HUSKY Maternity Bundle Payment Program

Office Hours

November 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 or raise your hand to ask questions.

Agenda

Goals for Today

- **Share program status updates** on progress toward key implementation activities
- **Review overview of PY 1 Case Rates** and answer your payment-related questions
- **Review programmatic refinements** made in response to provider feedback
- **Answer your questions** regarding the Maternity Bundle program

Program Status Update

Program Status Update

In response to stakeholder feedback, DSS has revised the launch date for the HUSKY Maternity Bundle Payment Program to **January 1st, 2025**.

Recently Accomplished

- ✓ Actuarial Modeling & Program Testing
- ✓ Draft Case Rates
- ✓ Historic Performance Reports
- ✓ Provider Resources: Video Guides, FAQs, Quality Measures Guide, and Billing Example
- ✓ Consideration of Program Refinements

Current Priorities

- ✓ Final Performance Year 1 Case Rates
- ✓ 835 Test File
- ✓ Encounter Form Template
- ❑ CMS State Plan Amendment (SPA) Approval
- ❑ Provider Bulletin

Upcoming

- ❑ Test File for Supplemental Payment Report
- ❑ 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**

Performance Year 1 (PY 1) Case Rates

Case Rate Development & Program Monitoring

Reminder

Ensuring member access to affordable, high-quality care is a key value that underpins all HUSKY Health programs. As such, this payment model was designed to increase investment in maternity care providers.

- **DSS Work to Date:** DSS rigorously developed the Case Rate payments based on each practice's historic utilization and FFS billing. DSS also tested Case Rate payment through the program's historic simulation and a separate fiscal impact analysis.
- **Case Rate Data:** DSS provided draft Case Rates in March and additional provider-specific data illustrating how the Case Rate was developed in August. Most recently, DSS refreshed the Case Rates with a more recent claim set and shared your final PY 1 Case Rates which will be effective as of 1/1/2025.
- **Program Monitoring:** DSS will monitor changes in member access, practice revenue, and billing patterns after program implementation to ensure that the roll-out of Case Rate payments occurs as designed and to preserve HUSKY Health members' access to care.
- **Rate Rebasing:** DSS will rebase the Case Rates no more than once annually to account for changes in risk mix or service delivery over time.

Overview of PY 1 Case Rate Data

Each practice's Case Rate is based on historical second trimester, third trimester, delivery, and postpartum professional claim expense for historically attributed episodes.

- Your Case Rate factors in your practice's historic utilization patterns to account for the complexity of your panel's acuity and the level of services provided.
- The data below was generated using prenatal, delivery, and postpartum claim experience of the deliveries that occurred between **10/1/2022 to 9/30/2023**.
- The rates are set to be the same for every episode per practice (billing Tax ID).

Practice Name	**Billing Tax ID**	**Medicaid ID Receiving Payment**

Attributed Episodes	Trimester 1 FFS Payments	*Case Rate Development Details*				Case Rate Add-On Payment	**PY 1 Case Rate with Add-On Payment**
		Trimesters 2, 3, Delivery & Postpartum FFS Payments		Average Months of Payments per Case	**PY 1 Case Rate**		
		Total	Per Episode				

Key Terms are included in the next two slides.

PY 1 Case Rate Key Terms

- **Medicaid ID Receiving Payment** represents that Medicaid (AVSR) ID that will receive payment on behalf of your practice's TIN. For each practice (billing Tax ID entity), DSS will make all Case Rate payments to the Medicaid (AVRS) ID that received the most revenue in the prior year. By default, your Case Rate payment will be made to the Medicaid ID Receiving Payment shown in the table above. Practices have the option to specify a different Medicaid ID to direct payment to, by sending a request to your CHNCT, Inc. Provider Engagement Services representative.
  - **If you would like to report a different Medicaid ID to direct payment, please submit your request by November 15, 2024.**

- **Attributed Episodes** represents the number of maternity episodes that the Accountable Provider TIN was responsible for in the historic period.

- **Trimester 1 FFS Payments** represents total professional service payment for maternal care services (defined by the "Case Rate Codes" posted on DSS website and billed by maternal specialty providers) rendered during the first trimester, as reimbursed via fee-for-service (FFS) payments. Services rendered during the first trimester are not included in the Case Rate.

- **Trimesters 2, 3, Delivery & Postpartum FFS Payments** represents total professional service payment for maternal care services (defined by the "Case Rate Codes" posted on DSS website and billed by maternal specialty providers) that will be included in the Case Rate, as reimbursed historically via FFS, during the second and third trimesters, delivery (if provided by the Accountable Provider TIN), and postpartum period – in total, and per episode.

