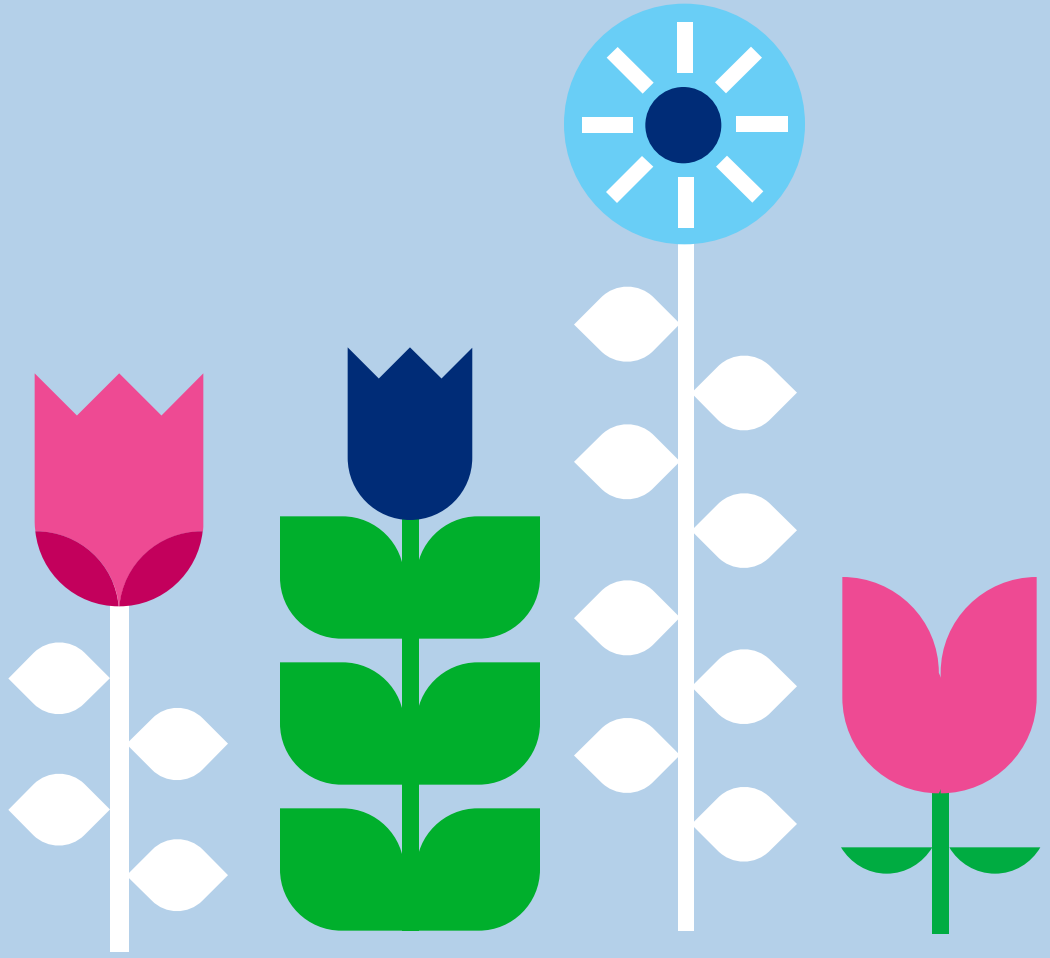
Co-Managed Pregnancies



Second Trimester

Third Trimester

Target Price



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Target Price

Services Included in the Target Price:

- OB/licensed midwife Professional Services
- OB/licensed midwife Professional-related hospitalization costs (Inpatient, Outpatient, and emergency department) if performed by the attributed 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
- Doulas
- Breastfeeding support (breastfeeding support is included with a broad spectrum of provider types, not limited to community health workers)
- 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

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 case rate payment for these cases.

- Pregnancy
  - There were no claims incurred during the first two trimesters of the pregnancy (case rate payments may still be paid for the third trimester, but the pregnancy would be excluded from the retrospective reconciliation)
- Delivery
  - Missing a facility claim in the episode (i.e., “orphan” episode)
- Newborn (for reporting purposes only)
  - Baby is stillborn
  - The 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.

