CT DSS Maternity Bundle

Advisory Meeting

November 22, 2022

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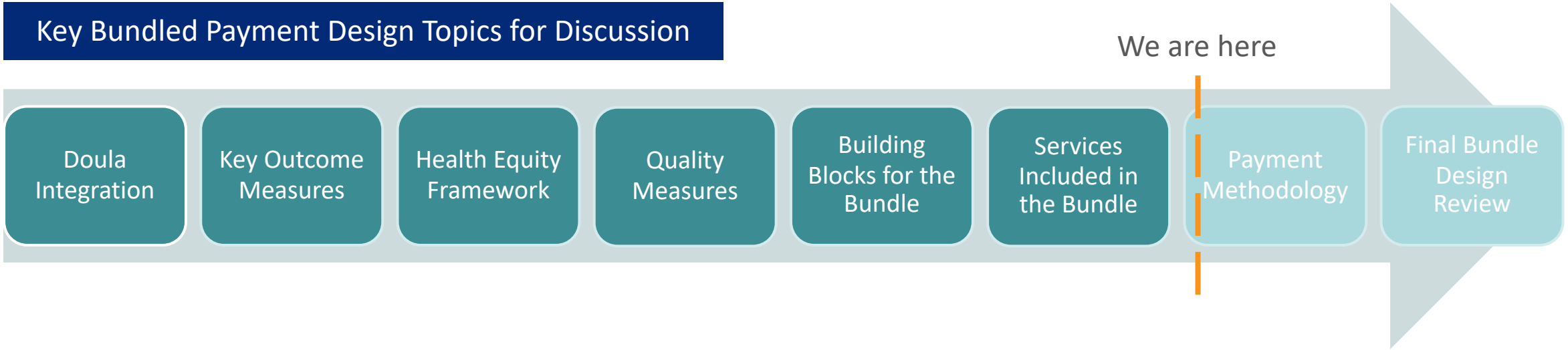
Bundled Payment Program Development

Key Bundled Payment Design Topics for Discussion



Date	Meeting	Upcoming Discussion Topics
11/15 & 11/22	Provider Discussion Group Maternity Bundle Advisory Meeting	Payment methodology, including episode pricing, prospective payment, reconciliation, and adverse actionable events
12/13 & 12/20	Provider Discussion Group Maternity Bundle Advisory Meeting	Quality measure & payment methodology (continued); financial risk; social risk adjustment, and billing/claims.
1/10 & 1/24	Provider Discussion Group Maternity Bundle Advisory Meeting	Input on outstanding policy questions; review of final bundle design

