Connecticut Department of Social Services
Making a Difference

HUSKY HEALTH CONNECTICUT

HUSKY Maternity Bundle Payment Program

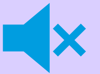
Provider Forum

June 2024

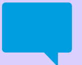
Welcome to the HUSKY Maternity Bundle Provider Forum

Please see the meeting's ground rules below.

This forum will be recorded and posted to the DSS Youtube channel. Meeting materials will also be posted on the DSS Maternity Bundle website.



If you are not speaking, please mute yourself.



Please limit use of the Chat for Zoom technical and audio issues only.

Please use Q&A feature to post questions.

Agenda

1. Program Status Update
2. Historic Performance Reports
3. Case Rate Updates

Program Status Update

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

Recently Accomplished

- ✓ Actuarial Modeling & Program Testing
- ✓ Draft Case Rates
- ✓ Historic Performance Reports
- ✓ Provider Resources: Video Guides and FAQs

Current Priorities

- ❑ CMS State Plan Amendment (SPA) Approval
- ❑ Program Readiness

Upcoming

- ❑ Provider Bulletin of payment policies and processes
- ❑ Final Performance Year Case Rates
- ❑ Performance Year Provider Reports

More information about the HUSKY Maternity Bundle can be found at this website: https://portal.ct.gov/DSS/Health-And-Home-Care/HUSKY-Maternity-Bundle

Historic Performance Reports

As part of the ongoing Actuarial Modeling & Program Testing (dry run of 2022 claims), DSS published draft provider-specific Historic Performance Reports in June 2024.

Historic Performance Report Goals – DSS generated this report for providers to:

1. To better understand the program's reconciliation process
2. To receive illustrative provider-specific data based on historic program simulation

The Historic Performance Report includes:

- Provider-specific historic cost and quality performance, based on claim experience for deliveries that occurred from 10/1/2021 to 9/30/2022
- Methodological details describing how each component was calculated
- *Report excerpts are shown on the following slides.*

Please note this report is not predictive of how providers will perform in the first performance year.

Reconciliation Overview

At the end of the Performance Year, DSS will perform a reconciliation process to determine whether Accountable Providers are eligible for incentive payments (upside only).

How does reconciliation work?

The process below outlines how DSS will calculate the incentive payment during reconciliation.

If **actual cost** for the episode is below the **target price** (i.e., there are **net savings**), providers will receive an **incentive payment** (up to 50% of net savings) based on their **final quality score**.

- Bundles will be reconciled once per year.
- For year one, providers will not be responsible for losses, but will share a portion of savings based on their quality measure performance.

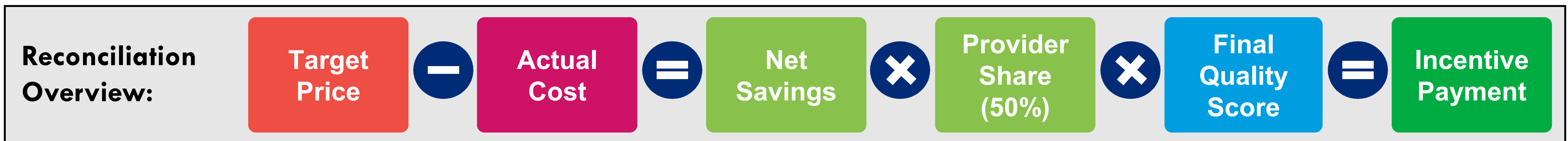
Historic Performance Report

Historic Performance Results: Reconciliation

For the illustrative purposes of historical program testing, DSS generated provider specific results based on claim experience for deliveries that occurred from 10/1/2021 to 9/30/2022.

Provider Name	Billing Tax ID

DRAFT Historic Performance Results – For Program Testing Only						
Attributed Episodes	**Target Price**	**Actual Cost**	**Net Savings**	**Provider Share (50%)**	**Final Quality Score**	**Incentive Payment**



Note: Practices that have been acquired since the dry run period (10/1/2021 to 9/30/2022) are not included in the above.

Please note this report is not predictive of how providers will perform in the first performance year.

Historic Performance Results: Quality Measure Detail

For the illustrative purposes of historical program testing, DSS generated provider specific quality score results.

