HUSKY Maternity Bundle Payment Program
Program Specifications

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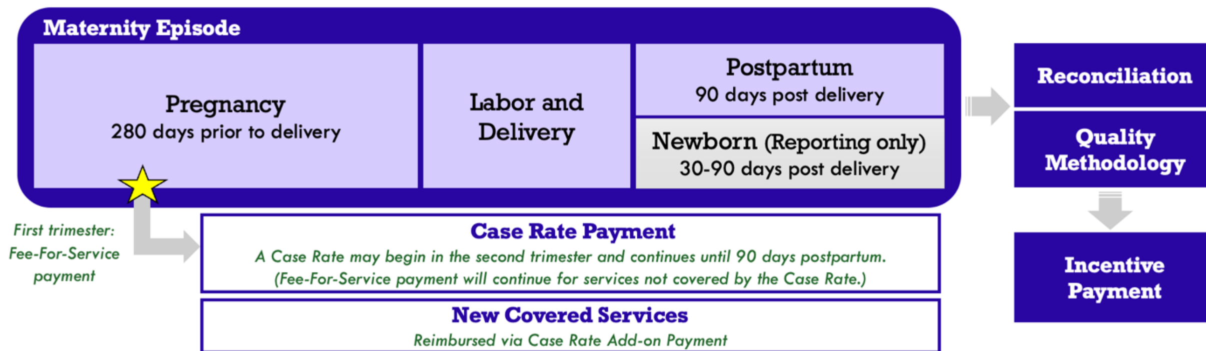
The Connecticut Department of Social Services (DSS) anticipates transitioning to an episode-based payment model for maternity care reimbursement with a planned launch effective on January 1, 2025 (i.e., the program is not yet in effect and the implementation date will be finalized, which will be subject to federal approval). This plan to implement the HUSKY Maternity Bundle Payment Program is part of DSS' overarching goal to move toward paying for equitable care in a value-based way.

Note: DSS reserves the right to update the Program Specifications after reviewing stakeholder input, completing program testing, and additional analysis.

Maternity Episode Definition

An episode of care describes the total amount of care provided to a beneficiary during a set timeframe. As shown below, the maternity episode includes services across the full perinatal period, spanning 280 days before the date of delivery to 90 days after the date of delivery.



Accountable Provider

In episode-based payment models, the "Accountable Provider" is the provider with the greatest influence and responsibility over the quality and cost of care delivered during the maternity episode. The Accountable Provider is the maternity billing provider entity delivering maternity services, and they may be eligible to receive Case Rate and/or incentive payments, which will be provided to the billing Tax ID.

Key Detail	Episode Base Definition
Provider Specialty	• Episodes may be attributed to outpatient Obstetrics (OB) and Licensed Midwife providers or provider groups[1] • Attribution eligibility is limited to a subset of provider specialties: Physician/Group Obstetrics and Gynecology (including Maternal Fetal Medicine); Certified Nurse Midwife/Group; Obstetric Nurse Practitioner/Group; Women's Health Nurse Practitioner/Group
Minimum Episode Volume	• Eligible providers that meet the minimum episode volume threshold of 30 deliveries in the past 12 months will be automatically enrolled in the program.
Trigger Code	• ICD-10-CM, HCPCS or service codes[2] that formally assign the beneficiary's episode to an Accountable Provider

[1]Payment for the provider group (billing TIN entity) will be made to the Medicaid (AVRS) ID that received the most revenue in the prior year, and practices may specify a different Medicaid ID to direct payment to, by request.
[2]A full list of codes is available on the DSS website.

Case Rate Methodology
Each Accountable Provider's Case Rate would be set before the beginning of Performance Year 1 (January 1, 2025 to December 31, 2025). For Performance Year 1, the deliveries incurred during the calendar year 2023 (10/1/2022 to 9/30/2023) that were attributed to each accountable maternal care specialty provider will be used to develop its Case Rate setting. Specifically, the claim costs for professional maternal care services incurred during the second and third trimester, delivery (if performed by the Accountable Provider), and postpartum period and billed by the attributed Accountable Provider will be included in the Case Rate. The maternal care services are defined by the Case Rate code set (a list of procedure codes), which is available on the DSS website.

