HUSKY Maternity Bundle Payment Program

Case Rate Questions

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Program Overview

1. **Does an office get penalized for not participating in this?**
    a. DSS will automatically enroll practices who have at least 30 births attributed per year.

2. **How is the Accountable Provider defined?**
    a. The Accountable Provider is the ambulatory maternity provider group who has the greatest role in delivering obstetric care in the episode.
    b. To qualify for Case Rate payment as an Accountable Provider, providers must meet the following criteria:
        1. Perform 30 or more deliveries annually
        2. Submit a claim with trigger codes (trigger diagnosis codes and E&M codes)
        3. Submit a claim with the qualifying place of service (11) location
        4. Bill as a qualifying maternity bundle specialty type, which include Obstetrics and Gynecology (including the subspecialty MFM), Family Medicine, Certified Nurse Midwife, Obstetric Nurse Practitioner, Family Nurse Practitioner, and Women's Health Nurse Practitioner.

3. **Does the Accountable Provider mean a maternity provider who bills professionally under the same TIN?**
    a. Yes, after the Case Rate is triggered by a practice, providers who bill professionally under the same TIN with an eligible maternity bundle specialty type will be considered as the same Accountable Provider who initiated the Case Rate payment.

4. **Will the provider attribution change monthly for multi-specialty groups?**
    a. No, if the qualifying specialty types are billed and provided under the attributed practice TIN, provider attribution will be maintained for multi-specialty groups. For example, if a patient receives care from various OB Physicians, Certified Midwives, and/or Advanced Registered Nurse Practitioners (ARNPs) within the same TIN, the practice will maintain episode attribution and the Case Rate payment will be directed to the practice's designated AVRS ID.
    b. In the Draft Case Rate letter provided in March, DSS indicated which AVRS ID will receive the Case Rate for the practice. Practices have the option to specify a different AVRS ID to direct payment to, by request to their CHN PES representative.

5. **How will multiple births be handled?**
    a. 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.

6. **When will there be additional information on incentive payments (i.e., shared savings)?**
    a. DSS is planning to provide more information about the program's incentive payments (i.e., shared savings) as soon as historic actuarial modeling and program testing is complete. Providers should

also expect a draft historic performance report, including quality performance data, to review the potential impact of the program.

General Case Rate Questions

7. **What will be the reimbursement rate?**
    a. Each provider's initial Case Rate is based on historical second trimester, third trimester, and postpartum claim expense for historically attributed episodes.
    b. In March, DSS provided letters with draft reimbursement rate information. Prior to Go Live, DSS will refresh the Case Rates with a more recent claim set to establish the Case Rate reimbursement amount that will be effective as of 9/1/2024. DSS anticipates providing the updated rates by Q3 2024.

8. **How is the Case Rate paid?**
    a. In the second or third trimester, the Case Rate payment may begin by billing a claim with specific trigger codes to indicate the initiation of the prenatal care services. After the trigger event(s), Case Rate payments will be made at the end of each month, and the claim with the trigger codes and all subsequent claims meeting the services included in the Case Rate criteria (listed below) will be zero-paid.
    b. To qualify for Case Rate payment as an Accountable Provider, providers must meet the following criteria:
        1. Perform 30 or more deliveries annually
        2. Submit a claim with trigger codes (trigger diagnosis codes and E&M codes)
        3. Submit a claim with the qualifying place of service (11) location
        4. Bill as a qualifying maternity bundle specialty type, which include Obstetrics and Gynecology (including the subspecialty MFM), Family Medicine, Certified Nurse Midwife, Obstetric Nurse Practitioner, Family Nurse Practitioner, and Women's Health Nurse Practitioner.

9. **Does each provider have a Case Rate or each TIN?**
    a. Each Accountable Provider TIN has one Case Rate.

10. **Can the Case Rate change within a Performance Year?**
    a. No, the Case Rate is fixed for the Performance Year.

11. **If a member completely leaves a group during their pregnancy, and the group has already rendered care under the bundle, could this potentially have any negative financial impact on them?**
    a. If the group previously rendering care to the member had triggered an episode during the second or third trimester, they would receive a Case Rate payment for those months and fee-for-service before triggering the episode and after it has shifted away from them. Further, the historical case mix and duration of episodes are used to calculate appropriate Case Rates to mitigate any negative financial impact.

