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HUSKY Maternity Bundle Payment Program

Advisory Council Meeting

October 25, 2023

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

Program Go Live Update

DSS anticipates implementing the HUSKY Maternity Bundle Payment Program on **September 1, 2024**, pending federal approval.

- It is possible that DSS may be able to launch the bundle payment program earlier than this date but will not do so without giving a 3 month notice to providers if launching earlier than September 1, 2024.
- The decision to delay the launch was made after carefully considering several factors including the need for the Centers for Medicare & Medicaid Services' (CMS) approval, further programmatic development, and the need for further stakeholder engagement.

Next Steps

Current Priorities

- CMS SPA Approval
- Actuarial Modeling
- Program Readiness

Upcoming Work

- Provider Bulletin of bundled payment policies and processes
- Program Testing (dry run of 2022 claims)
- 2022 Provider Historic Performance Reports
- Additional Provider Forums
- Doula Integration Policies

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Provider Attribution

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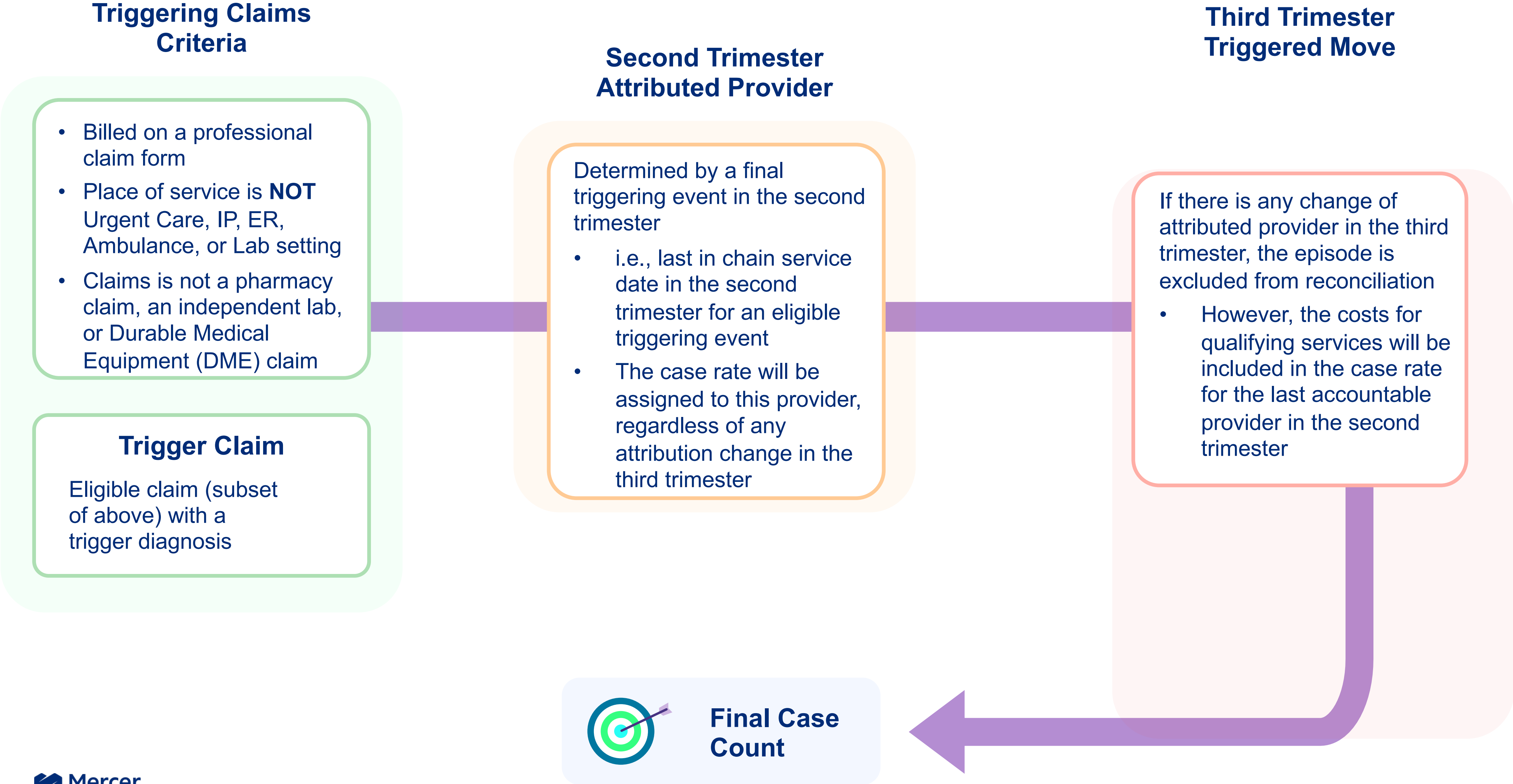
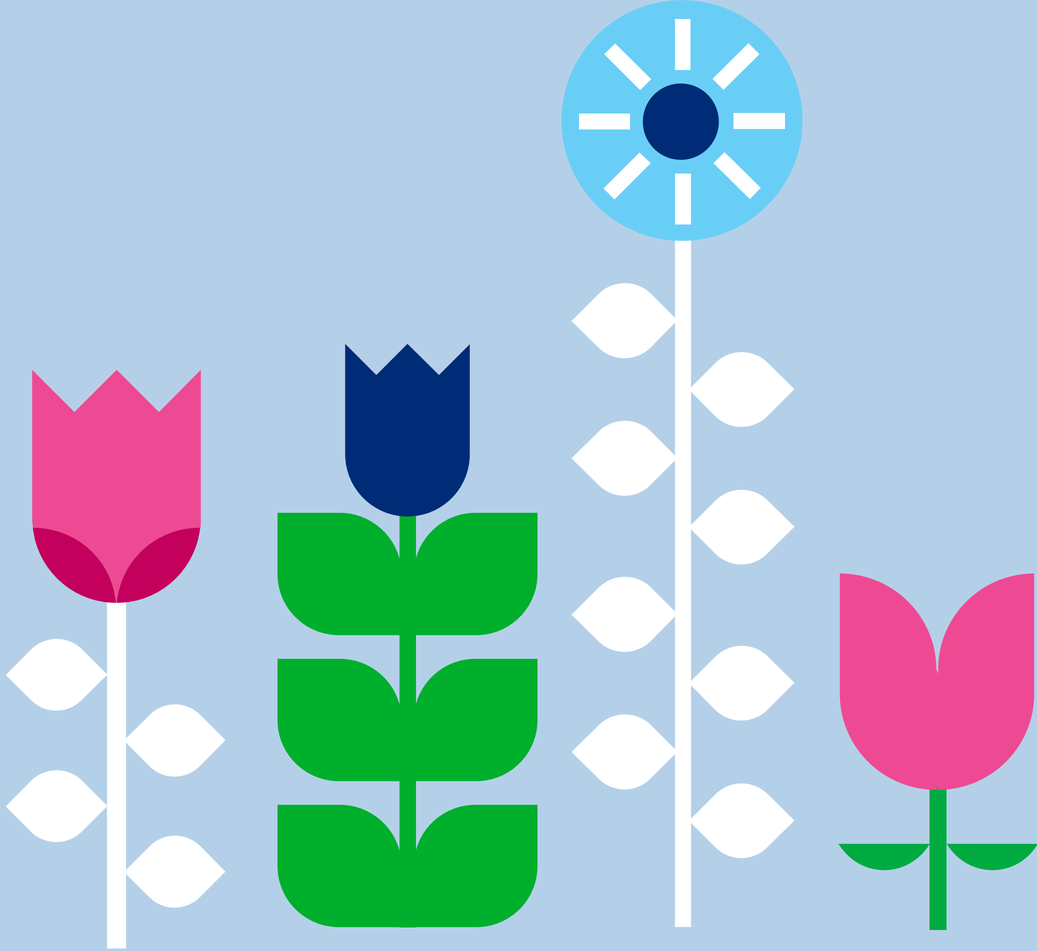
Attribution Logic