Risk Adjusted Historical Price (50%)

Risk-neutral historical price by provider TIN

State-wide Historical Price (50%)

State-wide historical price

Base Price by Provider

Performance Year Risk Factor

Risk adjustment factor of the performance year

Target Price by Provider

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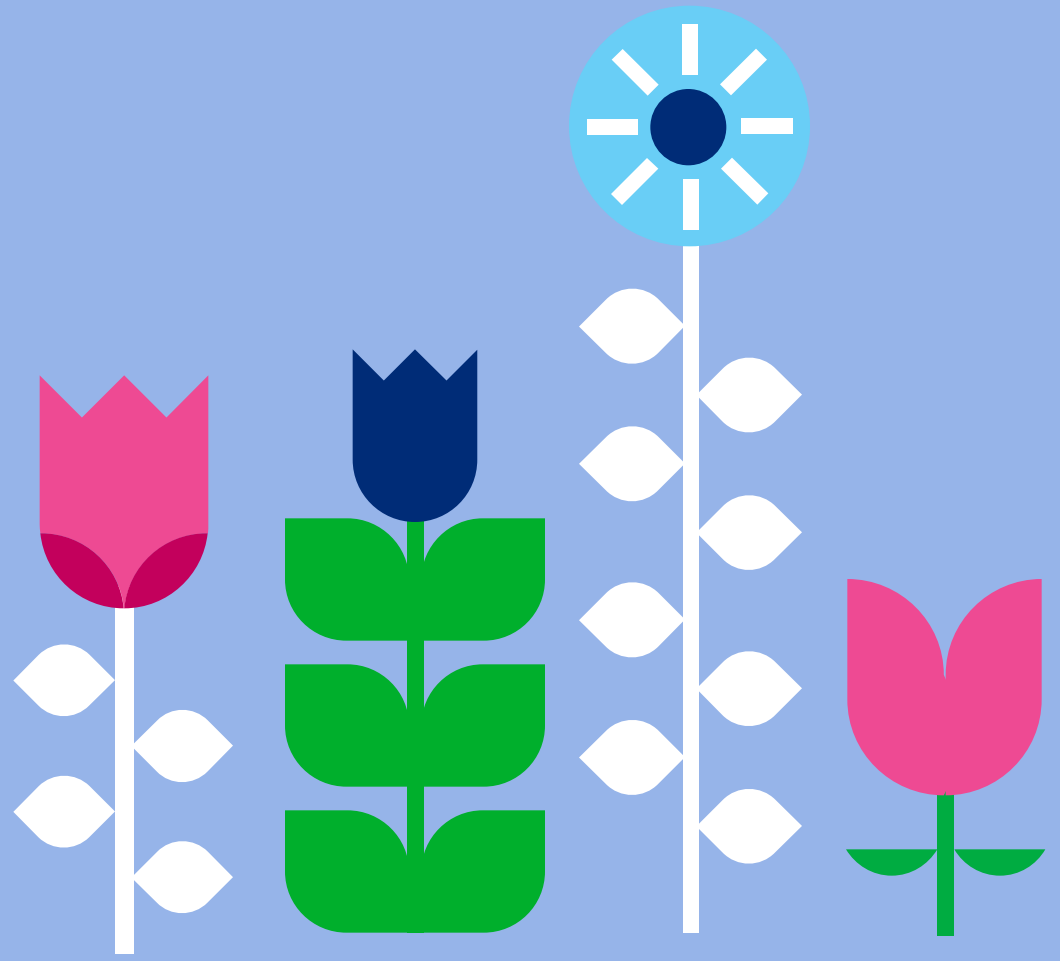
Clinical & Social Risk Adjustment

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.