12. **Will we get detailed data behind the episode counts provided in the Case Rate letter?**
    a. DSS plans to provide practices with quarterly data reports. As the design of the report is still underway, the feasibility of providing attributed patient- and provider-related data is still under review.

13. **Will there be more transparency in Case Rate calculations?**
    a. The Case Rate build-up and components are detailed in program documents and further in the Case Rate payment recording. More information can be found on the DSS website **here**.

14. **Do you have 1-on-1 meeting offerings or contacts to discuss the Case Rate or program in more detail?**
    a. Yes, please reach out to talunan@faulknerconsultinggroup.com and bradley.richards@ct.gov to schedule a meeting.

Service Inclusion & Exclusion

15. **What services are included in the Case Rate?**
    a. The Case Rate will only include professional services, per the Case Rate **code list**, which are submitted under the attributed Tax ID with eligible maternity bundle specialty types.
    b. In general, services included in the Case Rate include:
        - OB/licensed midwife Professional Services
        - OB/licensed midwife Professional-related hospitalization costs (Inpatient, Outpatient, and ED) including professional delivery fees, if performed by the Accountable Provider
        - OB/licensed midwife Professional-related Behavioral Health Evaluations, including screening for depression and substance use
        - Screenings (general pregnancy, chlamydia, cervical cancer, intimate partner violence, anxiety)
        - In-house OB/licensed midwife imaging
        - In-house labs and diagnostics
        - Prenatal group visits
        - Birth education services
        - Care coordination activities
        - Any of the above services provided via telehealth

16. **What codes are required to indicate pregnancy?**
    a. To trigger the Case Rate in the prenatal period, an E&M code and a trigger diagnosis code are required to indicate pregnancy.

17. **Are the Case Rate payments strictly for the professional fees or does that payment include payment for the facility charges when the patient delivers?**
    a. The Case Rate is intended to cover only the professional fees that the accountable provider incurs (i.e., facility claims are not part of the Case Rate).

18. **Will in-house MFM be carved out of the bundle?**
    a. No, in-house MFM (i.e., provided within the Tax ID) is included in the Case Rate as well as the overall maternity episode costs. Since MFM is an OBGYN subspecialty, MFM providers typically bill under the OBGYN billing provider specialty type, which qualifies in-house MFM providers to receive Case Rate payments.

19. **If an external MFM provides inpatient consultation, how would they get paid? For example, a patient may be referred to an external MFM when there's a pregnancy complication, such as preeclampsia.**

   a. The external MFM (i.e., different Tax ID than the OB practice) may receive the Case Rate payment if they submit a claim with trigger codes and the service occurs in an office setting.
   b. As long as both providers bill with a trigger event, the OB and MFM may both receive Case Rates for the months that patient care is provided.

20. **Are in-house L&D Triage, ED, and Endocrinology services (provided within the Tax ID) handled similar to MFM?**
   a. The Case Rate will include professional services, per the Case Rate code list, which are submitted under the Tax ID with eligible maternity bundle specialty types.
   b. For example, an endocrinologist may have an ineligible specialty type and would, therefore, receive FFS payment. However, if the provider who provides L&D Triage and ED services under the same Tax ID bill with a qualifying specialty type, those services would be included under the Case Rate.

21. **Does anesthesiology receive a Case Rate as well?**
   a. An anesthesiologist would have an ineligible billing provider specialty type and would, therefore, receive FFS payment.

22. **When labs are billed under a separate TIN, how does this work? How is the Case Rate baseline being pulled if labs are being captured?**
   a. Where a lab is provided by a provider in a different TIN, those services are not included in the Case Rate.

23. **For inpatient hospitalizations for diagnoses unrelated to maternity, would labs and radiology be paid FFS?**
   a. Yes, labs and radiology for non-maternity diagnoses would be paid FFS.

24. **Does this cover all types of births/deliveries? Is the professional component of delivery included in Case Rate?**
   a. The Case Rate covers professional delivery fees if the delivery (vaginal or cesarean) is performed by the Accountable Provider.

25. **Are payments for services given in the OB office, like administration of Flu, Covid and Tdap vaccines going to be included in the Case Rate?**
   a. Vaccines will be paid FFS.

26. **How are IUDs reimbursed if inserted during the 90 days postpartum timeframe?**
   a. IUDs will be paid FFS and its costs will be excluded from the total maternity episode's costs during reconciliation.

27. **Is Case Rate billing only for members with Medicaid primary? Are patients with Medicaid secondary excluded?**
   a. No, members with third party liability coverage will be included in the maternity bundle program.