Target Price



Target Price

Services Included in the Target Price:

- OB/licensed midwife Professional Services
- OB/licensed midwife Professional-related hospitalization costs (Inpatient, Outpatient, and emergency department) if performed by the attributed provider
- OB/licensed midwife Professional-related Behavioral Health Evaluations, including screening for depression and substance use
- OB/licensed midwife imaging, labs and diagnostics
- Screenings (general pregnancy screenings, chlamydia and cervical cancer, and screenings for intrapulmonary percussive ventilator and anxiety)
- Birth Centers and hospital costs related to maternity care
- Specialist/Professional Services related to maternity (e.g., anesthesia)
- General Pharmacy related to maternity
- Doulas
- Breastfeeding support (breastfeeding support is included with a broad spectrum of provider types, not limited to community health workers)
- Prenatal group visits
- Child education services
- Care coordination activities
- Any of the above services provided via telehealth

Time Frame	Target Price
Pregnancy	Yes
Delivery	Yes
Postpartum	Yes
Newborn	Reporting only at program launch

Target Price

Case Inclusion/Exclusion Criteria

All beneficiaries are included unless they meet one or more of the following exclusion criteria:

- Age <12 or >55
- Mother left the hospital against medical advice prior to discharge
- Any substantial gap in enrollment or eligibility during the delivery episode

The pregnancy, delivery, or newborn components of the maternity bundle can be excluded from the cases for target price and retrospective reconciliation for the following reasons. Note that payment will remain through the prospective payment for these cases.

- 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)
- Delivery
  - Missing a facility claim in the episode (i.e., “orphan” episode)
- Newborn (for reporting purposes only)
  - Baby is stillborn
  - The baby was born with a serious congenital anomaly
  - Baby could not be linked with the delivery episode

Target Price

Historical Price

- Calculate the average standardized* episode cost of all services by provider TIN.
- Winsorize outliers — set the total episode cost thresholds between the fifth and 99th percentile.
- Trending — utilize the institutional knowledge from CT Department of Social Services, such as fee schedule changes.

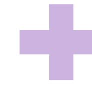
* Standardization includes applying average fee by diagnosis related group and severity level across providers. This process will be used for inpatient hospitals and some other services.

Risk Adjustment Factor

The historical year's risk adjustment factor, integrated with the Area Deprivation Index (an area-level measure of socioeconomic factor) will be used to risk adjust the historical price.

Risk Adjusted Historical Price (50%)

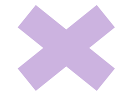
Risk-neutral historical price by provider TIN



State-wide Historical Price (50%)