PY 1 Case Rate Key Terms

- **Average Months of Payments per Case** represents the average number of months that the practice would have received a Case Rate payment in the historic period. Note that practices who trigger Case Rate at the start of second trimester will be eligible to receive Case Rate payments for each month of the episode that they are responsible for the attributed member's care (i.e., approximately 9 months for the full episode, including: second trimester, third trimester, and 3 months postpartum), if there is no other practice triggering case rate payments at a later date.

- **Performance Year 1 (PY 1) Case Rate** represents each practice's monthly, practice-specific Case Rate payment amount for maternal care services provided (defined by the "Case Rate Codes" posted on DSS website and billed by maternal specialty providers) during the second and third trimesters, delivery (if provided by the Accountable Provider TIN), and postpartum period. See the trigger event criteria for more details about the maternity bundle specialty types included in the development of the Case Rate.

- **Case Rate Add-On Payment** represents additive funding to be paid on top of the Case Rate to support reimbursement for doula and/or lactation support services provided by or under the supervision of the Accountable Provider practice. Practices may receive up to $21 total for add-on funding: $7 for lactation supports (for all practices) and $14 for doula services (for practices who have not opted out of receiving this funding). The add-on payment for doula and lactation support services will automatically be provided prospectively and excluded from incentive payment calculations, and add-on funding for doula services will be subject to a retrospective true-up process.

- **PY 1 Case Rate with Add-On Payment** represents the total rate that practices can expect to receive for attributed patients in Performance Year 1. This rate combines the PY 1 Case Rate and the Add-On Payment for doula and/or lactation support services.

Programmatic Technical Adjustments

Please note that the development of PY 1 Case Rates includes minor technical adjustments made in response to provider feedback (as shared at the September 2024 Provider Office Hours), including:

- Excluding services billed by Family Medicine physicians and Family Nurse Practitioners from the Case Rate coverage
- Excluding episodes for members with other insurance coverage(s)
- Allowing places of service for case rate triggering events to be 11 (office), 19 (off-campus outpatient hospital), & 22 (on-campus outpatient hospital)
- Excluding the comprehensive preventive medicine E&M codes 99381-99397
- *For certain Accountable Providers with known acquisitions* - Including the historical experience of acquired practices in the Case Rate calculation

Maternal Fetal Medicine (MFM) Provider Inclusion

Reminder

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

DSS Plan of Action

- **DSS will provide supplementary provider-specific data as part of the PY 1 case rate refresh report to support providers in understanding what portion of the case rate is associated with services delivered by an MFM within their TIN.**
  - DSS recognizes that accountable providers may need to modify their accounting practices to appropriately allocate case rate revenue by practice and/or provider; supplementary data is intended to support providers in operationalizing any accounting practice changes that need to occur.

November 2024 Update

In recognition of provider feedback on this topic, DSS plans to continually review and reassess the impact of MFM provider inclusion following program Go Live, such as monitoring MFM service access and utilization, to ensure this policy achieves program goals as intended, while balancing the needs of HUSKY members and providers.

Additional MFM Data

DSS provided additional practice-specific data below to help practices understand what portion of their Case Rate is associated with services rendered by MFMs (defined by one taxonomy code) within their TIN.

Practice Name	Billing Tax ID	Medicaid ID Receiving Payment
Total Trimesters 2, 3, Delivery & Postpartum FFS Payments	Maternal Care Dollars by Attributed MFM Providers	Percentage of MFM Care Cost in Attributed Dollars

Key Terms

- **Maternal Care Dollars by Attributed MFM Providers** represents the total payment for maternal care services (defined by the "Case Rate Codes" posted on DSS website and billed by maternal specialty providers) rendered by MFM providers that is included in the Case Rate within the attributed practice. This total is a subset of the Total Trimesters 2, 3, Delivery & Postpartum FFS Payments.
- **Percentage of MFM Care Cost in Attributed Dollars** represents the percentage of the total payment for maternal care services (defined by the "Case Rate Codes" posted on DSS website and billed by maternal specialty providers) included in the Case Rate rendered by MFM providers within the attributed practice. This percentage is determined by dividing the Maternal Care Dollars by Attributed MFM Providers by the Total Trimesters 2, 3, Delivery & Postpartum FFS Payments.

Medicaid ID Change Requests

For each practice (billing Tax ID entity), DSS will make all Case Rate payments to the Medicaid (AVRS) ID that received the most revenue in the prior year.