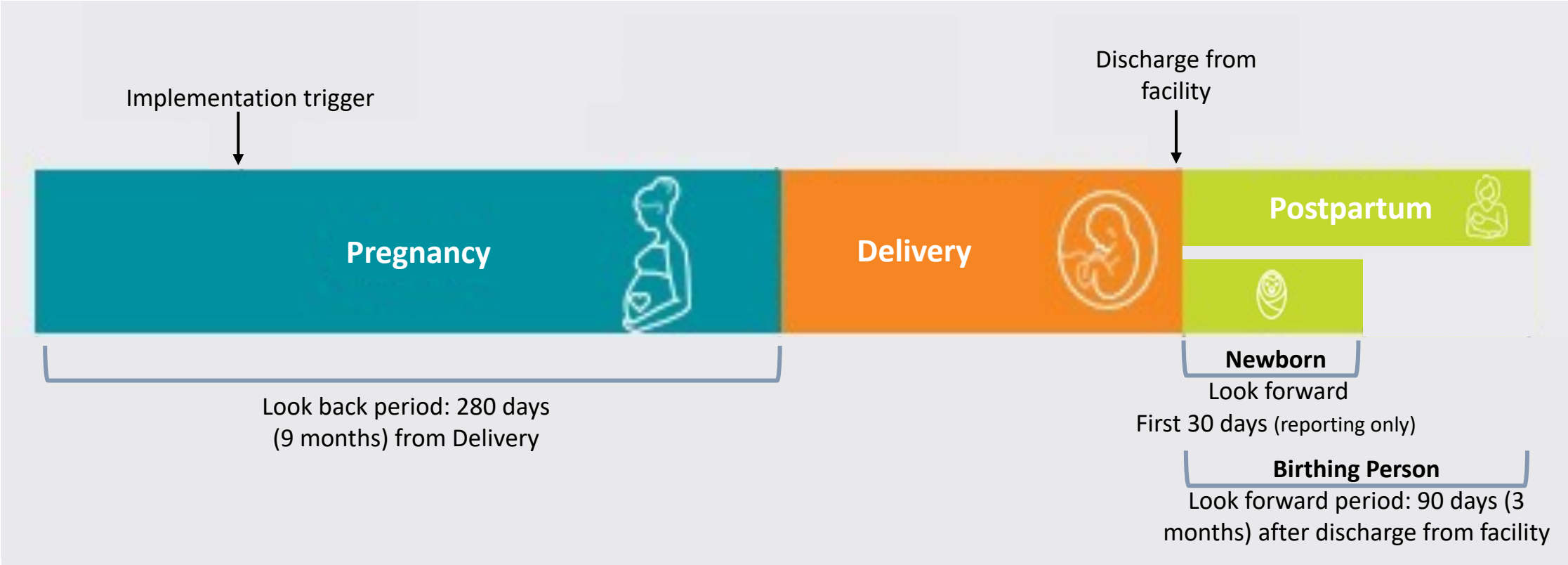
AGENDA

- Doula Integration Update
- Payment Methodology
  - Equity Lens
  - Prospective Payments
  - Retrospective Reconciliation
  - Equity Lens
  - Benchmarks
  - Episode Pricing
  - Adverse Actionable Events
  - Area Deprivation Index
- Questions

Doula Integration Update

- Community Health Network of Connecticut (CHNCT) is working with Primary Maternity Care (PMC), an organization with a local CT presence and an equity focus, to provide the doula integration support needed for implementation.
- Specific Objectives for Doula Integration Include
  - Establish partnerships between doula providers and Ob/GYN/Nurse midwife practices
  - Build the foundation for longer-term sustainability of doula services and sufficient capacity to meet HUSKY member needs
  - Develop and document a model and business process framework for the contract relationships
- Kick-off and Discovery Phase - October 2022 – January 2023
- Planning and Implementation Phase – November 2022 – March 2023
- Some Activities During Both Phases Include:
  - Current Doula Landscape Analysis
  - Action Plan to facilitate partnerships, capacity building for doulas/practices practice prior to launch
  - Develop workflows and business process between doulas and practices
  - Recommendation and implementation plan for DSS and Maternity Bundled Payment Adv. Council
- PMC will provide periodic updates to:
  - Stakeholder Advisory Group
  - Subcommittees
  - DSS Leadership
  - Legislative Oversight Bodies

Reminder: Maternity Payment Bundle



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

Reminder: Key Outcomes Measures

DSS will evaluate program success through six key outcome measures with an emphasis on addressing racial disparities. The aim is to cut racial disparities ***in half by 2027*** and to ***eliminate disparities for each measure by 2032***.

Health Equity Framework - Program Goals

What are the Maternity Bundle goals?	How will DSS accomplish these goals?
Reduce rates for the programmatic outcome measures: • Adverse maternal outcomes • NICU Utilization • NAS (Opioid Specific) • NAS (Overall) • NTSV c-section • Overall c-section	Develop maternity services that: • Close racial disparity gaps in maternal health and birth outcomes • Support parity between provider types (OBs & Midwives) • Include access to doula services, CHWs, lactation counseling, and other supports • Improve patient experience of care • **Structure payment methodologies to improve equity across program outcomes**

Today's discussion focuses on detailed design of the program's payment methodology.

Notes:

- The maternity bundle will monitor and incentivize high-quality, equitable care through *(1) key outcome measures* for progress tracking toward program goals and *(2) quality slate measures* for provider accountability and performance incentives.
- As a key goal is to improve patient experience of care, DSS is also striving to include a validated patient experience measure that spans the birthing person's pregnancy to postpartum period.

Equity Interventions & Improvement Strategies for Payment Methodology

The strategies listed below aim to improve health outcomes and reduce racial disparities for programmatic key outcome measures for HUSKY birthing members.