State-wide historical price

Base Price by Provider

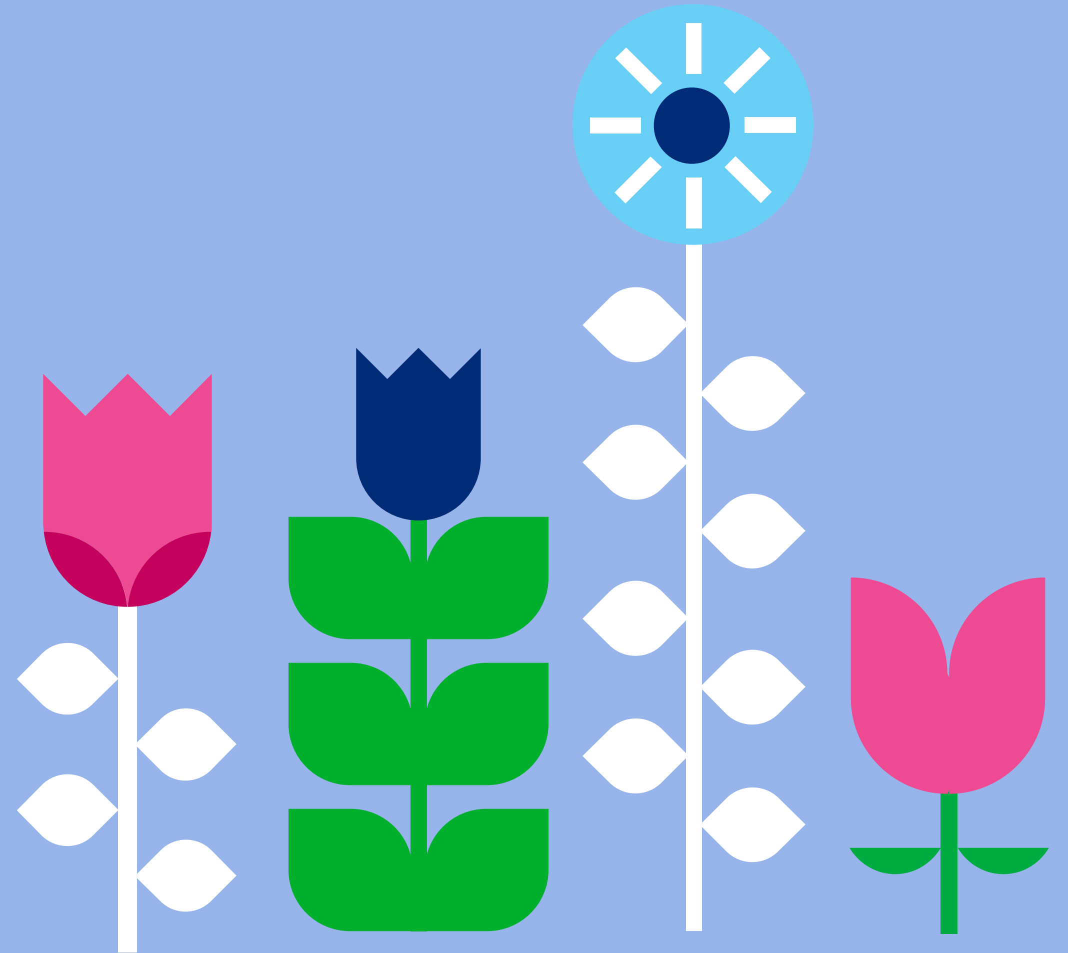


Performance Year Risk Factor

Risk adjustment factor of the performance year

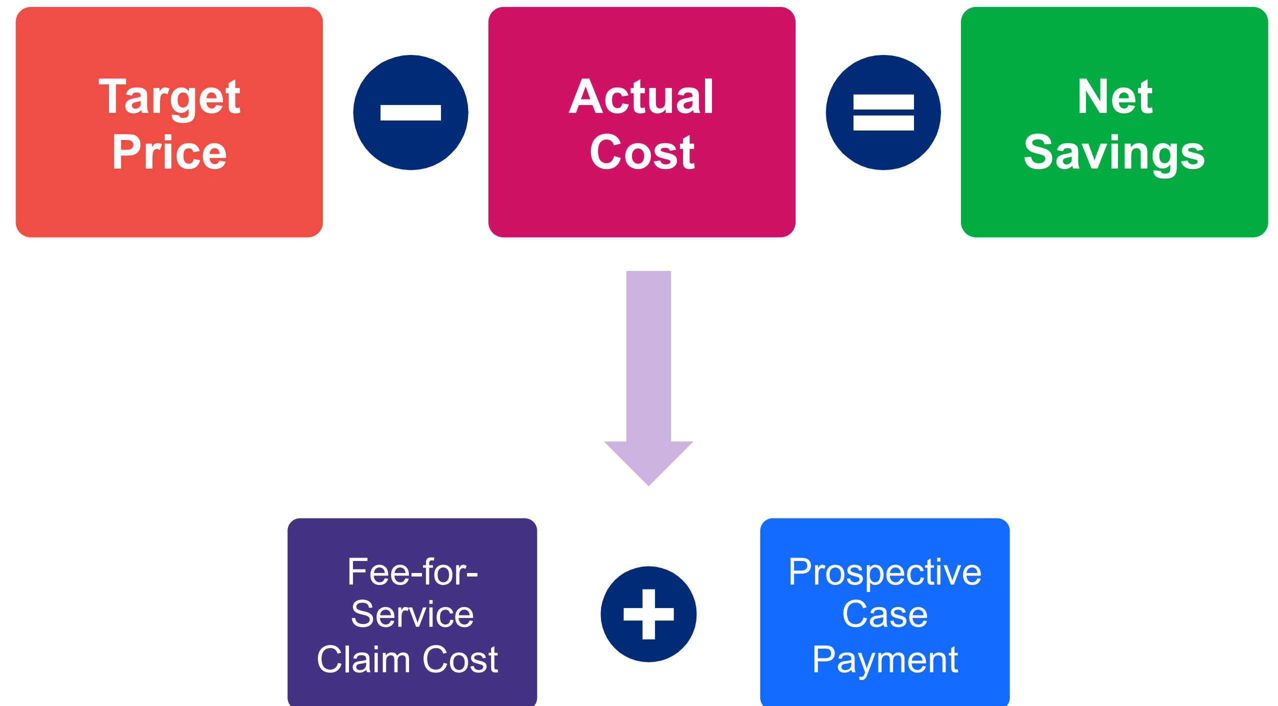
Target Price by Provider

Reconciliation



Reconciliation