Trigger Event Criteria
To qualify for Case Rate payment as an Accountable Provider, providers must submit a claim that meets the following criteria:

- Perform 30 or more deliveries annually
- Submit a claim with a trigger diagnosis code (outlined in the Code List on the DSS website here) and one of the following Evaluation & Management (E&M) codes 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215.
- Submit a claim with a qualifying place of service location: 11 (office), 19 (off-campus outpatient hospital), or 22 (on-campus – outpatient hospital)
- Bill as a qualifying maternity bundle specialty type, which includes Obstetrics and Gynecology (including the subspecialty MFM), Certified Nurse Midwife, Obstetric Nurse Practitioner, and Women's Health Nurse Practitioner.

Service Inclusion & Exclusion Criteria

Key Detail	Episode Base Definition
Services Included in the Episode	**Services Included for Case Rate Payment**[2] The provider-specific Case Rate payment reimburses a defined set of services rendered by the Accountable Provider during the prenatal and postpartum periods of the episode. Services eligible for or included in the Case Rate payment include: • Office visits • Emergency room visits • Inpatient professional or facility services • Labs, radiology, imaging or ancillary services *if performed by Accountable Provider* • Pregnancy health screenings (inclusive of chlamydia and cervical cancer screenings, intimate partner violence screening, and behavioral health evaluations • New maternal health services provided under the supervision of the accountable practice and within both the scope of the provider's overall services and the provider's plan of care for each beneficiary *(specifically, both doula care and lactation supports)* • Child birth and parenting education services • Care coordination activities **Services Included for Reconciliation (Incentive Payment Calculation)**[2] All Medicaid claim costs for covered services (regardless of the provider that performed the service) will be included in the incentive payment calculations. Services included in the incentive payment calculations will continue to be paid in accordance with the reimbursement methodology applicable to the provider and service. Unless excluded below, services included for reconciliation include, but are not limited to: • Office visits • Emergency room visits

	• Inpatient professional or facility services • Labs, radiology, imaging or ancillary services • Pregnancy health screenings (inclusive of chlamydia and cervical cancer screenings, intimate partner violence screening, and behavioral health evaluations) • Child education services • Care coordination activities • Birth centers and hospital costs related to maternity care • Specialist/professional services related to maternity (e.g., anesthesia) • General pharmacy related to maternity • Any of the aforementioned services provided via telehealth
Excluded Services from the Episode	**Services Excluded from the Bundle** The following services are excluded from the incentive payment calculations: • Pediatric Professional services • Neonatal Intensive Care Unit (NICU) services • Behavioral Health and Substance Use Disorder services • Long-acting reversible contraceptive (LARC) devices and related services • Durable Medical Equipment (DME), e.g., blood pressure monitors, breast pumps • High-cost medications (specifically, HIV drugs and brexanolone) • Flu and TdAP vaccines • Hospital costs unrelated to maternity (e.g., appendicitis) and other care unrelated to maternity that the beneficiary would still receive if they were not pregnant (e.g. Respiratory Care, Home Care, etc.). Other care and services unrelated to maternity are defined as services that the birthing person regularly receives or would receive when they were not pregnant.

New Coverage of Doulas and Lactation Support

DSS plans to incorporate access to doula services and lactation supports as core features of the HUSKY Maternity Bundle Payment Program to bridge the equity gaps for historically marginalized birthing people. The new high-value services shall be provided under the supervision of the Accountable Provider and within both the scope of the provider's overall services and the provider's plan of care for each beneficiary. Accountable Providers may receive up to $21 total for add-on funding: $14 for doula services and $7 for lactation supports. The add-on payment will be provided prospectively and excluded from reconciliation, and doula care will be subject to a retrospective true up process.

To enable provider flexibility, Accountable Providers may opt out of receiving the doula care Case Rate add-on payment prior to each performance year; no mid-year changes will be permitted. Prior to the performance year, all providers will receive outreach from CHNCT, Inc. Provider Engagement Services (PES), informing them of this opt-out option and providing the doula care Case Rate add-on payment opt-out form. Providers must complete and submit the opt-out form to their CHNCT, Inc. PES representative.

For Accountable Providers who receive doula care add-on funding, below is an overview of the doula care Case Rate add-on payment methodology and the subsequent true-up process. The doula care add-on funding will be provided prospectively, subject to a retrospective true-up process, and excluded from the incentive payment reconciliation. Accountable Providers must document and report on doula services provided over a period to be specified by DSS. This report must contain an aggregate count of doula services provided over the period with a certification that the provided doula services are not duplicative of any other Medicaid-funded service. Moreover, DSS will supply each Accountable Provider with a list of fee-for-service (FFS) doula claims and require

each Accountable Provider receiving add-on payments to attest that no FFS doula claims were made for beneficiaries tied to the add-on payment. In turn, DSS will reconcile the amount distributed to each Accountable Provider for the doula services portion of the add-on payment against actual doula services provided in the specified period. If actual doula services provided exceed prospective doula payments, DSS will provide additional payment to yield balance; conversely, if prospective doula payments exceed actual doula services provided, DSS will recoup the commensurate amount of extra payment to yield balance. DSS will only claim federal match for actual doula services provided.