Reconciliation



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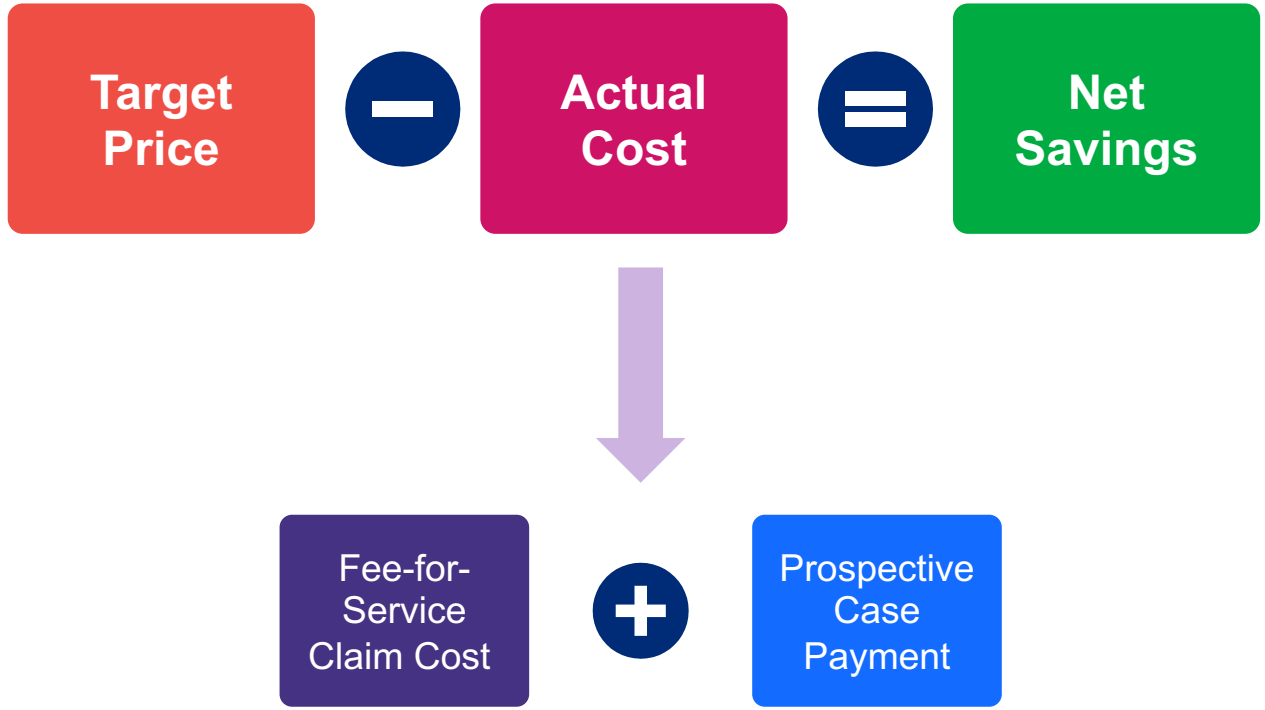
Reconciliation

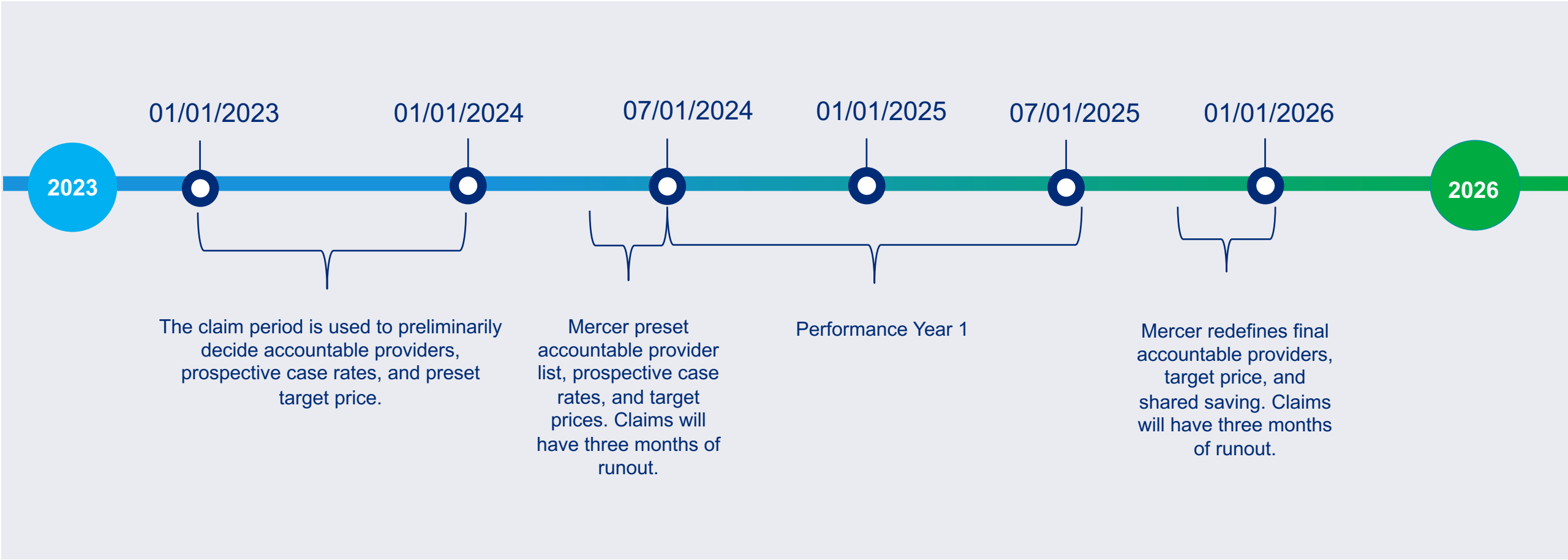
- Occurs no later than six months after the performance period ends.
- The total cost of care for services provided under the bundle will be compared to the target price.
- Bundles will be reconciled once per year with the provision of quarterly provider data reports.
- For year one, providers will not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



