CT DSS Maternity Bundle

Advisory Council Meeting
February 21st, 2023

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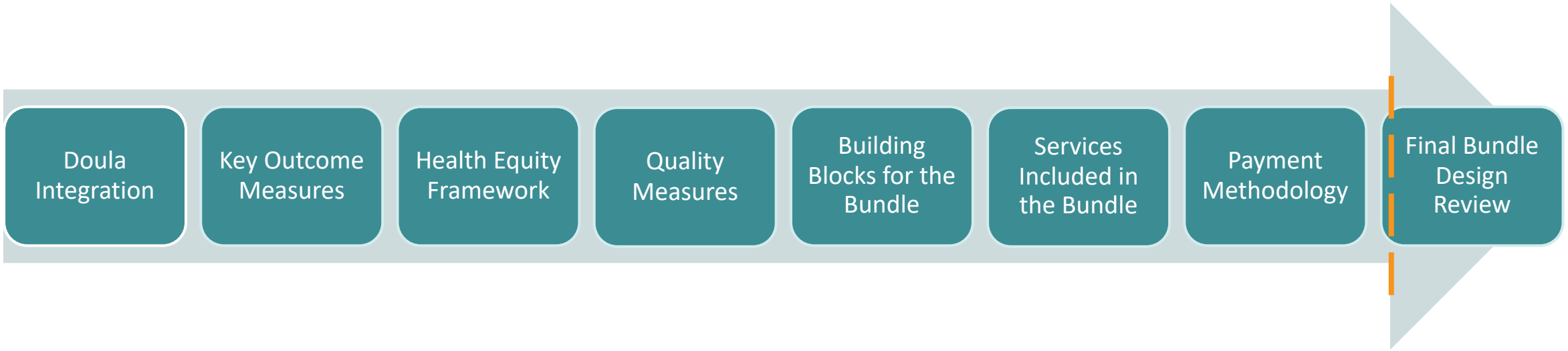
Bundled Payment Program Development

Key Bundled Payment Design Topics for Discussion

We are here



Date	Meeting	Upcoming Discussion Topics
2/21	Maternity Bundle Advisory Meeting	Review of final bundle design.

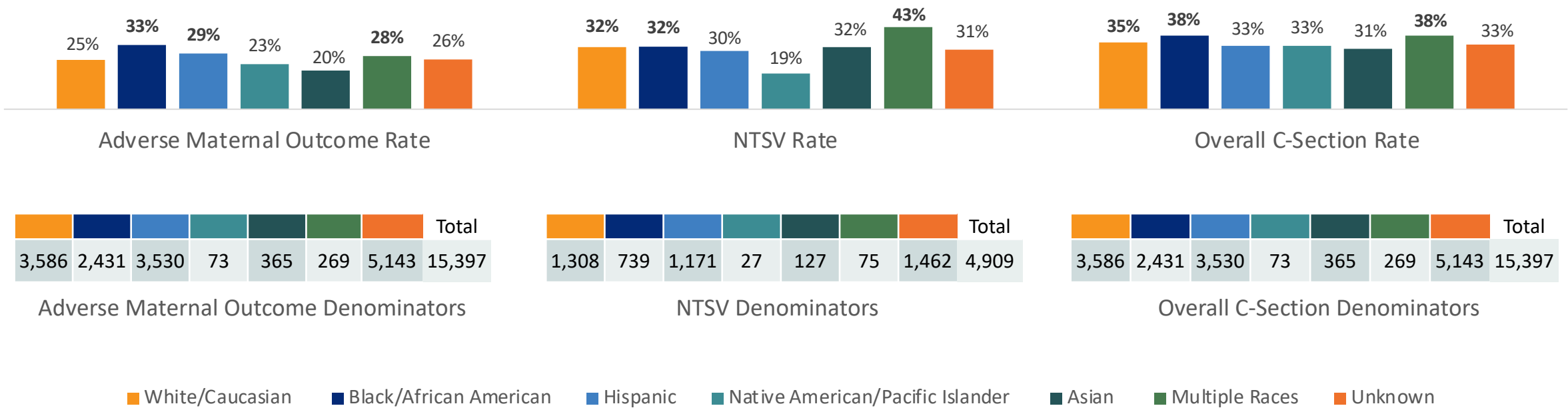
Today's Agenda

Review of Final Bundle Design:

- Defining Success
- Building Blocks of the Bundle
- Services Included
- Quality Methodology
- Payment Methodology
- Social Risk Adjustment

2021 Maternal Health Outcomes by Race & Ethnicity

Maternity Benchmarking Metrics by Race / Ethnicity, CT, 2021

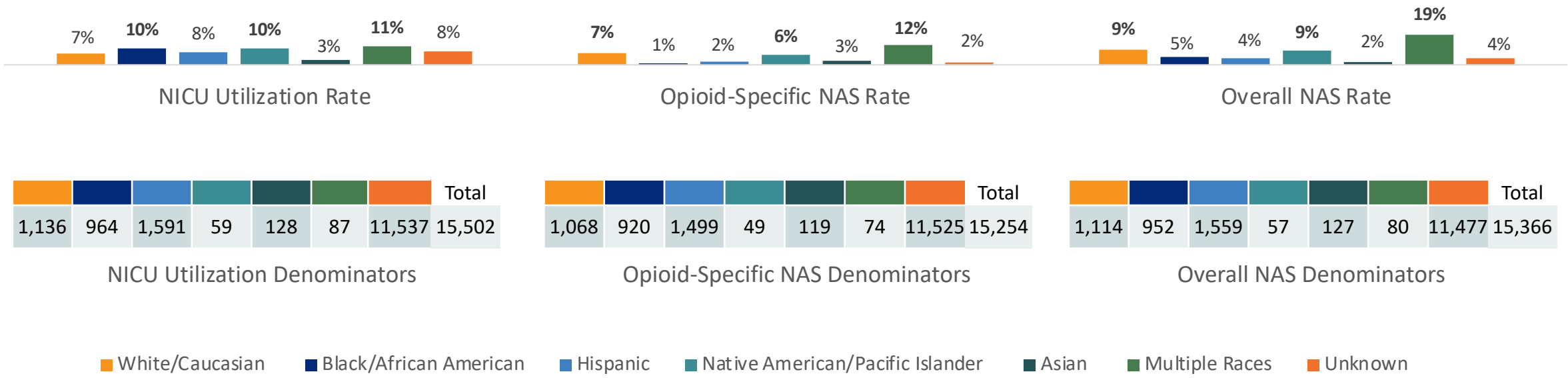


Source: CT DSS Provided Data, provided by CHN

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. ***NTSV*** – Race based on mother's member record. ***Overall C-Section*** – Race based on mother's member record. Determined by match in the C-Section value set.

2021 Infant Health Outcomes by Race & Ethnicity

Maternity Benchmarking Metrics by Race / Ethnicity, CT, 2021



Source: CT DSS Provided Data, provided by CHN

About the Metrics: ***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. ***Opioid-Specific NAS*** – Race based on baby's member record. Determined by diagnosis code P96.1 on baby's birth claim. ***Overall NAS*** - Race based on baby's member record. Determined by presence of one of the following diagnosis codes on baby's birth claim: P96.1, P04.42, P04.1A, P04.14, P04.40, P04.41, P04.81, P04.49, and P04.16.

Key Outcomes Measures of Program Success

Initial rounds of stakeholder discussions identified six key outcome measures to evaluate success of the overall bundled payment program with an emphasis on addressing racial disparities: reduce disparities by 50% by 2027 and eliminate entirely by 2033.

Goal - Reduce overall rates as well as disparities for the following key outcome measures:

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

Notes:

- Additional measures will also 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 aims to include a validated patient experience metric in quality slate that spans the birthing person's full perinatal period

Episode Definition

A **Comprehensive Bundle** inclusive of services across all phases of the perinatal period (prenatal, labor & delivery, postpartum)

Pregnancy:

- Monthly prenatal visits
- Routine ultrasound
- Blood testing
- Diabetes testing
- Genetic testing
- Doulas
- Care navigators
- Group ed meetings
- Childhood ed classes
- Preventive screenings (chlamydia, cervical cancer, etc.)

Labor and Birth:

- Vaginal or C-section delivery

Postpartum:

- Breastfeeding support
- Depression screening
- Contraception Planning
- Ensuring link from labor and birth to primary and pediatric care providers occurs for birthing person and baby

Payment Flow

Payment Approach

Hybrid Payment Approach: prospective payment to providers for services provided by OB/certified midwife + retrospective settlement of total costs associated with the services included in the maternity bundle, including related services outside the practice.

