HUSKY Maternity Bundle Payment Program

Provider Forum

September 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

1. Program Status Update
2. Program Updates in Response to Feedback
3. Additional Resource Documents
4. Q&A

Reminder: Revised Launch Date

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

With the revised launch date, DSS will continue to engage stakeholders throughout this period, providing additional information and opportunities for providers to ask questions and share feedback.

Recently Accomplished

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

Current Priorities

- ✓ Consideration of Program Refinements
- ✓ Updated FAQ
- ✓ Quality Measures Reference Guide
- ✓ Billing Example
- ❑ CMS State Plan Amendment (SPA) Approval

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

Program Updates in Response to Feedback

In June and July, various providers raised valuable questions and requests for program refinements as well as additional provider resources.

- **DSS has carefully considered all stakeholder requests** – from less substantive technical adjustments to more substantive programmatic changes – and has determined an approach to integrating stakeholder feedback on each request.
- Throughout this process, DSS has aimed to be responsive to provider feedback while balancing the integrity of the program's goals and recognizing the Department's operational capabilities.

- **Today, we will review key feedback and highlight program updates DSS is making** in response to stakeholder feedback on the following program elements:
  - Case Rate Development & Program Monitoring
  - Attributing Costs to MFM Providers
  - Family Medicine Exclusion
  - Billing for Members with TPL Coverage
  - Case Rate Services

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 to maternity care providers.

Policy Decision & Rationale

- **DSS does not plan to make upward or downward adjustments to reconcile Case Rate and FFS claims. If DSS were to implement the Case Rate true up, federal authority and state budget constraints would require the state to conduct an upside and downside reconciliation, which would create more harm than benefit to providers.**
- 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 ($17M total SFY 2025-27).
- In addition, participating providers will also be eligible to receive additive funding through lactation support add-on payments ($7 per-member-per-month payments) and upside only shared savings payments for delivering high-quality, cost-effective services.

Case Rate Development & Program Monitoring

DSS will monitor changes in member access, practice revenue, and billing patterns to preserve HUSKY Health access to care and to ensure financial stability for participating practice.

DSS Plan of Action

- **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 additional provider-specific data illustrating how the Case Rate was developed in August. This data should help providers compare their revenue under the Case Rate vs. FFS in the historic simulation. Prior to Go Live, DSS will refresh the Case Rates with a more recent claim set to establish the rate that will be effective as of 1/1/2025. DSS will share your PY 1 Case Rate along with similar, supplemental Case Rate development data.
- **Program Monitoring:** DSS will also 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 access to care.
- **Rate Rebasing:** DSS will rebase the Case Rates no more than once annually, based on risk adjustment and trend factors, to account for changes in risk mix or service delivery over time.

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

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.

Attributing Costs to MFM Providers

DSS recognizes that Accountable Providers will need to determine how to allocate Case Rate revenue and will provide supplemental data to support this process.

Stakeholder Feedback

- MFMs typically provide higher cost services to higher risk patients. Accountable Providers will need to determine how to allocate Case Rate revenue by practice and/or provider to ensure MFMs are adequately reimbursed for these services.

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.

Family Medicine Exclusion

Stakeholder Feedback

- Primary care services delivered by Family Medicine providers to pregnant members will be included in Case Rate payments because these services are typically billed with qualifying Case Rate codes. This will result in the inclusion of non-maternal health care services in the Case Rate.

DSS Decision and Rationale

- **DSS will update the program design to exclude Family Medicine physicians and Family Nurse Practitioners.**
- The Maternity Bundle program is intended to focus on payment for maternal health care services.
- While Family Medicine providers can provide obstetrics care, additional actuarial analysis and discussion with providers suggests that few Family Medicine providers are providing obstetrics care in CT.
- By excluding Family Medicine providers, DSS aims to simplify billing processes for providers, and ensure non-maternal health care services delivered by Family Medicine providers are not unintentionally incorporated in the Case Rate.