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



Reconciliation Timeline

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

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

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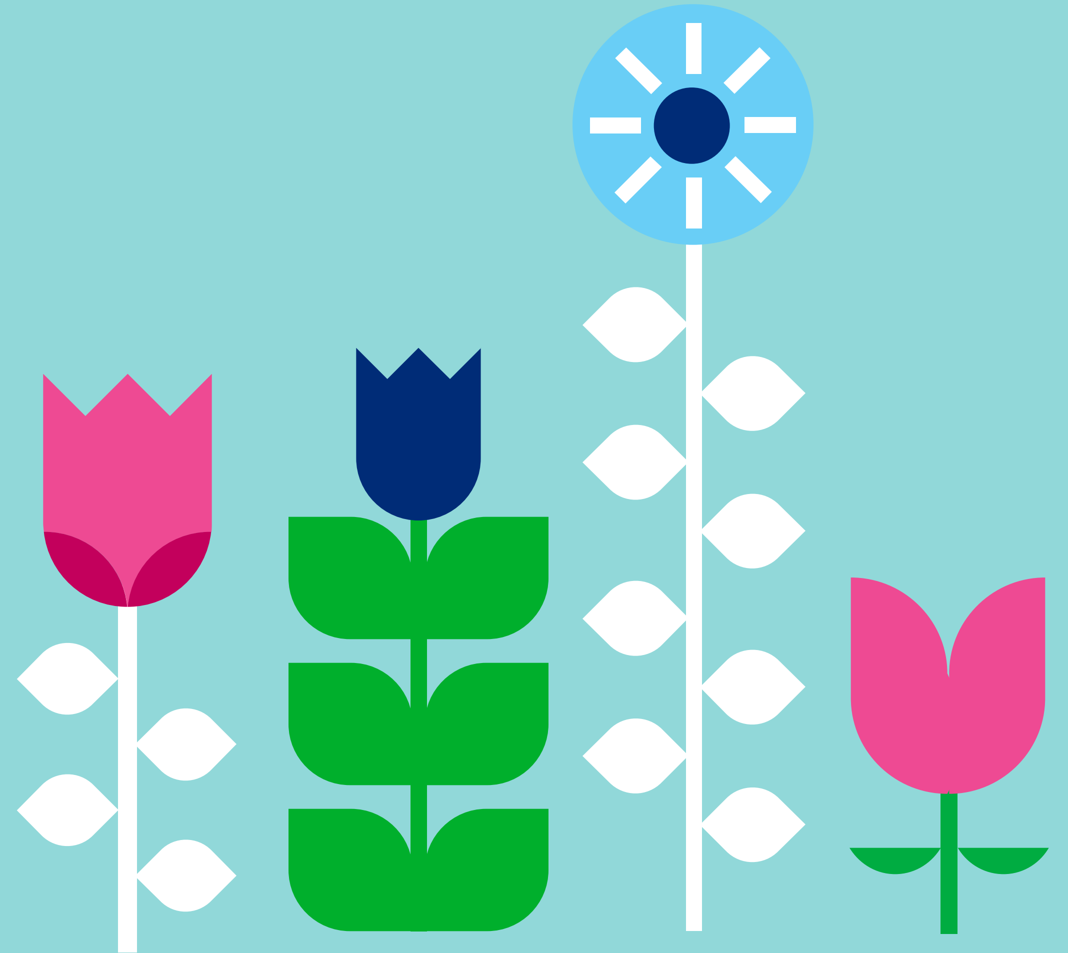
Quality Measure