Prospective Payment	Retrospective Reconciliation
Accountable providers will be paid a set amount of money for certain services that an expecting individual will need	Retrospective (e.g., at the end of the bundle) 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.

- **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 Entity (Provider)

The Medicaid Bundled Payment Program will include all Obstetrics (OB)/Licensed Midwife practices in CT's Medicaid program, as well as Family Medicine providers who provide OB services.

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 retrospective 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. The impact of changes in care providers is still being evaluated.
- Pregnancies for maternity providers that provide care during the prenatal period but do not perform the delivery are planned for inclusion.

Bundle Attribution

To promote better access to care and improved health outcomes, DSS is striving to improve and encourage earlier enrollment for program participation.

- In 2021, 89.1% of members enrolled in CT Medicaid in the first or second trimester. These members would be eligible for the prospective payment after meeting the criteria for attribution below.
  - To initiate prospective payments, a claim with a second trimester Z34, Z3A, or O09 code must be submitted.
  - That claim and subsequent maternity-related claims for that member from that provider would be paid through the prospective payment.
- Based on historical data, 68% of pregnancies would be attributed to a provider and be eligible for prospective payments. The non-attributed pregnancies are due to not being enrolled by the second trimester or not having a visit with an eligible trigger code in the second trimester.
- DSS is striving to improve and encourage earlier enrollments and prenatal visits. Launched HUSKY B Prenatal Care coverage program for unborn children of non-citizen pregnant individuals April 2022.

Medicaid Enrollment by Trimester

Husky Enrollment	Pregnancies	% of All Pregnancies
1st Trimester	12,666	82.0%
2nd Trimester	1,091	7.1%
3rd Trimester	1,602	10.4%
Unknown	78	0.5%
Total	**15,437**	**100.0%**

2021 data from CHNCT

Reasons for Non-Attribution:

- Enrollment after the 2nd trimester
- No trigger code billed
- No visit in the second trimester

Member Inclusion/Exclusion Criteria

All pregnant and birthing Medicaid members in Connecticut will be eligible for the Bundled Payment Program Retrospective Reconcilation 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

  Note: Persons who initially qualify for prospective payments but later meet exclusion criteria (i.e., someone who has a stillborn) will be excluded from retrospective reconciliation.

In addition, the pregnancy, delivery, or newborn components of the maternity bundle can be excluded in the retrospective reconciliation for the following reasons:

- 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
- Extending to 90 days (from 60) provides more support for lactation counseling in the extended postpartum period

Principles for Prospective, Retrospective and FFS 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 FFS.

	Principles
Covered services included for *Prospective* Payment	• Services provided in-house/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* Reconciliation	• 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 fee-for-service)	• Services provided by either the 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 doula care and breastfeeding support. 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 Fee for Service (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	*Excluded per 1st Order Decisions:* • Pediatric Professional Services • Neonatal Intensive Care Unit (NICU) *Other Exclusions:* • Behavioral Health & Substance Use services • Long-acting reversible contraception (LARC) • Sterilizations • DME (e.g., blood pressure monitors, breast pumps) • Select list of excluded high- cost medications (list to be finalized) • 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 and breastfeeding support. Services "excluded from the bundle" will not have its associated costs of care factored into bundle payment pricing or reconciliation.

Quality

Maternity Bundled Payment Year 1 Quality Measure Set

	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. *(Additional measures are still under consideration pending feasibility of data collection)*	Custom Measure	Encounter form
	Breastfeeding	Assesses the number of newborns exclusively fed breast milk during the newborn's entire hospitalization. *(Additional measures are still under consideration consideration pending feasibility of data collection)*	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).

Measure Weights for Pay for Reporting (P4R) vs. Pay for Performance (P4P)

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%	

Maternity Bundle Key Design Elements - 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 Tier 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 Tier 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 Tier Quality Score - Combined Metrics (All Measures)	Step 2D: Combined Metrics (P4P Only)	Step 3: Change from Baseline (P4P Only)	Step 4: - Improvement Tier Quality Score - % Change from Baseline (P4P Only)
90.1%	66.5%	14.3%	27.4%

Maternity Bundle Key Design Elements - Quality Score Impact to Payment

Proposed implementation is to look at both overall performance and percent improvement over baseline, where providers receive payment in accordance with their highest earnings percentage between the two tier options.