Provider Name				Billing Tax ID	
DRAFT Historic Performance Results – For Program Testing Only					
	Metric	**Metric Weight**	**Program Year Performance** (Percentile)	Performance Tier Score Calculation	Improvement Tier Score Calculation** (P4P Only)
Pay for Performance	Cesarean Births	24%			
	Postpartum Care	18%			
	Prenatal Care	12%			
	Low Birth Weight	12%			
	Maternal Adverse Events	6%			
(1 = Data is present; 0 = No data is present)					
Pay for Reporting	Contraception	6%			
	Preterm Birth/ Labor	6%			
	Doula Utilization*	6%			
	Breastfeeding*	6%			
	BH Risk Assessments*	6%			
% Shared Savings					
Final Quality Score *(MAX of Performance and Improvement)*					

For the purposes of historical program testing: Baseline Year = 10/1/20 to 9/30/21; Program Year = 10/1/21 to 9/30/22.
A blank cell indicates that the measure's denominator is below the credibility threshold; these measures are excluded from the tier score calculations.
*No historical data was available for these Pay for Reporting measures. The Contraception metric was used as a placeholder to demonstrate the reporting tier calculation.
**Pre-baseline year (10/1/19 to 9/30/20) data was not available; hence the Baseline year measure results were used as a placeholder to demonstrate the improvement tier calculation.

Case Rate Updates

In response to provider feedback, DSS will provide updates on the following key topics:

- MFM Inclusion
- Case Rate Reconciliation
- Doula Services

MFM Inclusion

After careful consideration of potential operational and actuarial consequences, DSS has confirmed its decision to include MFM care within the Maternity Bundle for Year 1.

Policy Decision & Rationale

DSS will include MFM care to align with the following goals:

- To align incentives across OB provider specialties
- To ensure the inclusion of higher risk patients in the program
- To reduce complexities in program design and operations related to MFM billing and the impact of attribution changes

Provider Implications

- **In-house MFM services (i.e., provided within the Tax ID) will be reimbursed by the Case Rate.** 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.
- **External MFM services provided by a participating Maternity Bundle provider (i.e., provided under a different Tax ID than the OB practice) may receive the Case Rate payment** if a claim with trigger codes is submitted, and the service occurs in an office setting. 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.

Case Rate Reconciliation

Since Case Rate payments were designed to ensure that practice revenue is not negatively impacted upon Program Go Live, DSS will not reconcile Case Rate payments against FFS payments.

Policy Decision & Rationale

DSS does not plan to make upward or downward adjustments to reconcile Case Rate and FFS claims.

- To ensure that the Case Rate results in more predictability and flexibility for providers, DSS will not reconcile Case Rate payments to FFS at the end of the performance year.
- Case Rate payments will be re-based no more than once annually, based on risk adjustment and trend factors.
- DSS will monitor changes in billing patterns after Program Go Live to ensure that the roll-out of Case Rate payments occurs as designed.

Provider Implications

- DSS has tested Case Rate payment adequacy through the program's dry run (historic simulation) and a fiscal impact analysis.
- DSS anticipates that there will be an **opportunity for providers to earn additional revenue through the Case Rate payment –** this program is expected to add $4.5M in SFY 2025, $6.2M in SFY 2026, and $6.3M in SFY 2027.

Doula Services

In response to provider feedback, DSS will give providers the option to opt-out of receiving doula care Case Rate add-on payments.

Policy Decision & Rationale

DSS will allow providers who do not intend to contract with doulas in Year 1 to opt-out of receiving the $14/month doula care Case Rate add-on payment.

- The doula care Case Rate add-on payment will be subject to a retrospective true-up process that identifies the actual amount of doula services accessed during the performance year.
- DSS is providing this opt-out to minimize administrative burden for providers who do not intend to contract with doulas in Year 1.

Provider Implications

- Prior to the establishment of the Year 1 Case Rate, providers must report to DSS if they are opting out of receiving the add-on payment; no mid-year changes will be allowed.
- **Providers must report their Case Rate add-on payment opt-out decision to their CHNCT, Inc. Provider Engagement Services representative by July 10, 2024.**
  - All providers will receive outreach from CHNCT, Inc. Provider Engagement Services informing them of this option.