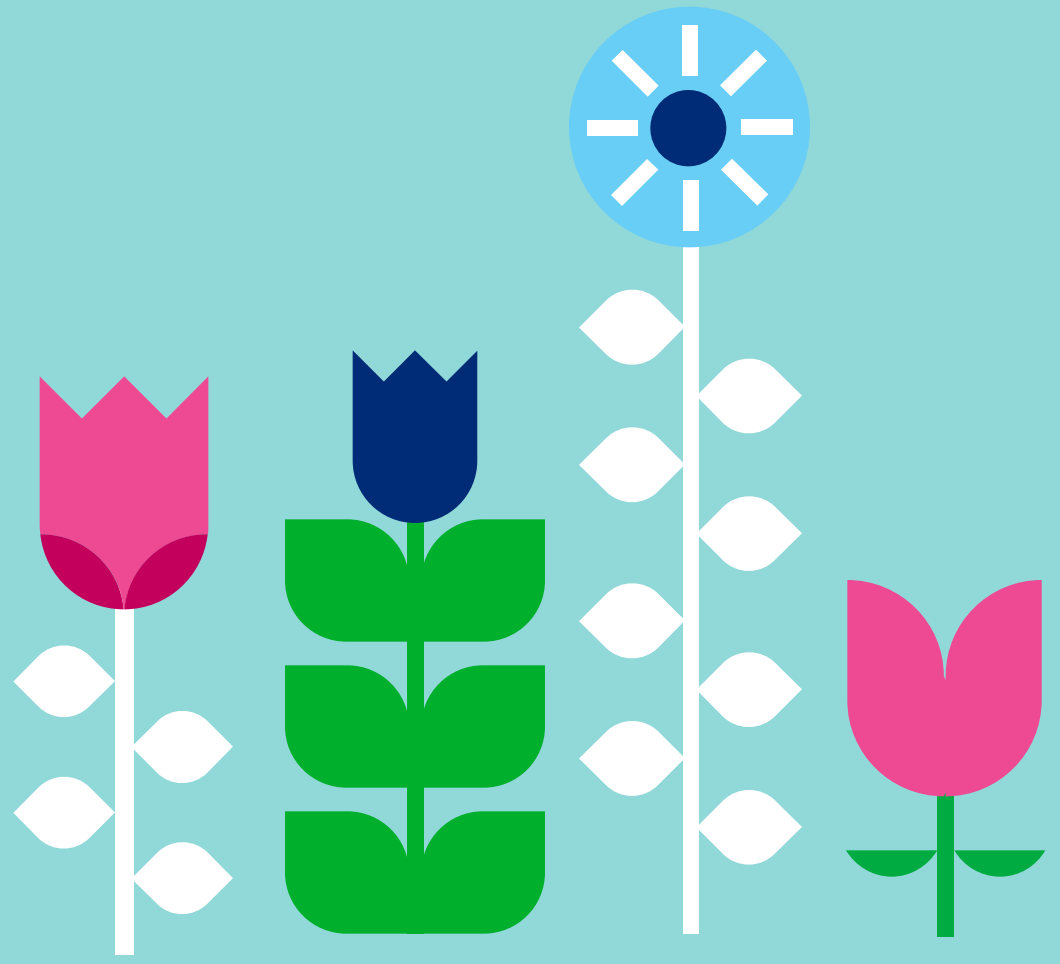
Reconciliation Timeline

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

(***This timeline reflects an assumption of a July 2024 go live; however, should final go-live date shift to September 2024, everything will shift by 3 months***)



Quality Measure



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Maternal Adverse Events Update