Payment Methodology

- **Step 1:** Map **Performance Tier Quality Score** to Performance: % Earnings
- **Step 2:** Map **Improvement Tier Quality Score** to Improvement: % Earnings
- **Step 3A:** Use the higher % Earnings between the Performance and Improvement Tiers to determine the Final % of Earnings
- **Step 3B:** If the Final % of Earnings is 70% (lowest tier), earnings are conditional upon submitting a quality improvement plan

Draft Performance Tiers

Overall Performance	Performance Tier	Performance: % Earnings
<60%	D	70%
60-75%	C	80%
76-90%	B	90%
>90%	A	100%

Draft Improvement Tiers

Improvement	Improvement Tier	Improvement: % Earnings
<3%	D	60%
3-5%	C	70%
5-10%	B	80%
10%+	A	90%

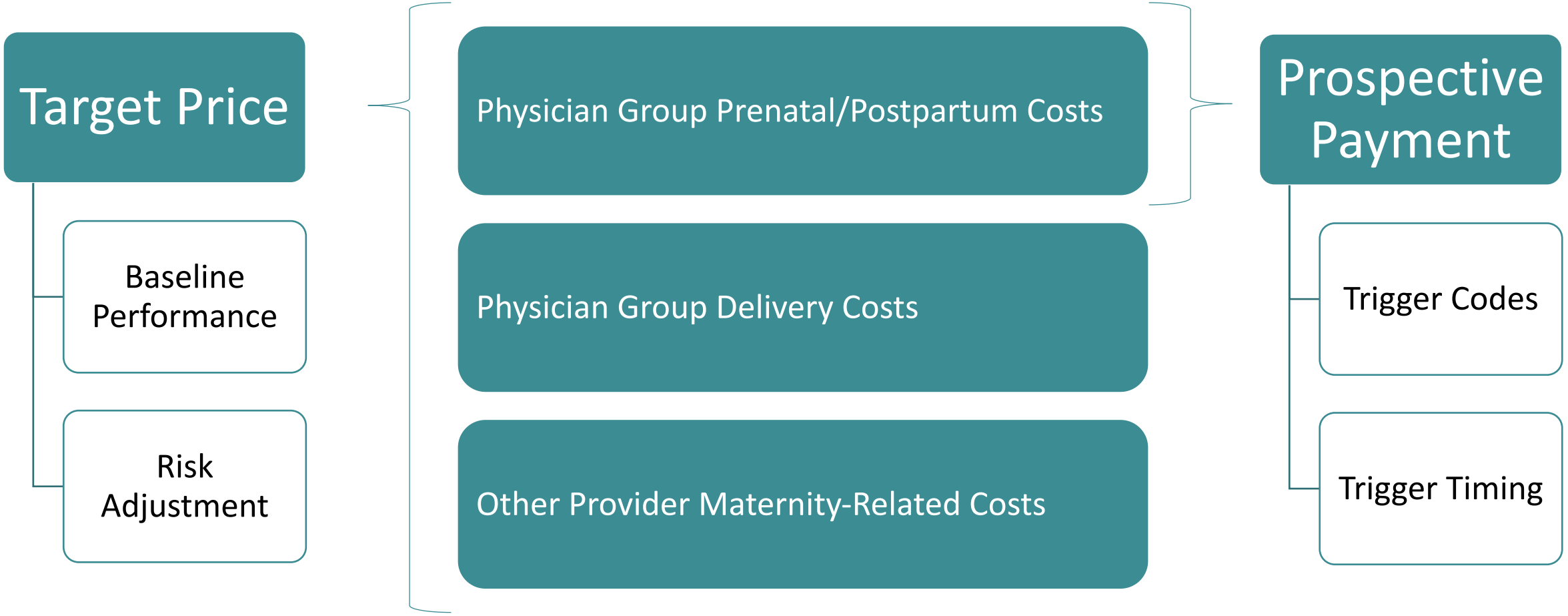
Example Scenarios

Provider Group	Performance Tier	Performance: % Earnings	Improvement Tier	Improvement: % Earnings	Final % of Earnings
Group 1	B	90%	D	60%	**90%**
Group 2	C	80%	D	60%	**80%**
Group 3	D	70%	A	90%	**90%**
Group 4	A	100%	A	90%	**100%**
Group 5	D	70%	A	90%	**90%**
Group 6	D	70%	D	60%	**70%***
		Step 1		**Step 2**	**Step 3A**

