

HUSKY Maternity Bundle Payment Program

Program Specifications

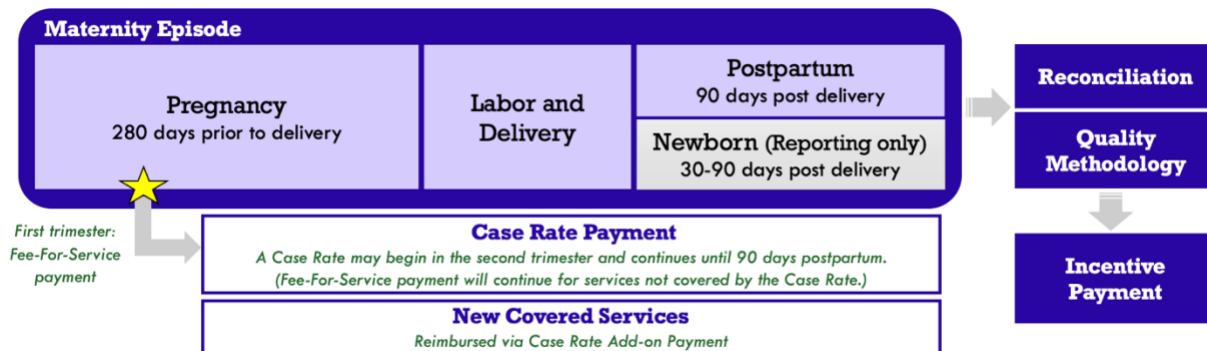
Published March 2024 for Effective Date September 1, 2024

The Connecticut Department of Social Services (DSS) anticipates transitioning to an episode-based payment model for maternity care reimbursement with a planned launch effective on or after September 1, 2024 (i.e., the program is not yet in effect and the implementation date will be finalized, which will be subject to federal approval). This plan to implement the HUSKY Maternity Bundle Payment Program is part of DSS’ overarching goal to move toward paying for equitable care in a value-based way.

Note: DSS reserves the right to update the Program Specifications after reviewing stakeholder input, completing program testing, and additional analysis.

Maternity Episode Definition

An episode of care describes the total amount of care provided to a beneficiary during a set timeframe. As shown below, the maternity episode includes services across the full perinatal period, spanning 280 days before the date of delivery to 90 days after the date of delivery.



Accountable Provider

In episode-based payment models, the “Accountable Provider” is the provider with the greatest influence and responsibility over the quality and cost of care delivered during the maternity episode. The Accountable Provider is the maternity billing provider entity delivering maternity services, and they may be eligible to receive Case Rate and/or incentive payments, which will be provided to the billing Tax ID.

Key Detail	Episode Base Definition
Provider Specialty	<ul style="list-style-type: none"> Episodes may be attributed to outpatient Obstetrics (OB), Licensed Midwife, and Family Medicine providers or provider groups¹ Attribution eligibility is limited to a subset of provider specialties: Physician/Group Family Medicine; Physician/Group Obstetrics and Gynecology; Certified Nurse Midwife/Group; Obstetric Nurse Practitioner/Group; Family Nurse Practitioner/Group; Women’s Health Nurse Practitioner/Group
Minimum Episode Volume	<ul style="list-style-type: none"> Eligible providers that meet the minimum episode volume threshold of 30 episodes in the past 12 months will be automatically enrolled in the program.
Trigger Code	<ul style="list-style-type: none"> ICD-10-CM, HCPCS or service codes² that formally assign the beneficiary’s episode to an accountable provider

¹Provider groups will designate which provider will receive payment on behalf of the practice.

²A full list of codes is available on the DSS website.

Case Rate Methodology

The case rates for Performance Year 1 will be set based on all deliveries that occurred from March 1, 2023 to February 29, 2024 with three months of claim run-out.