Description of Doula Services
Doula services are limited to childbirth education and support services, which includes emotional and physical support, provided during pregnancy, labor, birth, and postpartum. Doula services must be provided under the supervision of a physician, nurse practitioner, or nurse-midwife. Additional background resources for providers and doulas can be found at the DSS website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/HUSKY-Maternity-Bundle/Doula-Integration

Description of Lactation Support Services
1) Providers should provide first-line breast feeding education and support to all members. This includes information about the benefits of breastfeeding, as well as support for mothers who are struggling. It could also include existing or developed tools to assist mothers gauge breastfeeding success. This program could include online modules, in-person classes, and one-on-one support from lactation consultants.

2) Providers should also screen all members for potential breastfeeding difficulties or additional risk factors that may require additional expertise. Utilize or develop a screening tool to identify members who are at risk for breastfeeding problems. This tool could be used by nurses, midwives, IBCLCs and other healthcare providers during prenatal and postpartum visits.

3) Finally, providers should ensure appropriate access to International Board-Certified Lactation Consultants (IBCLCs) for members at risk or presenting with clinical problems related to breastfeeding/lactation. Establish a system for members who need clinical lactation support with breastfeeding. This system could connect members with IBCLCs who are available to provide in-person, video, or phone support.

Exclusion Criteria
If a patient meets one or more exclusion criteria below, DSS will no longer include them in the Maternity Bundle program. In these instances, the Accountable Provider may still receive Case Rate payments; however, their patient's episode of care (whether complete or incomplete) will be excluded from retrospective reconciliation (i.e., ineligible for incentive payments).

Key Detail	Episode Base Definition
Exclusion Criteria	• Age <12 or >55 • Mother/birthing person left the hospital against medical advice prior to discharge • Any substantial gap in enrollment or eligibility during the delivery episode • Patient began prenatal care in the third trimester (i.e., there were no claims incurred during the first two trimesters of the pregnancy) • Patient switched providers in the third trimester • Patient switched providers in postpartum to a provider who had not previously never submitted a pregnancy trigger in the second or third trimester • Missing a facility claim in the episode's delivery

	• Multiple birth deliveries • Stillborn delivery • Miscarriage or abortion *Newborn Exclusions (for reporting purposes only):* • The baby was born with a serious congenital anomaly • Baby could not be linked with the delivery episode

Treatment of Unique Cases

For members with third party liability (TPL), DSS will pay claims with a TPL paid amount using standard FFS processes. Providers who currently bill global code for members with Medicaid as secondary coverage can continue billing for these members using global code instead of triggering Case Rate payments.

For members with multiple births, multiple births deliveries will be paid through the Case Rate and can continue through the end of the 90-day postpartum period. Episodes with multiple births will be excluded from reconciliation.

For members with stillborn births, stillborn deliveries will be paid through the Case Rate but will stop the Case Rate the following month. Episodes with stillborn deliveries will be excluded from reconciliation. For members with miscarriages or abortions, miscarriage or abortion CPT codes will be paid FFS (i.e., excluded from the Case Rate). The Case Rate will stop once the miscarriage or abortion has been billed; however, other maternity services rendered within the same month prior to the miscarriage or abortion will still be paid through the Case Rate. Episodes with miscarriages or abortions will be excluded from reconciliation.

Risk Adjustment Factors

As described in the SPA, risk adjustment will be applied during retrospective reconciliation. Below are the risk factors that will be included during the clinical and social risk adjustment.