Billing for Members with TPL Coverage

Stakeholder Feedback

- Providers are constrained by other payer requirements when billing for members with Medicaid as secondary coverage. It will be particularly challenging for providers to trigger Case Rate payments for members with TPL coverage when the primary payer uses global code billing.

DSS Decision and Rationale

- **DSS will pay claims with a TPL paid amount using standard FFS processes. Providers who currently bill global code for members with Medicaid as secondary coverage can continue billing for these members using global code instead of triggering Case Rate payments.**
- DSS recognizes the importance of multi-payer alignment and understands that providers are constrained by other payer's billing requirements when billing for members with TPL. To minimize disruption and simplify billing processes for providers, DSS will continue to pay claims with a TPL paid amount using standard FFS processes.

Case Rate Services

Stakeholder Feedback

- The inclusion of codes related to preventative pediatric and adult care (e.g., annual physical exams) are not aligned with the goals of inclusion.

DSS Decision and Rationale

- **DSS will exclude the comprehensive preventive medicine evaluation and management codes 99381-99397 from Case Rate development.**
- Codes for preventative medicine were removed to ensure non-maternal health care services are not unintentionally incorporated in the Case Rate.

Additional Resources

DSS has provided the following resources including additional guidance for providers, in response to requests:

- ✓ **Updated Program FAQ** with newly added questions and updated program guidance
- ✓ **Quality Measures Reference Guide** with more information on the program's quality measure slate and reporting details
- ✓ **Billing Example** with a detailed example of how claims processing will work under the program
- ✓ **Updated Code List** reflecting minor modifications based on provider feedback

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 Overview

Program Start Date: January 1st, 2025

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

Key Design Components:

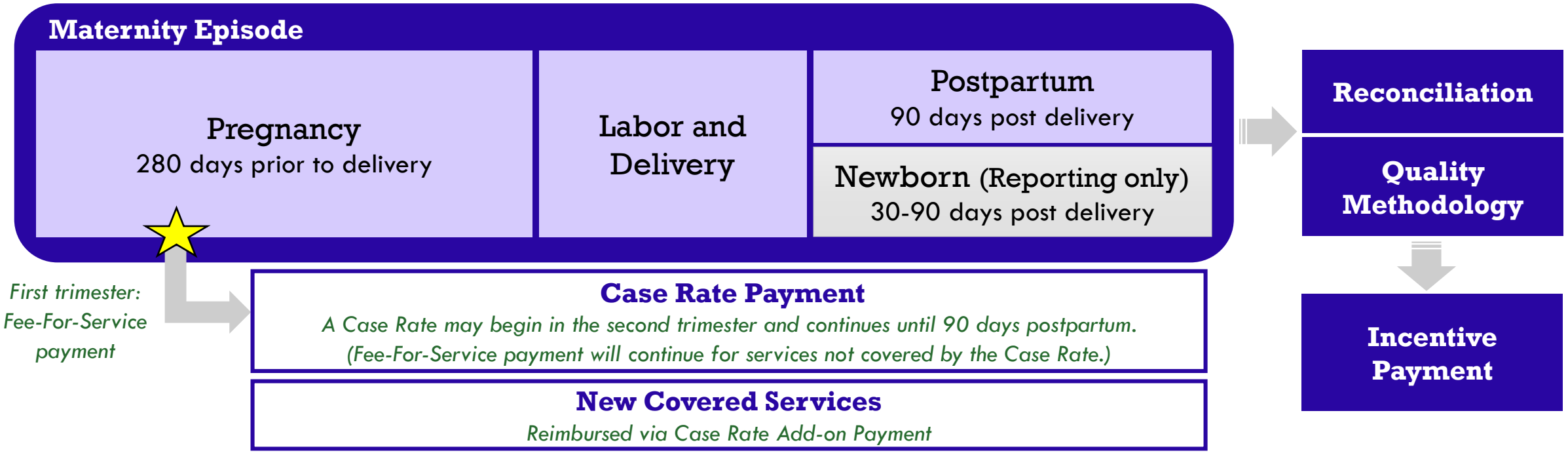
- Provider-specific **"Case Rate" payments** to encourage flexibility in care delivery
- Episode cost calculated through **retrospective reconciliation**
- **Quality measures** to ensure high-quality care and improvements in care
- **Social and clinical risk adjustment** to reward providers who care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

Case Rate Payments

Accountable Providers will receive monthly case rate payments for a subset of prenatal 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.