Service Inclusion & Exclusion Criteria

Key Detail	Episode Base Definition
<p>Services Included in the Episode</p>	<p>Services Included for Case Rate Payment² The provider-specific Case Rate payment reimburses a defined set of services rendered by the Accountable Provider during the prenatal and postpartum periods of the episode. Services eligible for or included in the Case Rate payment include:</p> <ul style="list-style-type: none"> • Office visits • Emergency room visits • Inpatient professional or facility services • Labs, radiology, imaging or ancillary services <i>if performed by Accountable Provider</i> • Pregnancy health screenings (inclusive of chlamydia and cervical cancer screenings, intimate partner violence screening, and behavioral health evaluations) • New maternal health services provided under the supervision of the accountable practice and within both the scope of the provider’s overall services and the provider’s plan of care for each beneficiary (<i>specifically, both doula care and lactation supports</i>) • Child birth and parenting education services • Care coordination activities <p>Services Included for Reconciliation (Incentive Payment Calculation)² All Medicaid claim costs for covered services (regardless of the provider that performed the service) will be included in the incentive payment calculations. Services included in the incentive payment calculations will continue to be paid in accordance with the reimbursement methodology applicable to the provider and service. Unless excluded below, services included for reconciliation include, but are not limited to:</p> <ul style="list-style-type: none"> • Office visits • Emergency room visits • Inpatient professional or facility services • Labs, radiology, imaging or ancillary services • Pregnancy health screenings (inclusive of chlamydia and cervical cancer screenings, intimate partner violence screening, and behavioral health evaluations) • Child education services • Care coordination activities • Birth centers and hospital costs related to maternity care • Specialist/professional services related to maternity (e.g., anesthesia) • General pharmacy related to maternity • Any of the aforementioned services provided via telehealth
<p>Excluded Services from the Episode</p>	<p>Services Excluded from the Bundle The following services are excluded from the incentive payment calculations:</p> <ul style="list-style-type: none"> • Pediatric Professional services • Neonatal Intensive Care Unit (NICU) services • Behavioral Health and Substance Use Disorder services • Long-acting reversible contraceptive (LARC) devices and related services • Durable Medical Equipment (DME), e.g., blood pressure monitors, breast pumps • High-cost medications (specifically, HIV drugs and brexanolone) • Hospital costs unrelated to maternity (e.g., appendicitis) and other care unrelated to maternity that the beneficiary would still receive if they were not pregnant (e.g. Respiratory Care, Home Care, etc.). Other care and services unrelated to maternity are defined as services that the birthing person regularly receives or would receive when they were not pregnant.

New Coverage of Doulas and Lactation Support

DSS plans to incorporate access to doula services and lactation supports as core features of the HUSKY Maternity Bundle Payment Program to bridge the equity gaps for historically marginalized birthing people. The new high-value services shall be provided under the supervision of the Accountable Provider and within both the scope of the provider’s overall services and the provider’s plan of care for each beneficiary. Accountable Providers will receive \$21 total for add-on funding: \$14 for doula services and \$7 for lactation supports. The add-on payment will be provided prospectively and excluded from reconciliation, and doula care will be subject to a retrospective true up process.

Description of Doula Services

Doula services are limited to childbirth education and support services, which includes emotional and physical support, provided during pregnancy, labor, birth, and postpartum. Doula services must be provided under the supervision of a physician, nurse practitioner, or nurse-midwife. Additional background resources for providers and doulas can be found at the DSS website at this link: <https://portal.ct.gov/DSS/Health-And-Home-Care/HUSKY-Maternity-Bundle/Doula-Integration>

Description of Lactation Support Services

1) Providers should provide first-line breast feeding education and support to all members. This includes information about the benefits of breastfeeding, as well as support for mothers who are struggling. It could also include existing or developed tools to assist mothers gauge breastfeeding success. This program could include online modules, in-person classes, and one-on-one support from lactation consultants.