***Step 3B:** Group 6 earnings are conditional, contingent upon submission of a quality improvement plan

Example from prior page:
90.1% performance and 27.5% improvement =
Performance Tier A and Improvement Tier A.
Therefore:
Provider would earn 100% of payment

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, 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

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 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

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Prospective Payment Amount

- The prospective payment will be paid during the prenatal and postpartum periods.
- The payments are based on each provider's historically provided services during the prenatal and postpartum periods and exclude delivery costs.
- Draft monthly prospective payments average $149 and vary from $57 to $195 (5th percentile to 95th percentile).
- An additional $21/month will include doulas.
  - Note: DSS is still determining how to handle the Doula payments during retrospective reconciliation.
- These numbers are draft and are subject to change.

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Provider Specific Target Prices

- Target prices include the overall costs of the pregnancy and delivery for all providers.
- Provider-specific targets 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.

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Provider Specific Target Prices Cont'd

- The calculation of the practice specific payment rates will reflect clinical and social risk adjustment.
- For year one, target prices will be adjusted to add amounts for funding doulas.
- 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.

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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 once per year with the provision of quarterly provider data reports.

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 were calculated using a regression analysis.
- The regression analysis used maternity-related health factors and social factors as the independent variables and per-delivery costs as the dependent variable.
- The regression assigns each factor a weight, representing the estimated impact on cost that each factor has.
- 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.
- A risk score greater than 1 is expected to lead to higher cost, and a risk score less than one is expected to lead to lower cost.

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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.
- ADI 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, including individual-level, may be used as further data becomes available.

Social Risk Adjustment

To address differences in social risk in the members served by different providers, DSS intends to adjust for social risk based on ADI decile.

ADI Decile	Count of Births	Average Per-Delivery	IP Adjusted Per-Delivery	Normalized Health Risk Score	Health Risk Adjusted Spend
1	427	$ 9,527	$ 9,588	0.984	$ 9,745
2	877	$ 9,330	$ 9,317	0.948	$ 9,825
3	1,178	$ 8,967	$ 9,024	0.976	$ 9,246
4	1,638	$ 9,271	$ 9,317	0.974	$ 9,563
5	1,599	$ 9,239	$ 9,226	0.987	$ 9,346
6	2,300	$ 9,388	$ 9,380	0.997	$ 9,412
7	3,020	$ 9,499	$ 9,525	0.999	$ 9,538
8	4,104	$ 10,007	$ 10,002	0.997	$ 10,033
9	5,253	$ 10,156	$ 10,183	1.012	$ 10,066
10	6,994	$ 10,193	$ 10,262	1.014	$ 10,120
Total	27,390	$ 9,812	$ 9,842	1.000	$ 9,842

- Since ADI data were last shown, deciles for additional pregnancies have been determined.
- To adjust for differences in Inpatient costs, the IP Adjusted Per-Delivery amount shown uses the statewide average cost of an Inpatient DRG and severity rather than that of a specific hospital.
- The Per-Delivery costs are adjusted using a Health Risk Score for maternity-related health status.
- After risk adjustment, the ADI deciles 8-10 are 6% higher in cost compared to 1-7.
- From a risk score analysis, ADI deciles 8-10 represent a 3-4% cost increase over 1-7. By using 6%, ADI would be weighted more heavily than it would be in a typical risk score.
- DSS' goal is to ensure a level playing field for providers, and therefore intends to adjust for social risk based on the ADI decile.

Next Steps

- PMC's Doula Integration Update (special Advisory Council meeting)
- Before and after the program launch, DSS will hold reoccurring forums to discuss data, best practices, and any new programs updates
- Document bundled payment policies and processes through a draft concept paper
- Planned launch for Summer 2023

Appendix

Project Objectives: DSS Goals & Principles for Design

Goals: Develop an innovative and nation-leading value-based payment for maternity services that:

1. Addresses **racial disparities** in maternal health (including SUD) and birth outcomes
2. Reduces incidence of **unnecessary Cesarean procedures & early elective births**
3. Supports parity between OBs & midwives, and includes **access to doula services, CHWs and breastfeeding support**
4. Creates opportunities to **align payment models** across Medicaid and State Employee Health Plan (particularly quality measures)
5. Ensures implementation remains **cost neutral** for DSS budget, and ultimately program should **save money** attributable to improved maternal & newborn outcomes
6. Considers impact of **timing of enrollment** in limited benefits on maternal health and birth outcome

Principles: Use the following principles when making policy recommendations:

1. Align with DSS Goals
2. Use evidence-based practices and model after best practices, including aligning financial incentives across public payer & providers
3. Health Equity Plan
4. Consider stakeholder input and priorities in bundle design
5. Keep bundle methodology simple wherever possible

Reflected in work completed to date

Overview of the "Health Equity Yardstick"

Promoting health equity is a central component of CT DSS' work.