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Reminder

Doula Services

Doula services support positive maternal and infant health outcomes:

- Doulas help create better outcomes
- Doulas help address racial and ethnic disparities in outcomes
- Doulas can provide culturally matched care
- Doulas promote dignity, trust, bodily autonomy, and relationship-based care
- Doulas help alert providers to symptoms and concerns that can lead to severe maternal morbidity or mortality
- Doulas activate community-based support networks

DSS is utilizing a dual approach to provide and fund doula access in Medicaid:

1. **Paying through the maternity bundle**
   Maternity bundle providers have the option to partner with doulas, who will receive payment through the bundle.

2. **Paying fee-for-service**
   DSS anticipates implementing direct Medicaid reimbursement of certified doulas as a separate but parallel doula payment pathway.

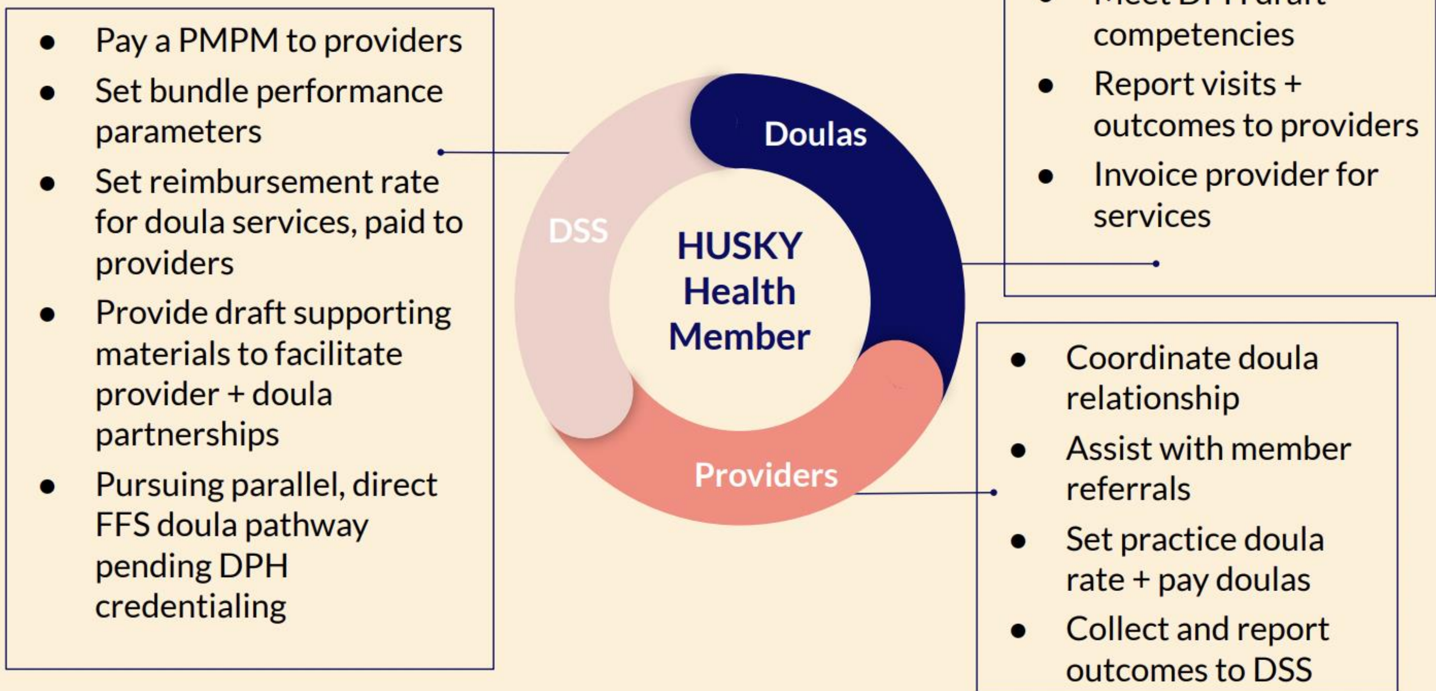
Reminder

Doula Services through the Maternity Bundle

Doula services will be rendered and reimbursed under the medical provider's supervision through the bundle payment.

Provider supervision means…

- medical provider sets the overall care plan
- medical provider holds professional and administrative responsibility for the doula's services
- doula uses their own professional judgment in performing services
- doula works to the full extent of their scope of practice



Doula Payment through the Maternity Bundle

Doula Service Case Rate Add-on Payment

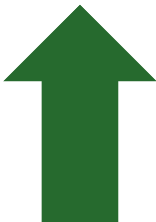
A Case Rate add-on payment of $14/month will be provided to fund doula services.