2) Providers should also screen all members for potential breastfeeding difficulties or additional risk factors that may require additional expertise. Utilize or develop a screening tool to identify members who are at risk for breastfeeding problems. This tool could be used by nurses, midwives, IBCLCs and other healthcare providers during prenatal and postpartum visits.

3) Finally, providers should ensure appropriate access to International Board-Certified Lactation Consultants (IBCLCs) for members at risk or presenting with clinical problems related to breastfeeding/lactation. Establish a system for members who need clinical lactation support with breastfeeding. This system could connect members with IBCLCs who are available to provide in-person, video, or phone support.

Exclusion Criteria

If the beneficiary meets one or more exclusion criteria below, their Accountable Provider will be ineligible for retrospective reconciliation. In these instances, the Accountable Provider may continue to receive Case Rate payments; however, they will be ineligible for incentive payments.

Key Detail	Episode Base Definition
Exclusion Criteria	<p><i>Beneficiary Exclusions:</i></p> <ul style="list-style-type: none">• 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 <p><i>Pregnancy Exclusion:</i></p> <ul style="list-style-type: none">• There were no claims incurred during the first two trimesters of the pregnancy

Delivery Exclusion:

- Missing a facility claim in the episode (i.e., “orphan” episode)

Newborn Exclusions (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

Risk Adjustment Factors

As described in the SPA, risk adjustment will be applied during retrospective reconciliation. Below are the risk factors that will be included during the clinical and social risk adjustment.

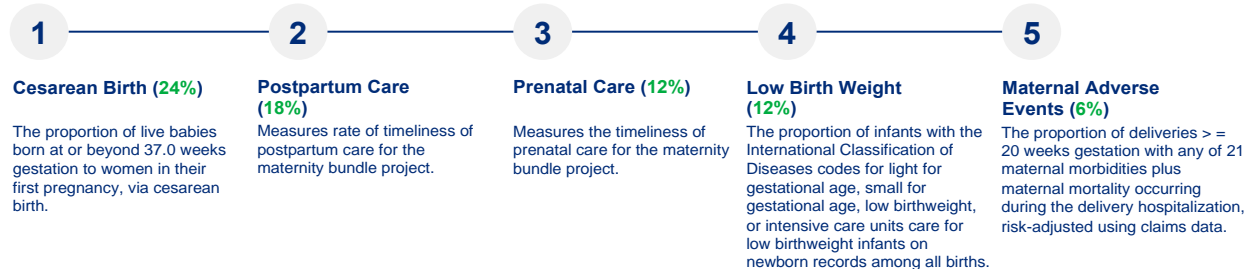
Key Detail	Episode Base Definition
Clinical Risk Adjustment	<p>The following list of risk factors will be used to capture the clinical risk of the individual patient and the effect on the episode of care cost:</p> <ul style="list-style-type: none"> • Member demographics: age and gender • Episode subtypes: subcategories of an episode that identify different modalities and cost trajectories • Risk factors: comorbidities present at the start of the episode which could influence episode cost • Supplemental risk adjustors: enrollment duration and line of business
Social Risk Adjustment	<ul style="list-style-type: none"> • To support or promote the provision of services to individuals in underserved communities and promote health equity in the model design, the Area Deprivation Index (ADI) will be used for social risk adjustment. • The ADI is a relative index of affluence and deprivation between areas at the 9-digit ZIP code level. • The ADI will be determined for the population each Accountable Provider serves, and that information will be used as an adjustment factor similar to the health-based risk adjustment. • For members living in area without an ADI, the average ADI for the Accountable Provider’s patient panel will be used.