- The team created a Health Equity Framework that aims to help DSS intentionally apply an equity lens at each program stage of development: initiation, design/implementation, and evaluation
- This tool will be used to ensure that equity is the driving force for all aspects of design and implementation of new DSS programs and existing program updates
- The Maternity Bundle Project will be the first opportunity to put this tool into practice

Section 1: Design Readiness Checklist

- Completed at the beginning of project work and the answers should be consistent throughout the project, but this section is open to changes as we learn more throughout the design process

Section 2: "The Equity Yardstick" for Design & Implementation Principles

- Completed for each element of design so is expected to potentially be completed several times and may have different responses (Ex. Responses for Doula Integration details may be differ from those related to Blended Case Rate)

Section 3: Post-Implementation Evaluation of the Overall Program

- Completed for each element of design to evaluate whether the program goals are being met and to identify changes or updates that may be needed to the program design

Note: The current draft of the health equity framework is intended for feedback and discussion. All questions and comments pertaining to the tool are welcome.

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Health Equity Framework Summary

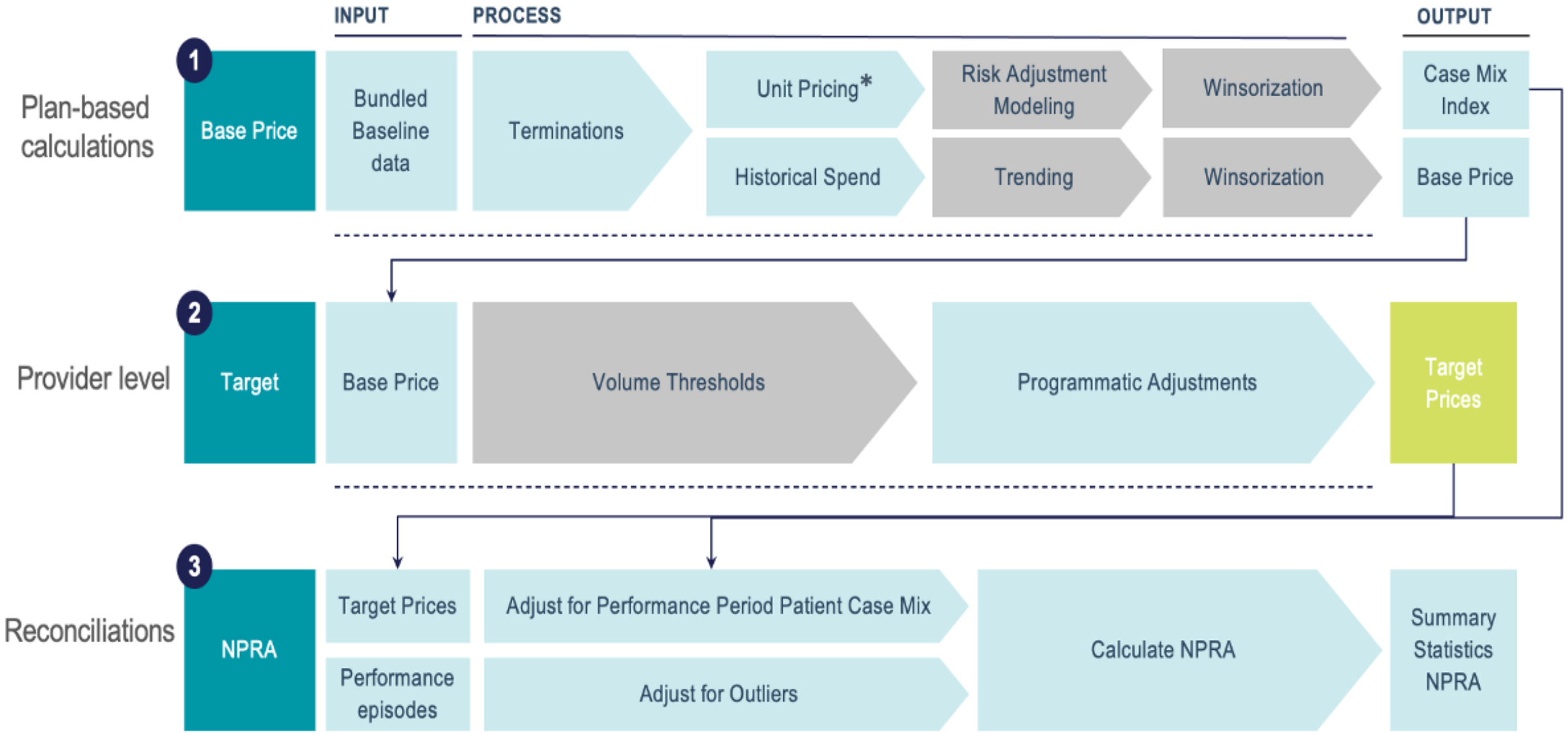
This slide provides a summary of the Health Equity framework. The Advisory Council has worked through detailed analysis of each component through an equity lens.