11/22 Payment Topics	Interventions & Improvement Strategies
Payment Methodology Overview	• Design provider performance payment methodology to align clinical and financial incentives for achieving overall performance and quality metric improvements in aggregate and when stratified by race/ethnicity. • Once implemented, DSS will continuously review and monitor impact of methodology on outcomes to make mid-course adjustments as needed
Prospective Payments	• Give providers upfront capital to encourage greater flexibility in how they deliver care to achieve better outcomes • Utilize as a vehicle to offer new coverage of high-value maternity services, such as doulas and lactation supports
Episode Pricing	• Consider adjusting pricing for blended price of deliveries and/or reduction targets in c-section rate; monitor outcomes
Retrospective Reconciliation, Including Risk Adjustment	• Adjust for historical underutilization by race through social determinants risk adjustment when setting the benchmark & in reconciliation. Consider proxy measures for socioeconomic disadvantage, such as the Area Deprivation Index, to recognize/not penalize providers serving patients with greater social risk

Discussion: What other considerations or interventions should DSS consider?

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/ breastfeeding 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, breastfeeding support

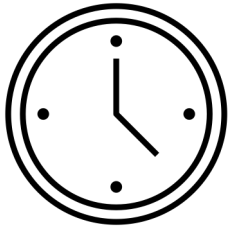
Of all services included, a portion will be paid prospectively. All services included (including those paid prospectively) would be reconciled retrospectively:

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

Timing

Prospective payments will be made **monthly***.



After initiated, all the 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.

***Recommendation from provider subgroup**

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Prospective Payments

Trigger	***Discussion: The following text reflects proposed methodology for prospective payments beginning -- any concerns with this approach? Additional triggers that should be included?***
	Prospective payments will be triggered with a single encounter in either the first or second trimester.
	Tentatively: The earliest evaluation and management (E&M) claim **paired with pregnancy-related ICD-10 diagnoses*** .
Attribution Change	***Discussion: The following text reflects proposed methodology for ending prospective payments when a member changes their care provider -- any concerns with this approach? Additional triggers that should be included?***
	If a beneficiary changes their OB practice after a payment has been triggered, the payments will stop.
	If the pregnancy is in between **X-XX** weeks along at the time of the change, the prospective payment would be remitted to the new OB practice.

***Recommendation from provider subgroup**

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Prospective Payments

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Termination Rules	***Discussion: The following text reflects proposed methodology for prospective payments ending -- Are there other termination rules that should be considered?***
	If a claim is submitted carrying a code indicating the pregnancy was miscarried/terminated
	At 90 days postpartum
Pricing	Prospective payment amounts may vary by practice based on provider-specific utilization history in accordance with prospective payment principles.
	Any variations in amounts paid prospectively will be counterbalanced through the reconciliation process.
	The calculation of the practice specific payment rates will reflect clinical and social risk adjustment.

Retrospective Reconciliation

- Happens at the end of the episode.
- 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 (first year, subsequent years include both up- and downside risk) 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 at least twice per year; as often as Quarterly.***
- ***Discussion: Is twice per year a reasonable timeline for reconciliation?***

*Recommendation from provider subgroup

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Equity Considerations

- The bundled payment is an opportunity to address underserved populations.
- Underservice may show up as fewer services initially but can lead to more expensive emergency room and inpatient services, which are also worse outcomes for the patient.
- Prospective payments to physicians for underserved populations can be adjusted to include costs for Adverse Actionable Events (AAE) that would historically have gone to ER or inpatient services to help prevent AAE.
- The program will allow for monitoring quality for all populations.
- ***Discussion: What factors should DSS consider when implementing risk adjustment for social determinants of health to address health equity?***

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Initial Data Summaries

- This following slides show initial looks at the data.
- The numbers shown are draft and pending final decisions on inclusions and exclusions.
- The numbers include physician, hospital, and other costs and are reflective of total bundled amounts and not physician payments, except when specifically broken out.
- These numbers help frame the components of the bundled payment and show some areas where costs can be changed to improve outcomes.

Benchmarks for Bundled Baseline Data

- The numbers below represent the percentiles for the bundled baseline data.
- This table includes all categories of service.
- This table shows potential thresholds for outliers (winsorization).

Delivery Type	Percentile of Total Dollars per Episode						
	5	10	25	50	75	90	95
Vaginal	$ 2,936	$ 4,693	$ 6,592	$ 8,038	$ 9,974	$ 12,547	$ 14,819
C-Section	$ 3,061	$ 7,228	$ 9,678	$ 11,686	$ 14,511	$ 18,565	$ 22,367

Numbers are draft and subject to change based on final inclusion/exclusion decisions.