Quality Methodology

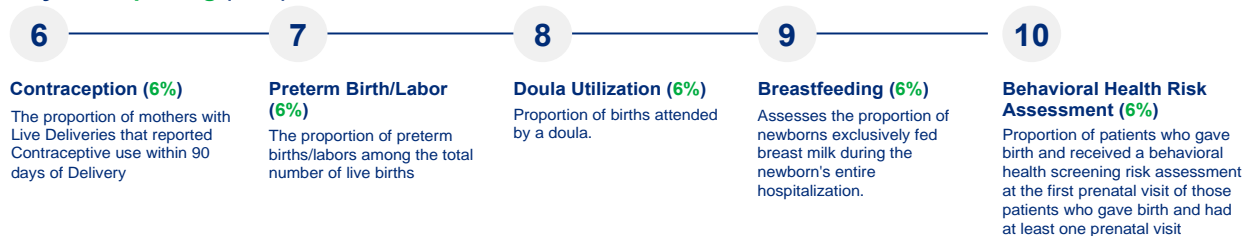
Incentive payments are contingent upon Accountable Providers meeting quality performance criteria established by Medicaid.

Quality Measures and Weights

Pay for Performance (71% Total)



Pay for Reporting (29%)

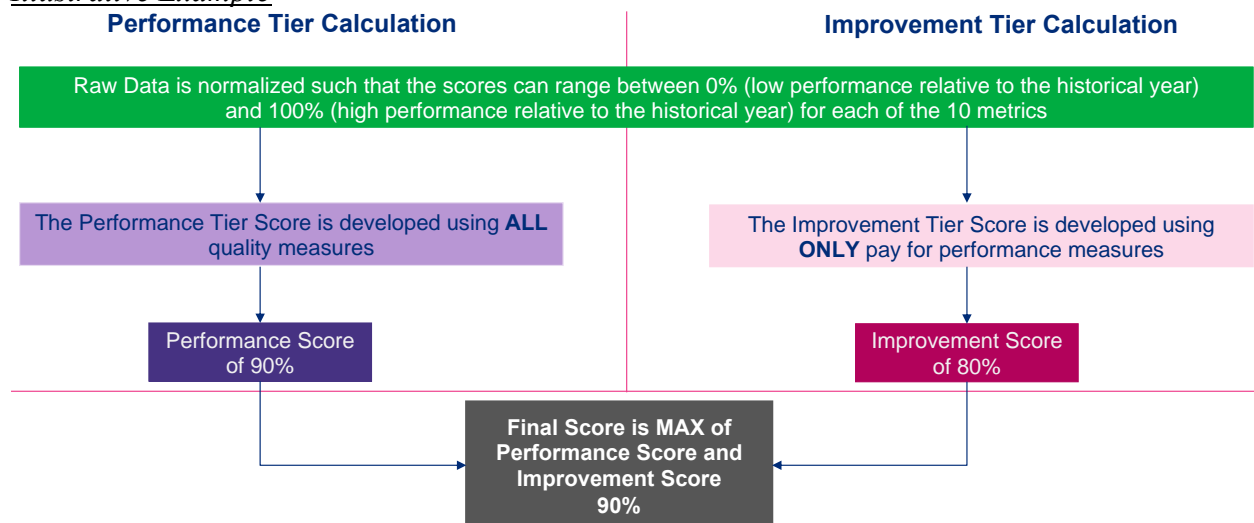


Methodology and Assumptions

The distribution of incentive payments is adjusted based on either the overall performance in relation to peer performance (“Performance Tier Score”) or the percent improvement over baseline from historical performance (“Improvement Tier Score”). As demonstrated in the illustrative example below, Accountable Providers will receive payment in accordance with their highest earnings tier between the two methodologies.

Accountable Providers who fall into the lowest tier (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 for the Performance Year. In the subsequent Performance Year, if an Accountable Provider consecutively maintains quality performance in Tier F for both tiers, the provider will be ineligible for the incentive payment of that performance period.

Illustrative Example



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
< 55 th Percentile of peer group	F	50%
55–60 th Percentile of peer group	D	60%
60–70 th Percentile of peer group	C	70%
70–75 th Percentile of peer group	B	80%
75–80 th Percentile of peer group	A	90%
> 80 th 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%