	Overall	Doula Integration	Payment Methodology	Building Blocks for the Bundle (Who?)	Services Included in the Bundle	Quality Measures
Design Element Goals	Reduce rates and close racial disparities for key outcome measures	Invest in doula infrastructure and capacity building to improve access to doula care, which improves maternal and infant health outcomes	Structure payment methodologies to improve equity across program outcomes, such as factoring SDOH into risk adjustment methodology	Define program parameters to maximize scope of program impact, such as inclusion of higher risk pregnancies	Designate services to create incentives that improve quality of care, including access to community-based services that are not traditionally covered by Medicaid (i.e., doulas, CHWs, breastfeeding support, contraception counseling)	Prioritize metrics for provider accountability based on impact on equity
Community Context	• Promote culturally responsive care and improve the overall patient experience of birthing members • Include access to community-based supports, like doulas, CHWs, etc., to strengthen a workforce that is reflective of the community being served • Continuously review and monitor impact of payment methodology on outcomes to make mid-course adjustments as needed					
Community Engagement	• The Advisory Committee includes two members who have lived birthing experience through Husky Health. • Smaller focused discussions will be scheduled for some of the design elements where appropriate to allow for additional time for design discussions.					
Data Analysis & Measurement	• Advisory Council input will be sought for (1) Quality slate and process measures and (2) Methods for data tracking, reporting, and communication of the metrics • Performance data will be stratified by race/ethnicity, while DSS continues to explore strategies that improve race/ethnicity data collection • DSS will monitor outcomes to inform necessary updates to the program design					

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.

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



NPRA= Net payment reconciliation amount - essentially the savings rate

*Control for facility price variation when setting bundled payment benchmarks, so providers' shared savings potential is not dependent on choice of facility for delivery

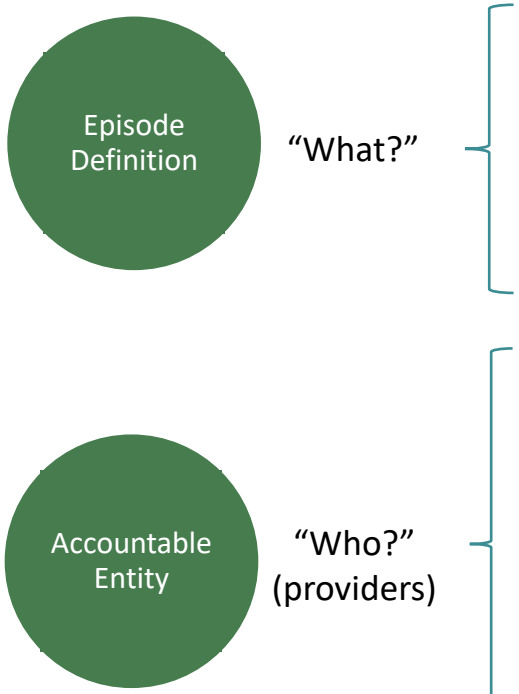
Overview of Pricing Process

Reminder of Quality Measure Goals and Prioritization

In addition to the Maternity Bundle's Key Outcome Measures on overall program success, Quality Measures will assess provider-level performance on critical activities and outcomes.