- By default, your Case Rate payment will be made to the Medicaid ID Receiving Payment specified in your Case Rate letter.
- Practices have the option to specify a different Medicaid ID to direct payment to, by sending a request to your CHNCT, Inc. Provider Engagement Services representative.
- **If you would like to report a different Medicaid ID to direct payment, please submit your request by November 15, 2024.**

New Programmatic Refinements

New Trigger Event Guidance for Go Live

For the first quarter of the program, DSS will only allow Case Rate trigger events in the 2nd trimester.

- **Background:** DSS received provider feedback regarding concerns about episodes triggering the Case Rate in the 3rd trimester upon Go Live.
- **DSS Considerations:** DSS reviewed actuarial assumptions and tested the operational feasibility of limiting trigger events to the 2nd trimester only for the first three months of the program. Limiting to 2nd trimester trigger events only for the first three months ensures that a provider will be eligible to receive Case Rate payments for the full duration of the episode.
  - Note that this impact is limited to the start of the program only. There is no impact on final PY 1 Case Rate amounts, which were based on each practice's historic utilization (i.e., practice patterns for patients who seek or change care mid-pregnancy or postpartum have been factored into the Case Rate).
- **Policy Decision**
  - **Effective 1/1/25 - 3/31/25, trigger events *in the 2nd trimester only* will initiate Case Rate payment.** This means providers will not receive the Case Rate payment for patients who are in the 3rd trimester or postpartum period for the first three months of the program.
  - **Effective 4/1/25, trigger events in the 2nd trimester, 3rd trimester, and postpartum period will initiate Case Rate payment.**

Pay-for-Reporting Guidance

DSS will implement the following quality measure-related refinements, which have been indicated in the latest quality-related provider resources (Quality Measures Reference Guide & Encounter Form Template):

Pay-for-Reporting (29%)

6 Contraception
(6% doula add-on 7% doula opt-out)

The proportion of mothers with Live Deliveries that reported Contraceptive use within 90 days of Delivery

7 Preterm Birth/Labor
(6% doula add-on 7% doula opt-out)

The proportion of preterm births/labors among the total number of live births

8 Doula Utilization[1]
*(6% doula add-on N/A doula opt-out)**

Proportion of births attended by a doula.

9 Breastfeeding[2]
(6% doula add-on 7% doula opt-out)

Assesses the proportion of newborns exclusively fed breast milk during the newborn's entire hospitalization.

10 Behavioral Health Risk Assessment[2]
(6% doula add-on 7% doula opt-out)

Proportion of patients who gave birth and received a behavioral health screening risk assessment at the first prenatal visit of those patients who gave birth and had at least one prenatal visit

Policy Updates:

*DSS will only require practices that receive the doula care add-on payment to report on the doula utilization measure. For practices that do not receive the doula care add-on payment, Pay-for-Reporting measure weights will be reweighted.

[1] 100% Encounter Form submission threshold required for measure reporting/payment.

[2] 90% Encounter Form submission threshold required for measure reporting/payment.

Recent Technical Adjustment: CARC Code Update

DSS recently conducted a provider survey to request feedback on the proposed CARC code. Based on survey results, DSS will update the CARC code on the 835 electronic remittance advice to CO245.

- **Background:** After the Accountable Provider initiates Case Rate payments, DSS will process the trigger claim and all subsequent claims (assuming the Accountable Provider maintains episode attribution). The system will subsequently assign a unique EOB code (M15) that will display on the Remittance Advice, and the 835 will contain a CARC indicating the reason for claim zero payment.

- **Survey Process:** DSS had proposed using CARC code CO97; however, based on recent provider feedback, the Department conducted a provider survey to request your input on whether to keep or change the proposed CARC to the proposed alternative CO245.
  - *Survey Results:* Most survey participants prefer or don't mind updating the CARC to CO245.

- **Policy Decision:** Based on survey responses, DSS updated the CARC code to CO245.

Next Steps

Additional Resources

In response to provider requests, DSS has provided the following new or updated program resources, including additional guidance for providers:

- ✓ **(New) Sample 835 File** for practices to preview a mock-up 835 file for case rate and incentive payments
- ✓ **(New) Sample Encounter Form** for data submission on select Pay-for-Reporting measures
- ✓ **(Updated) Program FAQ** with newly added questions and updated program guidance
- ✓ **(Updated) Quality Measures Reference Guide** with more information on the program's quality measure slate and reporting details
- ✓ **(Updated) Code List** reflecting minor modifications based on provider feedback

Provider Next Steps: If you would like to report a different Medicaid ID to direct payment, please submit your change request to your CHNCT, Inc. Provider Engagement Services representative by **November 15, 2024**.