- Add-on payments for doula care will not impact opportunity for incentive payment earnings to encourage uptake of the new benefits; doula services will be excluded from incentive payment calculations.

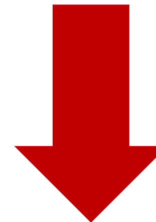
Doula Service Retrospective True-Up

Doula services will be subject to a retrospective true-up process.

The true-up process will identify, through provider cost reporting, the actual amount of doula services accessed during the performance year.



When actual utilization at the provider level exceeds total payment, **DSS will make additional payments** to ensure providers are made whole for doula care services provided.



When actual utilization is lower than total payment, **DSS will recoup doula care payments** based on the utilization level.

- Providers will be reimbursed for **up to four prenatal and postpartum visits and one delivery doula service** per member, per provider.
- The cost per unit identified in the cost report will be modeled after the State of Connecticut fee schedule for doula services. DSS will **include administrative funding for providers** in the retrospective true-up.
- Providers will not be reimbursed through the add-on payment if a FFS claim has been submitted for the service.

Next Steps and Additional Resources

Next Steps

- ❑ Providers must report their Case Rate add-on payment opt-out decision to their CHNCT, Inc. Provider Engagement Services representative by July 10, 2024.
- ❑ Providers will receive Final Performance Year Case Rates prior to Go Live.

Additional Resources

- For additional information about this program, please visit the DSS Maternity Bundle Website.
- Program specifications and other provider resources can be found in the Details of Connecticut's Maternity Bundle section.

Appendix

Program Overview

Program Start Date: September 1st, 2024

Eligible Providers: Maternity practices who deliver 30 or more births per year

Key Design Components:

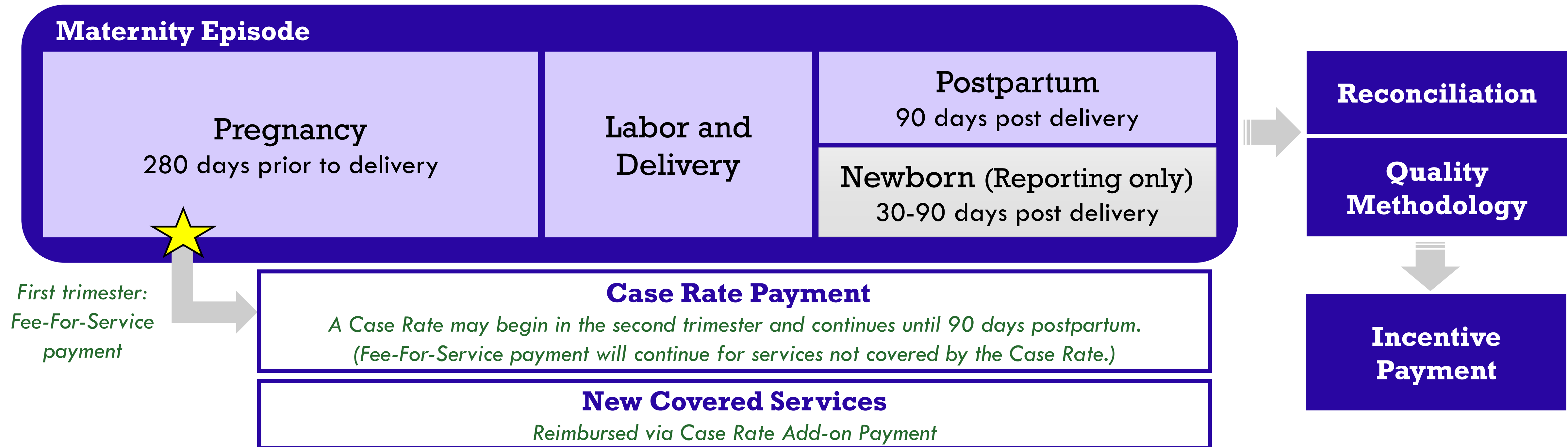
- Provider-specific **“Case Rate” payments** to encourage flexibility in care delivery
- Episode cost calculated through **retrospective reconciliation**
- **Quality measures** to ensure high-quality care and improvements in care
- **Social and clinical risk adjustment** to reward providers who care for Medicaid members with greater social and health needs

Program Highlights:

- New coverage of **doula and lactation support** services
- Opportunity for **“incentive” payments** (shared savings) without downside risk

Maternity Episode

An episode of care describes the total amount of care provided to a patient during a set timeframe. In this program, the maternity episode includes services across all phases of the perinatal period, spanning 280 days before birth to 90 days postpartum.