DSS Feels that the MAE Measure is Important to Keep as Part of the P4P Portion of the Quality Program

Measure Description	Provider Feedback About the Measure	DSS Considerations in Evaluating the Measure	Recommended Changes to the Measure Based on Provider Feedback
• The 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 (30 risk variables).	• Based on a measure created for measuring the quality of hospital labor and delivery services • Focuses on conditions that are heavily influenced by hospital clinical care protocols • Not developed for the purpose of assessing the quality of care delivered by community OB practices.	• Disproportionate impact maternal adverse events have on birthing people of color • Importance and support the advisory group has placed on this goal in the past • Yale CORE (which developed the original measure for CMS) has modified it for DSS and is assisting with the implementation • The measure is risk-adjusted and accounts for small number variation at the provider level	• Adjust the impact of the measure from 18% to 6% for the first year with the aim of: — Further validating the measure — Increasing the importance of the measure in future years pending further measure refinement

Quality Measures and Weights

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 birthweight, 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%)

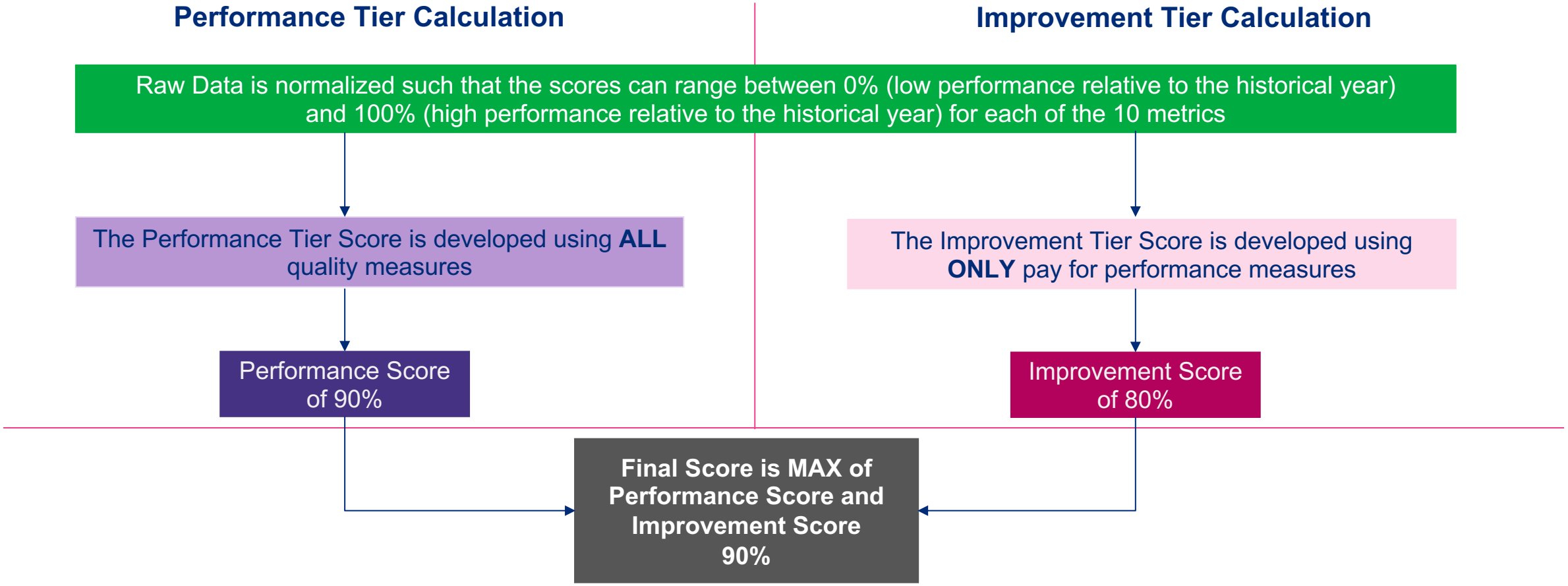
Assesses the proportion of newborns exclusively fed breast milk during the newborn's entire hospitalization.

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

Illustrative Methodology Example - Draft



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.