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.

Questions?

Appendix:
Program Overview

Revised Launch Date

In response to stakeholder feedback, DSS is revising the launch date for the HUSKY Maternity Bundle Payment Program to **January 1, 2025**.

- This new payment model aims to strengthen maternal health and improve health outcomes for HUSKY Health members through improved quality of care and access, with an emphasis on reducing health disparities and improving the patient's care experience.
- To enable program success, DSS values providers as critical partners in this initiative and has aimed to incorporate and be responsive to stakeholder feedback throughout the design and implementation process.
- After careful consideration, DSS has decided to update the launch date of the program to enable consideration of program refinements and provide additional provider resources and guidance in response to stakeholder feedback.

Program Overview

Program Start Date: January 1, 2025

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

Key Design Components:

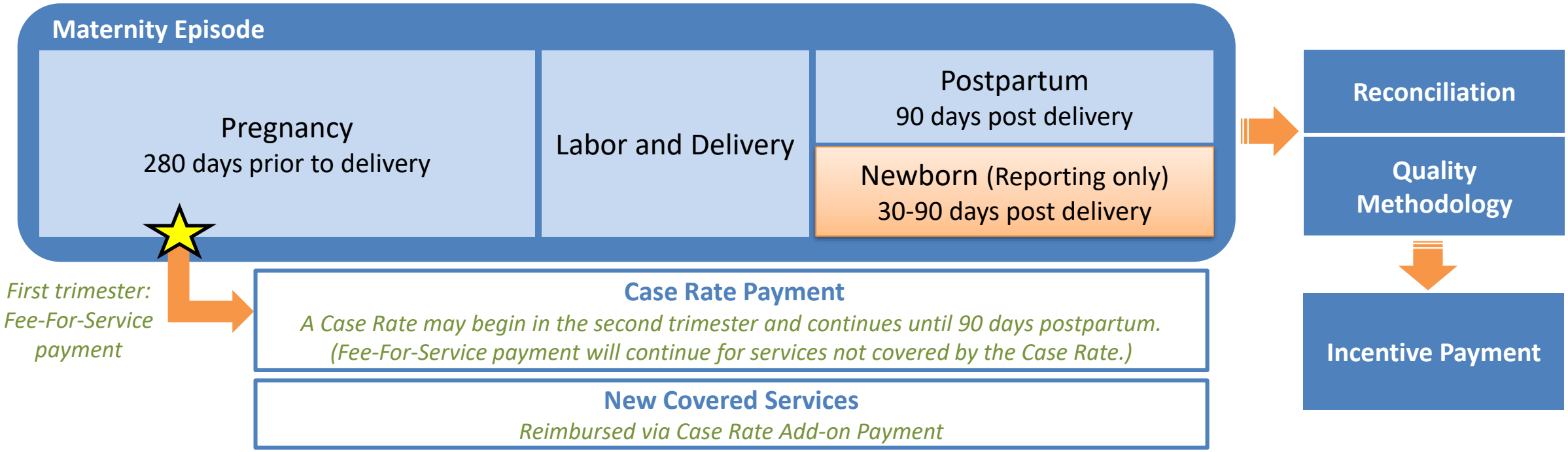
- Provider-specific **"case rate" payments** to encourage flexibility in care delivery
- Episode cost calculated through **retrospective reconciliation**
- **Quality measures** to ensure high-quality care and improvements in care
- **Social and clinical risk adjustment** to reward providers who care 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 education meetings
- Birth education 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

Case Rate Payments

Accountable providers will receive monthly case rate payments for a subset of prenatal, delivery and postpartum services.

- **What?** For a subset of services, DSS will make monthly "case rate" payments for the majority of prenatal and postpartum care that a birthing person receives.
  - Each provider's initial case rate is based on historical second trimester, third trimester, delivery (if performed by the accountable provider), and postpartum claim expense for historically attributed episodes.
  - The rates will be rebased, not more frequently than once every 12 months.
  - A case rate may begin in the 2nd trimester. Claims submitted in the first trimester will be paid fee-for-service.
  - If/when a different provider takes over the patient's case within the second or third trimester, the case rate for the original accountable provider will cease.
- **Who?** Case rate payments will be paid to the Accountable Provider to which the birth is attributed.
- **Why?** DSS designed the maternity bundle's case rate payment to give providers greater flexibility in how they deliver care.

Maternity Episode Services

Included Services	Excluded 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	• 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 DSS' institutional knowledge regarding fee schedule changes, etc..