Maternity Episode Services

See the full list on the following slide.

Pregnancy

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

Labor & Delivery

- Vaginal delivery
- C-section delivery

Postpartum

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

HUSKY Maternity Bundle Payment Program:

Historic Performance Report Appendix

Contents: This appendix includes additional information on:

- Maternity Episode Services
- Target Price
- Final Quality Score

Additional Information:

More information about the Maternity Bundle Program can be found at the DSS Maternity Bundle website **here**.

Actual Cost

Target Price

Maternity Episode Services

Reconciliation will consider all episode services, both those included in the Case Rate, and those paid FFS.

Included Services

- ➢ OB/licensed midwife Professional Services
- ➢ ***In-house*** OB/licensed midwife Professional-related hospitalization costs (Inpatient, Outpatient, and ED) including professional delivery fees
- ➢ OB/licensed midwife Professional-related Behavioral Health Evals, 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
- *If performed outside the participating Accountable Provider:* OB/licensed midwife imaging & labs
- Birth Centers and hospital costs related to maternity care
- Specialist/Professional Services related to maternity (e.g., anesthesia)
- General Pharmacy related to maternity

Excluded Services

- Pediatric Professional Services
- Neonatal Intensive Care Unit (NICU)
- Behavioral Health & Substance Use services
- Long-acting reversible contraception (LARC)
- Sterilizations
- DME (e.g., blood pressure monitors, breast pumps)
- High-cost medications (specifically, HIV drugs and brexanolone)
- Hospital costs unrelated to maternity (e.g., appendicitis)
- Other Care, including Nutrition, Respiratory Care, Home Care, etc.
- Maternal Oral Health services

Key:
- ➢ Services reimbursed and included in the Case Rate.
- • Services reimbursed Fee-For-Service

Target Price

The provider-specific target price is the expected total cost of care for the maternity episode based on a blend of the statewide average cost for maternity care and the provider's historical cost.