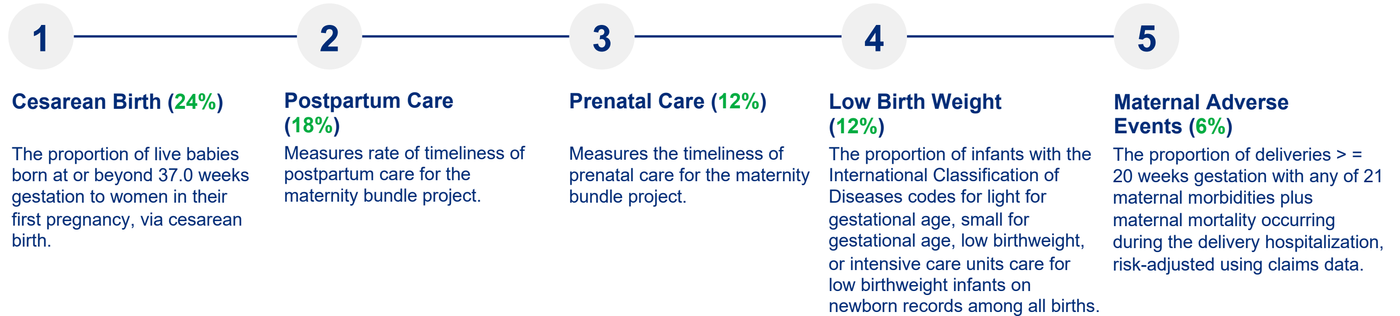
Key Detail	Episode Base Definition
Clinical Risk Adjustment	The following list of risk factors will be used to capture the clinical risk of the individual patient and the effect on the episode of care cost: • Member demographics: age and gender • Episode subtypes: subcategories of an episode that identify different modalities and cost trajectories • Risk factors: comorbidities present at the start of the episode which could influence episode cost • Supplemental risk adjustors: enrollment duration and line of business
Social Risk Adjustment	• To support or promote the provision of services to individuals in underserved communities and promote health equity in the model design, the Area Deprivation Index (ADI) will be used for social risk adjustment. • The ADI is a relative index of affluence and deprivation between areas at the 9-digit ZIP code level. • The ADI will be determined for the population each Accountable Provider serves, and that information will be used as an adjustment factor similar to the health-based risk adjustment. • For members living in area without an ADI, the average ADI for the Accountable Provider's patient panel will be used.

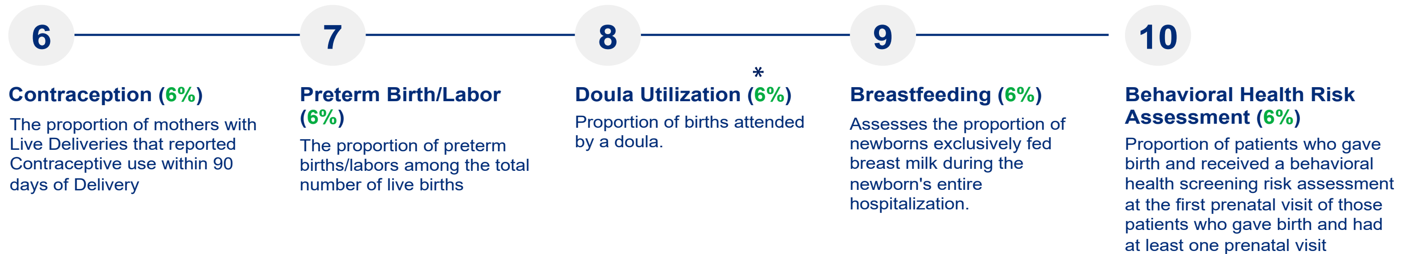
Quality Methodology

Incentive payments are contingent upon Accountable Providers meeting quality performance criteria established by Medicaid.

Quality Measures and Weights

Please see the Quality Measures Guide on the DSS website for more information.





*DSS will only require practices that receive the doula care add-on payment to report on the doula utilization measure. Pay for Reporting measure weights for practices that do not receive the doula care add-on payment will be reweighted, in which the four remaining Pay for Reporting measures will be weighted at approximately 7% each. Please see the Quality Measures Guide on the DSS website for more information.

Methodology and Assumptions

The distribution of incentive payments is adjusted based on either the overall performance in relation to peer performance ("Performance Tier Score") or the percent improvement over baseline from historical performance ("Improvement Tier Score"). As demonstrated in the illustrative example below, Accountable Providers will receive payment in accordance with their highest earnings tier between the two methodologies.

Accountable Providers who fall into the lowest tier (Tier F) for both the Performance Earnings Tier and the Improvement Earnings Tier will be required to submit a quality improvement plan in order to earn incentive payments for the Performance Year. In the subsequent Performance Year, if an Accountable Provider consecutively maintains quality performance in Tier F for both tiers, the provider will be ineligible for the incentive payment of that performance period.

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%

Illustrative Example