** 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.

State-wide Historical Price (50%)

Risk Adjusted Historical Price (50%)

Risk-neutral historical price by provider TIN

Base Price by Provider

Base Price by Provider

Performance Year Risk Factor

Risk adjustment factor of the performance year

Target Price by Provider

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%)

6 Contraception (6%)

The proportion of mothers with Live Deliveries that reported Contraceptive use within 90 days of Delivery

7 Preterm Birth/Labor (6%)

The proportion of preterm births/labors among the total number of live births

8 Doula Utilization (6%)*

Proportion of births attended by a doula.

9 Breastfeeding (6%)

Assesses the proportion of newborns exclusively fed breast milk during the newborn's entire hospitalization.

10 Behavioral Health Risk Assessment (6%)

Proportion of patients who gave birth and received a behavioral health screening risk assessment at the first prenatal visit of those patients who gave birth and had at least one prenatal visit

*DSS will only require practices that receive the doula care add-on payment to report on the doula utilization measure. For practices that do not receive the doula care add-on payment, Pay-for-Reporting measure weights will be reweighted to 7% each.

Quality Methodology and Scoring

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

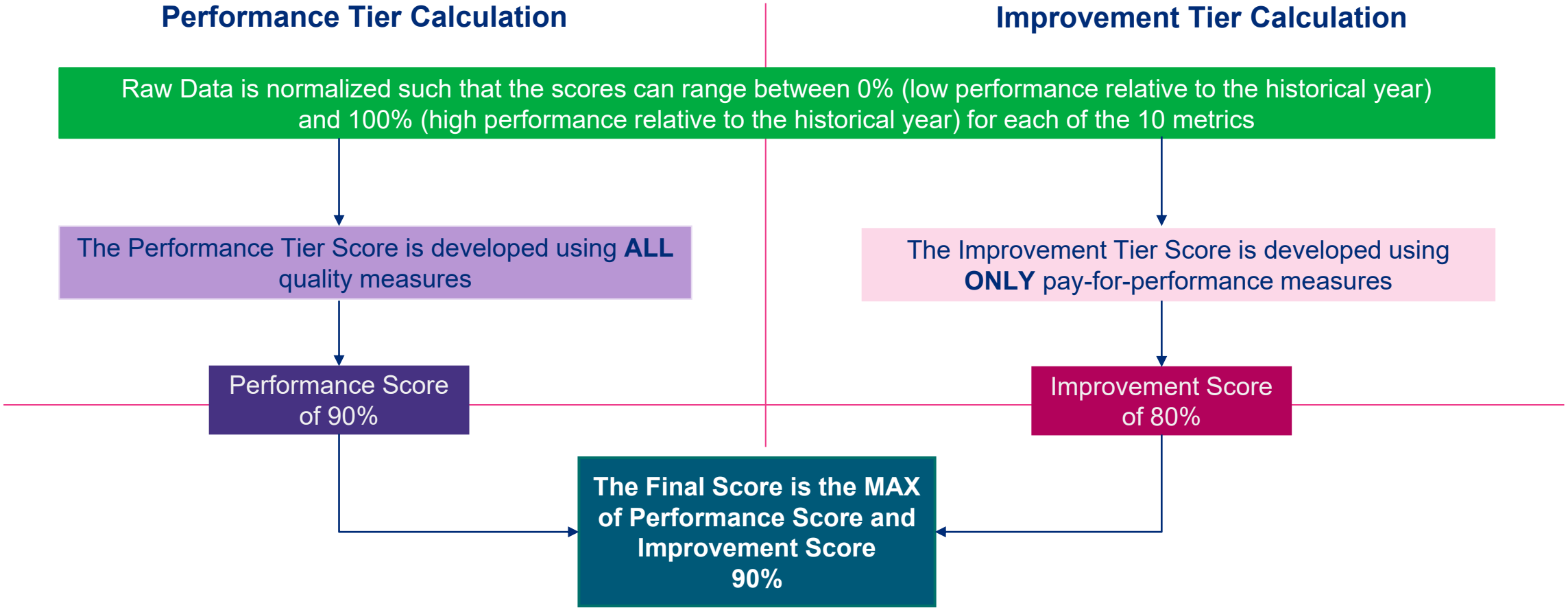
Overall Performance	Performance Earnings Tier	Performance: % Shared Savings
< 55th Percentile of peer group	F	50%
55–60th Percentile of peer group	D	60%
60–70th Percentile of peer group	C	70%
70–75th Percentile of peer group	B	80%
75–80th Percentile of peer group	A	90%
> 80th Percentile of peer group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

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.



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.