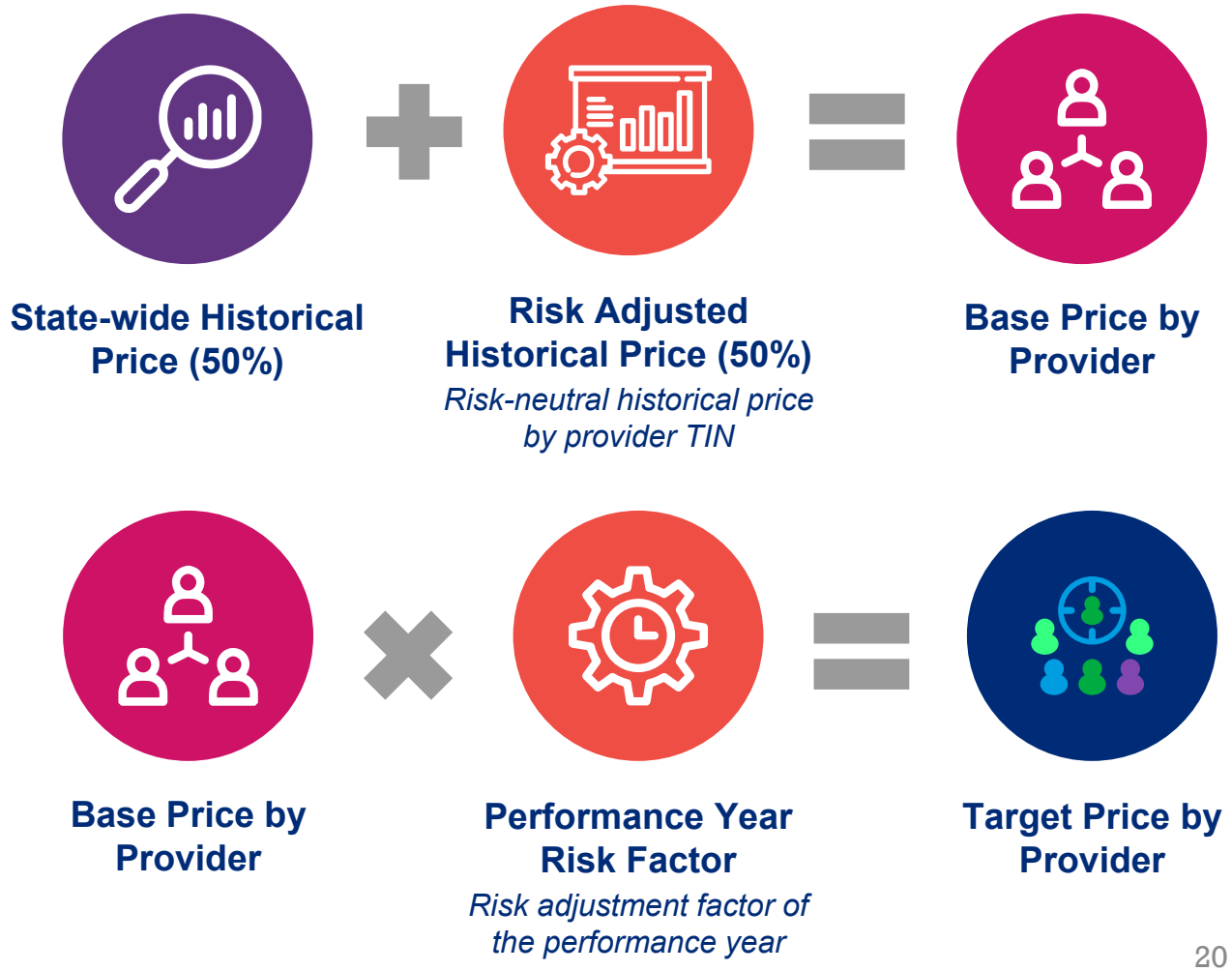
Historical Price

- 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 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.