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Episode Components

- The numbers below show the breakdown by categories of service for the bundled data.
- The physician numbers specifically include maternity related procedures.
- This table shows that the cost variation between vaginal and c-section deliveries is primarily driven by the inpatient hospital component.

Delivery Type	Percent of Deliveries	Physician	Hospital Inpatient	Hospital Outpatient	Other	Total
Vaginal	66.6%	$ 2,353	$ 3,621	$ 1,230	$ 1,305	$ 8,509
C-Section	33.4%	$ 2,826	$ 6,456	$ 1,551	$ 1,691	$ 12,524
Blended	66.6%/33.4%	$ 2,511	$ 4,567	$ 1,337	$ 1,434	$ 9,849

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Adverse Actionable Events (AAE)

- The numbers below represent the data broken down by stage of the pregnancy and AAE and Typical costs.
- This table includes all categories of service.
- AAE costs not only represent increased costs, but also worse outcomes for the patient. They are opportunities to refocus spending on proactive patient engagement to improve outcomes.

	Typical	AAE	Total
Prenatal	$ 5,247	$ 314	$ 5,562
Delivery	$ 3,850	$ 105	$ 3,955
Postpartum	$ 141	$ 186	$ 327
Total	$ 9,238	$ 605	$ 9,843

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Area Deprivation Index (ADI)

- The Area Deprivation Index (ADI) is a measure for ranking relative income, education, employment, and housing quality between neighborhoods.
- A low ADI score indicates affluence relative to CT as a whole, and a high ADI score indicates high levels of deprivation relative to CT as a whole.
- The data are organized into deciles for the purpose of summarization.
- This is one measure that could potentially inform adjustments for social determinants of health.

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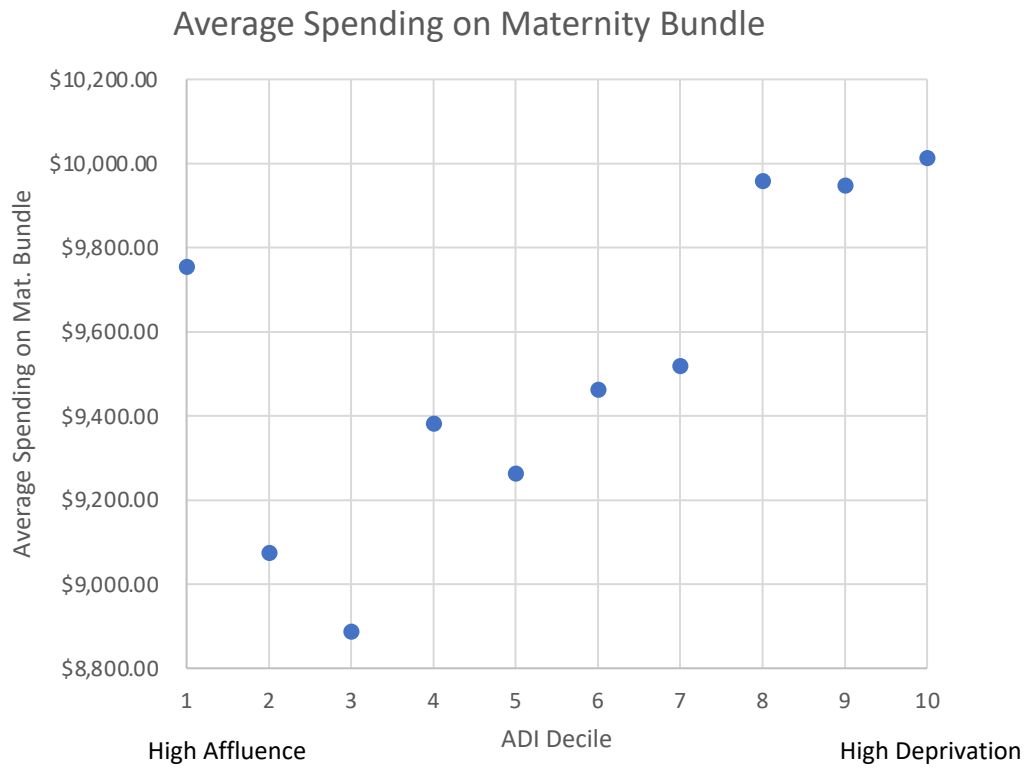
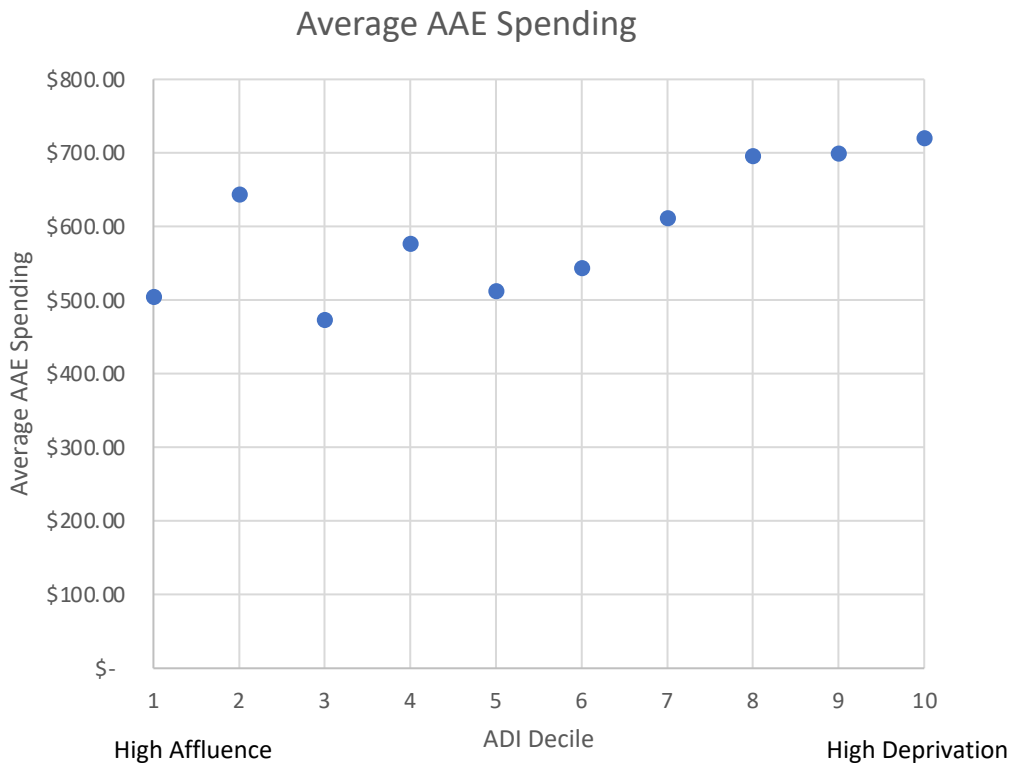
Area Deprivation Index (ADI)