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Maternal Adverse Events Update

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

Measure Description

- The proportion of deliveries ≧ 20 weeks gestation with any of 21 maternal morbidities plus maternal mortality occurring during the delivery hospitalization, using claims information for risk adjustment (30 risk variables).

Provider Feedback About the Measure

- Based on a measure created for measuring the quality of hospital labor and delivery services
- Focuses on conditions that are heavily influenced by hospital clinical care protocols
- Not developed for the purpose of assessing the quality of care delivered by community OB practices.

DSS Considerations in Evaluating the Measure

- Disproportionate impact maternal adverse events have on birthing people of color
- Importance and support the advisory group has placed on this goal in the past
- Yale CORE (which developed the original measure for CMS) has modified it for DSS and is assisting with the implementation
- The measure is risk-adjusted and accounts for small number variation at the provider level

Recommended Changes to the Measure Based on Provider Feedback

- Adjust the impact of the measure from 18% to 6% for the first year with the aim of:
  - Further validating the measure
  - Increasing the importance of the measure in future years pending further measure refinement

Quality Measures and Weights

Pay for Performance (71% Total)

1 Cesarean Birth (24%)

The proportion of live babies born at or beyond 37.0 weeks gestation to women in their first pregnancy, via cesarean birth.

2 Postpartum Care (18%)

Measures rate of timeliness of postpartum care for the maternity bundle project.

3 Prenatal Care (12%)

Measures the timeliness of prenatal care for the maternity bundle project.

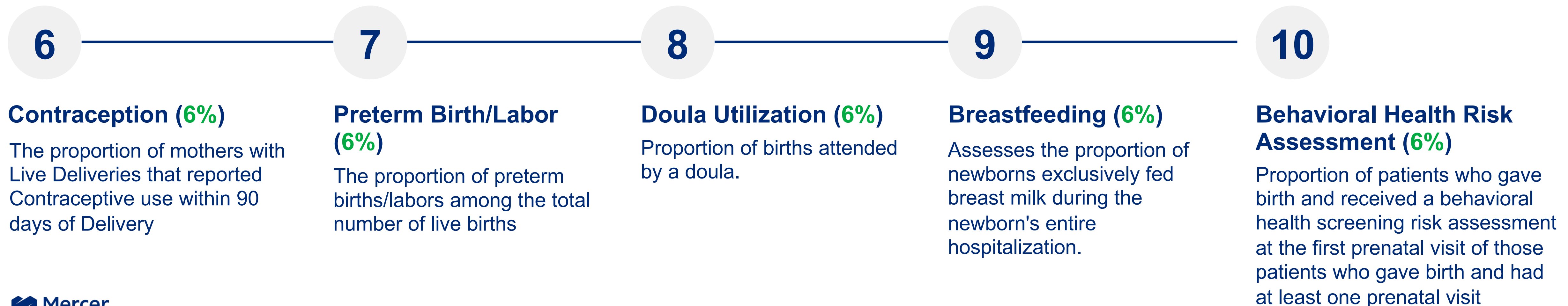
4 Low Birth Weight (12%)