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

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

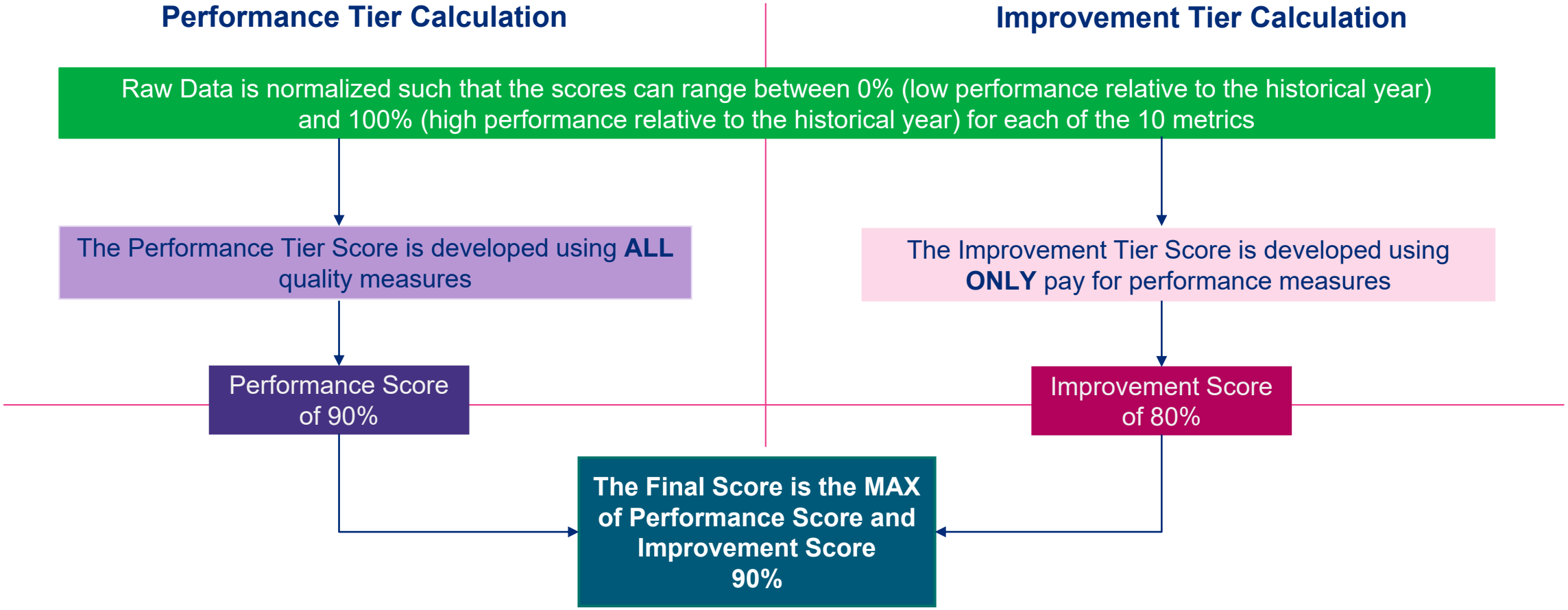
Overall Performance	Performance Earnings Tier	Performance: % Shared Savings
< 55th Percentile of peer group	F	50%
55–60th Percentile of peer group	D	60%
60–70th Percentile of peer group	C	70%
70–75th Percentile of peer group	B	80%
75–80th Percentile of peer group	A	90%
> 80th Percentile of peer group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