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Area Deprivation Index (ADI)

ADI Decile	# births	Average spending on maternity bundle	Median spending on maternity bundle	Average AAE Spending	% of births, American Indian/Alaska Native, not Hispanic	% of births, Asian, not Hispanic	% of births, Black, not Hispanic	% of births, Native Hawaiian or other Pacific Islander, not Hispanic	% of births, White, not Hispanic	% of births, Other Race, not Hispanic	% of births, Hispanic, any race
1 (relative high *affluence*)	254	$ 11,016	$ 9,754	$ 505	<1%	4%	12%	0%	29%	44%	10%
2	552	$ 10,426	$ 9,074	$ 644	<1%	3%	11%	0%	35%	35%	14%
3	751	$ 10,020	$ 8,887	$ 474	<1%	3%	10%	<1%	37%	37%	12%
4	1,156	$ 10,473	$ 9,382	$ 577	<1%	3%	14%	<1%	33%	35%	14%
5	1,156	$ 10,101	$ 9,264	$ 512	<1%	3%	12%	<1%	38%	29%	16%
6	1,825	$ 10,375	$ 9,463	$ 544	<1%	3%	15%	<1%	30%	30%	21%
7	2,452	$ 10,656	$ 9,519	$ 612	<1%	3%	18%	<1%	27%	29%	22%
8	3,546	$ 10,965	$ 9,958	$ 696	<1%	2%	22%	<1%	21%	27%	27%
9	4,620	$ 11,110	$ 9,948	$ 699	<1%	2%	21%	<1%	19%	27%	31%
10 (relative high *deprivation*)	6,315	$ 11,146	$ 10,014	$ 720	<1%	1%	22%	<1%	12%	28%	35%

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Questions?
Additional Feedback?

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