The proportion of infants with the International Classification of Diseases codes for light for gestational age, small for gestational age, low birthweight, or intensive care units care for low birthweight infants on newborn records among all births.

5 Maternal Adverse Events (6%)

The proportion of deliveries > = 20 weeks gestation with any of 21 maternal morbidities plus maternal mortality occurring during the delivery hospitalization, risk-adjusted using claims data.

Pay for Reporting (29%)



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Illustrative Methodology Example - Draft

Performance Tier Calculation

Improvement Tier Calculation

Raw Data is normalized such that the scores can range between 0% (low performance relative to the historical year) and 100% (high performance relative to the historical year) for each of the 10 metrics

The Performance Tier Score is developed using **ALL** quality measures

Performance Score of 90%

The Improvement Tier Score is developed using **ONLY** pay for performance measures

Improvement Score of 80%

Final Score is MAX of Performance Score and Improvement Score 90%

Methodology and Assumptions Overview - Draft

Performance Tier Score Calculation

There are four steps to calculating the Performance Tier Score:

- **Step 1:** Normalize each Pay for Performance Metric against the Historical year minimum and maximum values.
  - Pay for Reporting Metrics are assigned a value of 1 if data for the metric is present otherwise 0 if no data is present.
- **Step 2:** Invert the appropriate metrics such that a higher score is better.
- **Step 3:** Ensure that the metrics are within the boundaries of 0 and 1.
- **Step 4:** Utilize the metric weights to calculate a final composite, metric-weighted Performance Score.

Improvement Tier Score Calculation

There are three additional steps to calculate the Improvement Tier Score:

- **Step 1:** The improvement tier score is calculated with the same steps as the Performance Tier Score, but from the Pay for Performance Metrics only.
- **Step 2:** Take the difference in the Current (2022) Pay For Performance Score from the Historical (2021) Pay For Performance Score.
- **Step 3:** Divide the difference between the Current (2022) and Historical (2021) scores to get the Improvement Tier Score.

Percentage of Shared Savings Earned

- The Performance Tier Score and Improvement Tier Score are each cross-walked to a Percentage of Shared Savings Earned. **The maximum Percentage of Shared Savings Earned between the two scores is selected as the final Percentage of Shared Earning Earned**.