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

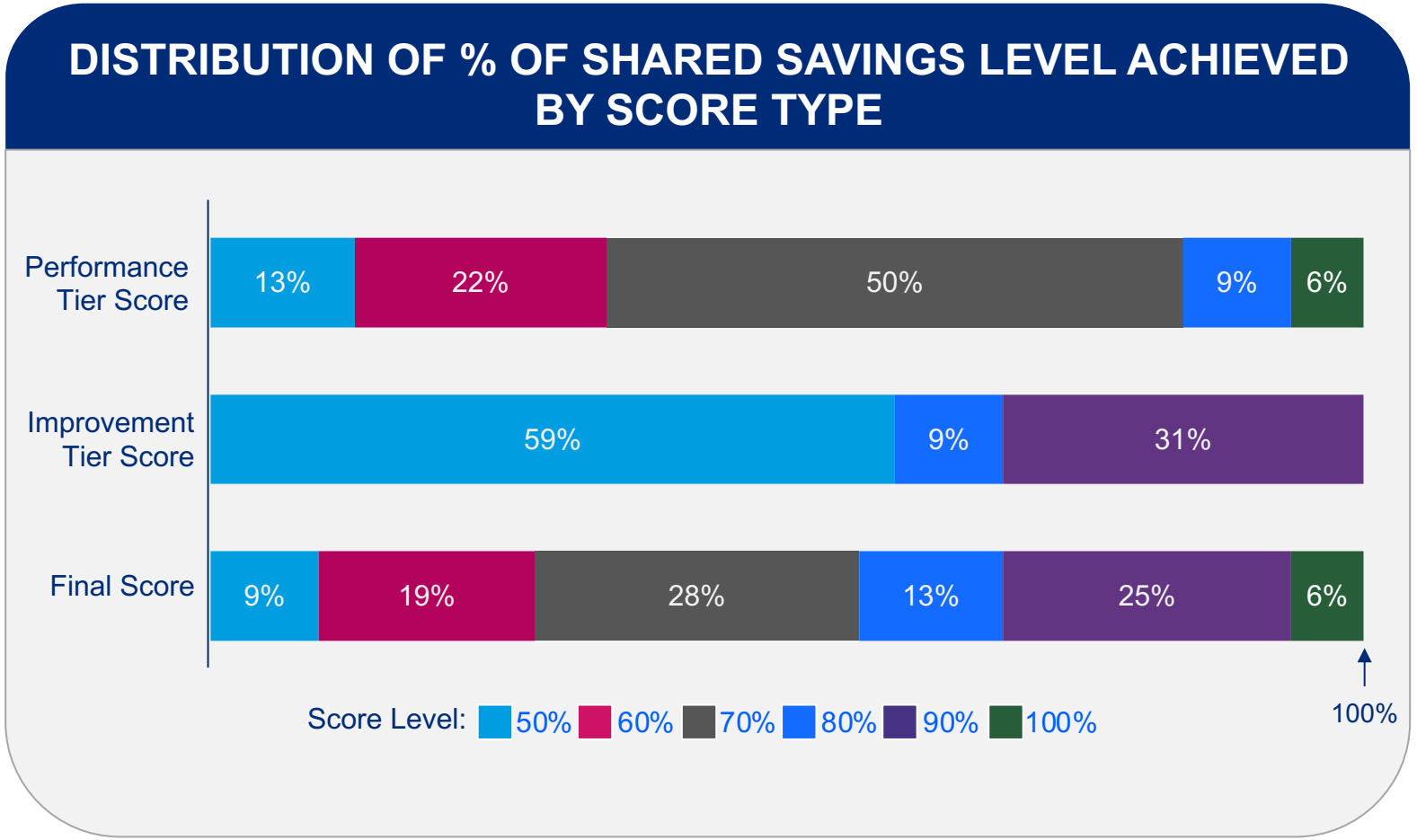
Overall Performance	Performance Earnings Tier	Performance: % Shared Savings
< 55th Percentile of peer group	F	50%
55–60th Percentile of peer group	D	60%
60–70th Percentile of peer group	C	70%
70–75th Percentile of peer group	B	80%
75–80th Percentile of peer group	A	90%
> 80th Percentile of peer group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

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 centre 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



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

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Next Steps & Questions

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What's Next?

Current Priorities

- CMS CMS State Plan Amendment (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 & 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
Provider Bulletin	Provide technical details of the program's payment/billing policies and processes	Q1 2024
2022 Provider Historic Performance Reports	Share previews of each provider's draft case rate payment amount and anticipated performance in the HUSKY Maternity Bundle Program based on 2022 claims data	Q1 2024
Provider Forums	Discuss and review the historic performance reports and share best practices	Q1 2024
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