Case Rate Initiation & Termination

28. **If Go Live is September 2024, does this payment method only apply to newly pregnant patients AFTER the go live date? What if we have a patient at 24 weeks at time of go-live, are they paid FFS at the time of delivery or will they draw a Case Rate until their delivery?**

a. For patients who are mid-pregnancy upon the program's September 1st Go Live, the Case Rate should be initiated by billing a claim with a trigger event on or after 9/1/24 as DSS will not review claims prior to Go Live. For example, if the pregnancy is already at 24 weeks and there is a trigger event billed on or after 9/1/24, the Case Rate will be initiated.

29. **Is there a definition of the first trimester?**
    a. The first trimester ends after the 13th week of pregnancy. All services included in the Case Rate calculation are after a claim with a trigger event that indicates the second trimester or later in the pregnancy.

30. **When does the Case Rate end?**
    a. The Case Rate will cease after completion of the three months postpartum, if the episode of care moves away from the TIN (i.e., attribution change), or if one of the following events occur: Missing a facility claim in the episode (i.e., "orphan episode"), Baby is stillborn, Miscarriage or abortion.

31. **In the case of stillbirth, if that stops the Case Rate – how does the provider get reimbursed for ongoing postpartum care?**
    a. Subsequent postpartum care would be reimbursed FFS.

Claims & Billing

32. **What is the plan to train billers and coders for this program?**
    a. More information, including technical billing and coding guidance, is forthcoming. Note that at program launch, providers will continue to bill all claims as usual to demonstrate services provided to the patient.

33. **How are Case Rate payments distributed? Do you anticipate Case Rate payments included in bi-weekly remits or will the payment be distributed in a separate remit file?**
    a. Once initiated through the submission of a claim with a trigger event (indicated through a combination of trigger diagnosis codes and Case Rate E&M codes), Case Rate payments will be identified and generated at the end of the month. The expenditures will be included on the existing semi-monthly Remittance Advice (RA) and X12 835 in the first payment cycle of the month.
    b. For example, if a trigger claim is received in the month of February with a date of service (DOS) in January, the January DOS will $0 pay, a Case Rate payment for the month of January and February will be generated at the end of February and the provider will see the Case Rate payments for the 2 months in the first payment cycle in March. Case Rate payment for March (if the provider is still the attributed provider) will be paid in the first payment cycle in April.

34. **Please explain how the payments will be sent to us. What information accompanies claims payment? Are claims tied to a specific patient claim number?**
    a. The RA will display Client ID, Client Name, From DOS and Case Rate payment. The From DOS will always be the first day of the month. The X12 835 will report the Case Rate in the PLB segment. The PLB03-1 field (Adjustment Identifier) will indicate LS – Lump Sum. The PLB03-2 field (Reference Identification) will be populated with an internal tracking number. It will be prefaced with a value of MB (maternity bundle).

35. **When Medicaid acknowledges the claim submitted for a service included in the Case Rate payment will they provide a CARC code [i.e. CO24] indicating a per member per month payment was made?**
    a. The system will assign a unique EOB code that will display on the Remittance Advice. The X12 835 will contain a CARC indicating the reason for claim zero payment. CARC code will be CO97.

36. **For claims processing, what should be charged and when?**
    a. Providers should indicate that they are the primary obstetric care provider for a patient by billing a claim in the second or third trimester with specific trigger codes, which formally attribute the beneficiary's episode to their TIN. A full list of codes are available on the DSS website **here**.
    b. After the attribution is indicated by a claim, providers will start receiving Case Rate payment by the end of the month and the months afterwards until a different provider TIN indicates their relationship with the individual.

37. **Should we hold claims after delivery?**
    a. No, providers should continue to bill all claims as usual to demonstrate services provided to the patient. In subsequent performance years, DSS will continue to review claims history.

Case Rate Add-On Payment

38. **Does the draft Case Rate include a $21 add-on payment?**
    a. No, the draft Case Rate does not include the $21 add-on payment.

39. **If a member does not use a doula or lactation consultant, is there a global reconciliation or is reconciliation granular?**
    a. The means to recoup doula PMPMs where not used is still being developed. We are seeking feedback from providers to determine the least burdensome way of accomplishing this reconciliation.

40. **How will the true-up for doula services work?**
    a. DSS will share more information on the methodology for the doula services reconciliation.