Performance Tier Score

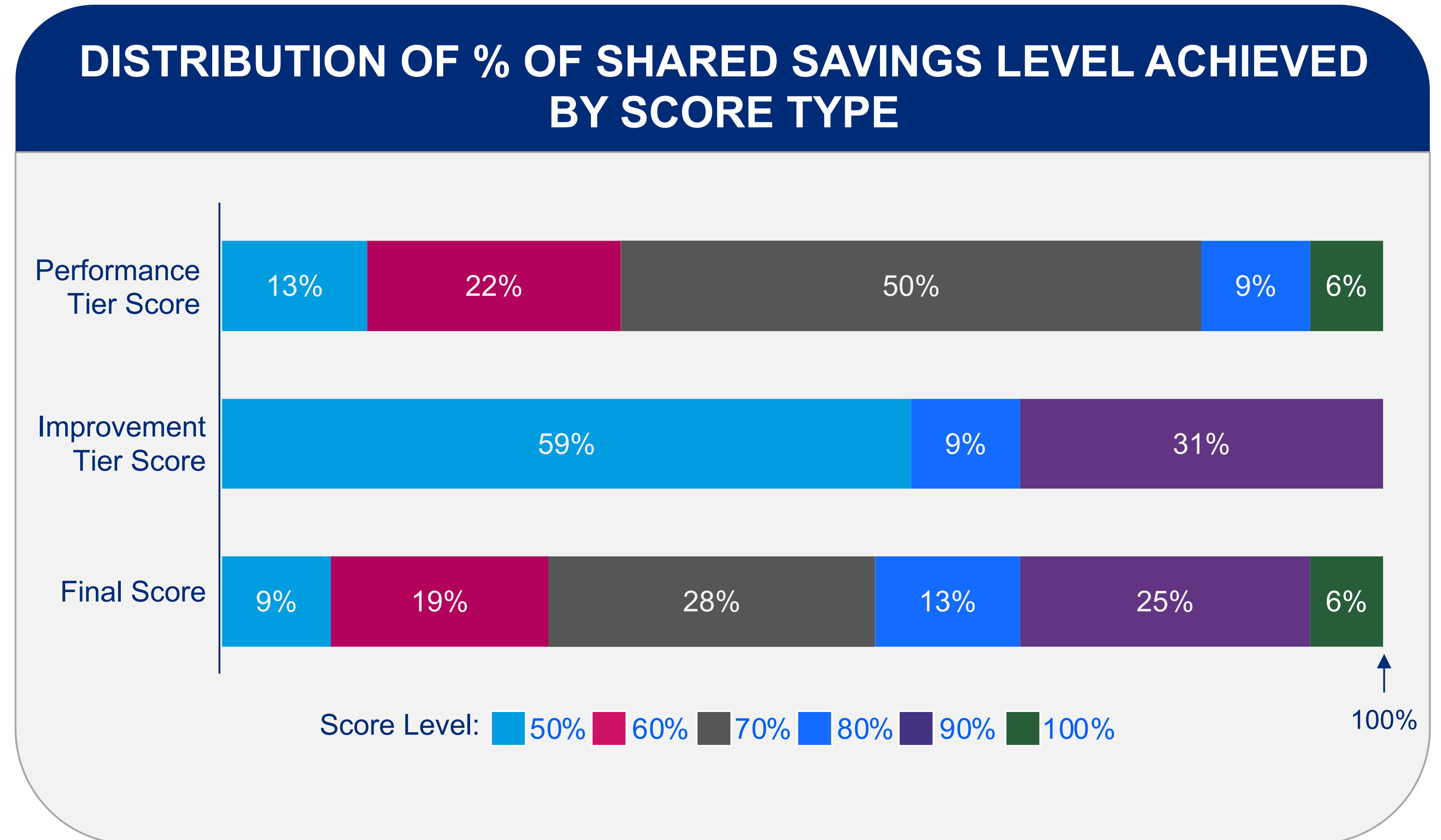
Overall Performance	Performance Earnings Tier	Performance: % Shared Savings
< 55th Percentile of peer group	F	50%
55–60th Percentile of peer group	D	60%
60–70th Percentile of peer group	C	70%
70–75th Percentile of peer group	B	80%
75–80th Percentile of peer group	A	90%
> 80th Percentile of peer group	S	100%

Improvement Tier Score

Improvement	Improvement Earnings Tier	Improvement: % Shared Savings
<0%	F	50%
0–3%	D	60%
3–5%	C	70%
5–10%	B	80%
10%+	A	90%

Model Results Observations - Draft

- 59% of providers would earn 70% to 80% of the Shared Savings using the Performance Tier score..
  - 59% of Providers did not improve or did worse than the prior year.
- The distribution of shared savings is well- balanced.
  - The average Earned Shared Savings is 74%, almost exactly at the centre point.
  - There is now a wider arrangement of Shared Earnings ranging from 50%–100% compared to only 70%–100%
  - 6% of Providers Obtained 100% of Shared Earnings.
- 50% of Shared Earnings is the lowest level of savings possible under this methodological approach.
  - 9% of Providers scored at 50% of Shared Earnings



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