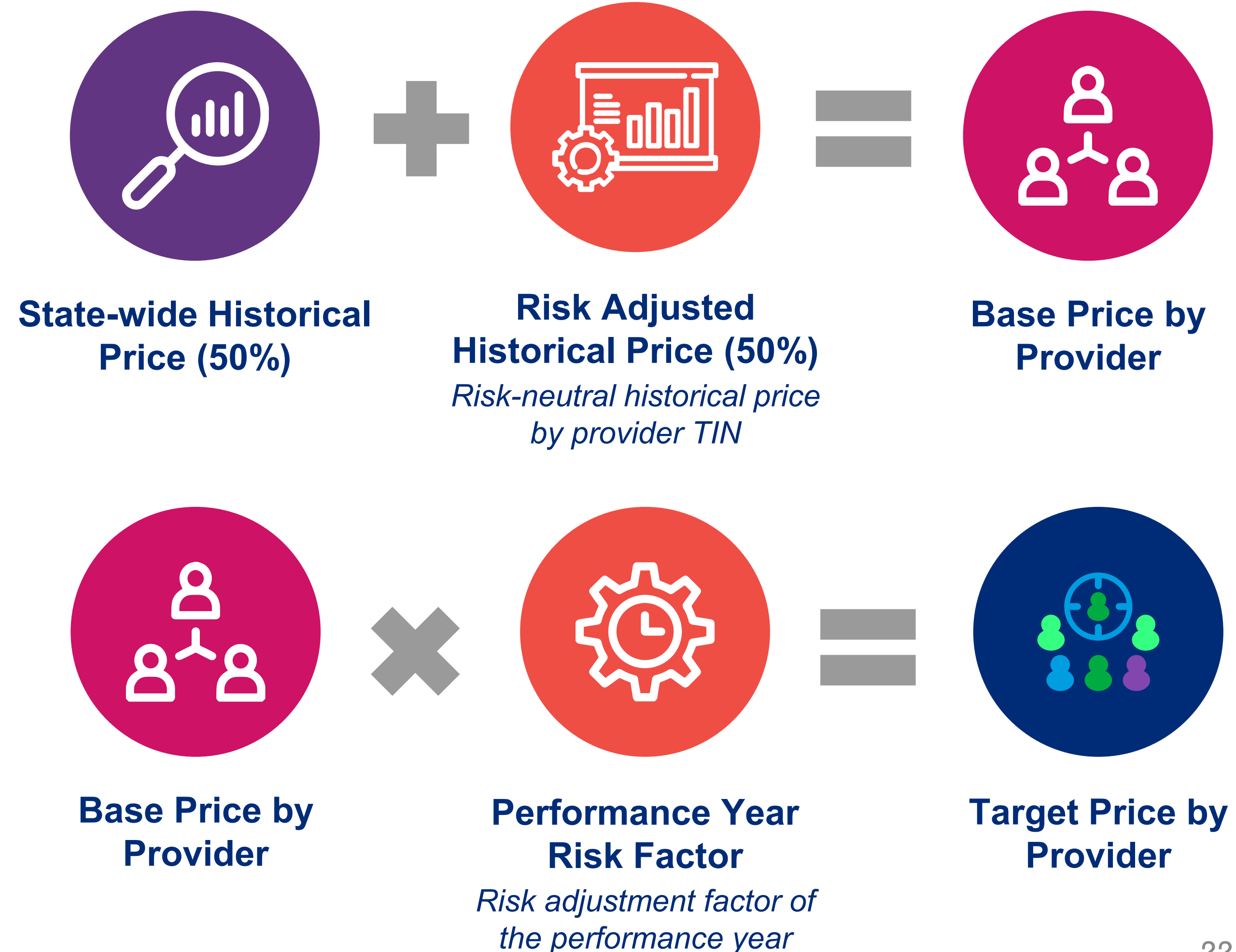
Historical Price

- 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 standard fee schedule by diagnosis related group and severity level. This process will be used for inpatient hospitals and some other services, if applicable.*

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.



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Final Quality Score

Quality Measures and Weights

This program has ten quality measures: five are Pay for Performance measures and five are Pay for Reporting measures.

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.

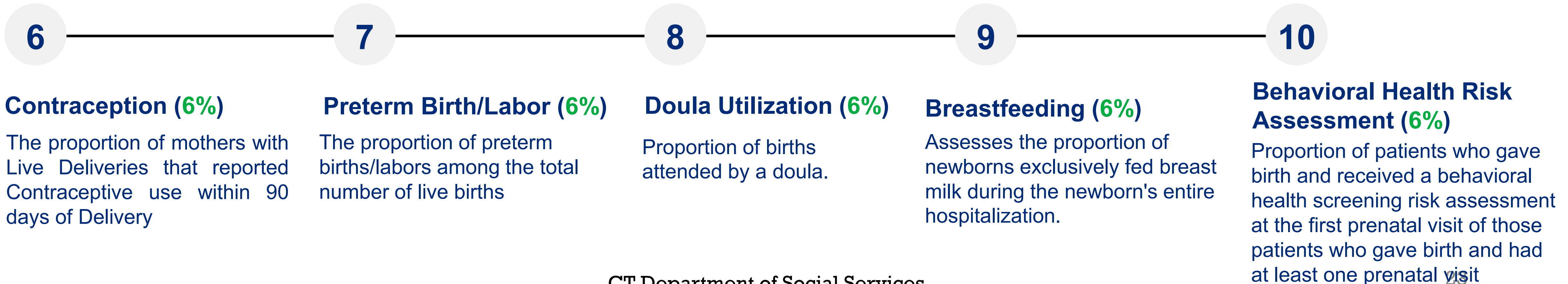
4 — Low Birth Weight (12%)

The proportion of infants with the International Classification of Diseases codes for light for gestational age, small for gestational age, low birth weight, 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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Quality Methodology and Scoring

Final Quality Score

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%

Final Quality Score

Quality Methodology Example

The distribution of incentive payments will be adjusted based on the Accountable Provider's quality performance. The example below illustrates how DSS will produce the final quality score.

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%

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

Quality Gate Check

- Accountable Providers who fall into 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.
- In the subsequent year, if an Accountable Provider consecutively maintains quality performance in Tier F for both tiers, the provider will be ineligible for the incentive payment that year.