- Quality Measures will be used for reporting on provider performance to support improvements in care. In certain cases, Quality Measures will be tied to accountability and payment.
- The initial measures under consideration reflect early stakeholder input as well as the following design principles:
  - **Alignment with other state initiatives and quality measure sets** (CMS Adult/Child Core, CT OHS, SEHP)
  - **Focus on outcomes and processes that reduce maternal disparities**
  - **Ensuring utilization of key services within the bundle**
  - **Feasible to collect and report**
- Quality Measures will be stratified by race, ethnicity, and language (REL) when possible.
- DSS may update the quality measures, specifications, and designation of pay for performance vs. pay for reporting as quality best practices evolve.
  - Additional measures, such as Patient Care Experience measures, are under consideration for Year 2 pending feasibility to implement.

Maternity Bundle Key Design Elements



Design Element	DSS Approach	Rationale
1. Episode Definition Bundle Inclusions/ Exclusions	Episode defined as a **Comprehensive Bundle** inclusive of services across all phases of maternal health (prenatal, labor and delivery, postpartum)	Focus on change at the provider level.
2A. Accountable/ Contracting Entity	All Obstetrics (**OB)/Licensed Midwife practices** in CT's Medicaid program, as well as Family Medicine providers who provide OB services	Aligns with other states' Medicaid bundles, Connecticut (CT) contracting arrangements (CT State Employee Health Plan (SEHP)), and best practices as recommended by the Health Care Payment Learning & Action Network (HCPLAN). Most other states' Medicaid maternity bundles have been implemented as mandatory; achieves DSS' goals and maximizes scope of impact.

Maternity Bundle Key Design Elements

"Who?" (members)

"How?"

Design Element	DSS Approach	Rationale
3A. Population Newborn care?	Newborn care is initially included in the bundle for **reporting purposes**. Over time, **phase in newborn care for financial accountability.**	Medicaid bundles operating today exclude newborn (WA & PA plan to include newborns in upcoming programs). Newborn to be included for reporting purposes as a glidepath to **phase in newborn care** to align with CT SEHP.
3B. Population Any exclusion criteria?	All Medicaid births, except those excluded for **administrative reasons** (e.g. non-continuous enrollment, death, etc).	Identify **limited risk exclusion criteria**, so that most births can be included in the program while protecting providers from risk exposure beyond their control.
4. Payment Flow	Hybrid financial model of **prospective payment** for services provided by OB + **retrospective reconciliation** for related services outside OB practice.	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. CT will be a Medicaid pacesetter in using a prospective payment model.

Timing, Price, Risk

Maternity Bundle Key Design Elements

	Design Element	DSS Approach	Rationale
"How long?"	**Episode Timing**	**40 weeks before birth to 90 days postpartum,** with future considerations to extend to longer postpartum to 365 days	• Episode timing of 40 weeks before birth/90 days postpartum is in line with most other maternity bundles. • Phase 2: increase postpartum period to 365 days within the episode
"How much?"	**Type and Level of Risk**	**Phased approach**, such as: Year 1: Upside Only Years 2-3: Asymmetric upside/downside (larger upside potential than downside exposure) Year 4: Symmetrical up/downside risk	• All other maternity bundles analyzed use both upside gain-sharing and downside risk, as does CT SEHP. • Moving to downside risk early as part of an asymmetric risk arrangement supports CT goals, while balancing provider readiness. Glidepath gives providers time to prepare.
"What am I measured against?"	**Episode Pricing**	Blended price using **statewide and provider-specific utilization history**, including single blended rate for c-sections and vaginal births. Also adjusted for any reimbursement rate changes. **Risk-adjust based on clinical and social risk.**	• Pricing based solely on individual provider utilization history creates an unfair advantage for providers who have historically had higher costs/does not reward providers who have previously worked to reduce costs. Blended price that incorporates a statewide average utilization aligns financial incentives. Consider glidepath to more heavily weighting statewide average over time. Risk adjustment by various clinical risk factors is in line with most other maternity bundles; will help ensure providers have a fair benchmark for higher-risk patients.
	Impact of Quality Performance on Payment	Select key measures as **pay for performance (P4P),** with remaining as **reporting only (P4R)**. Move more measures from P4R to P4P over time. Use stratification of performance by race/ethnicity/language to incent improvements in quality disparities.	• Including some P4R (Pay for Reporting) measures helps ensure that services included in the bundle are in fact provided and is in line with most other Medicaid maternity bundles. • Including some P4P (Pay for Performance) measures tied to a quality withhold helps prevent stinting of care; use of a future quality bonus for select measures can help close the gap where disparities exist.