Questions on HUSKY maternity bundles from the CT Health Policy Project

DSS answers in blue

October 2022

Indented "a" questions are follow ups as the project is developing

October 2023

1. Are bundles voluntary for providers?

   DSS is changing payment for maternity services from a combination of global payments and fee-for-service to a bundled payment program. The program will be mandatory for certain maternal health providers. Providers who are not eligible to participate in the bundled payment program will continue to bill using a combination of global payments and fee-for-service for services rendered.

   1a. For which providers is the program mandatory and which are exempted? What is the reasoning behind the difference?

   All qualified Medicaid maternity provider practices (specifically, outpatient obstetricians, licensed midwives, or family medicine providers) who meet the minimum episode volume threshold (30 or more births per year) will automatically be enrolled in the program. Hospital providers and providers who do not meet the meet the minimum episode volume threshold will not be eligible to participate in the program.

   For FQHC providers, the specific federal reimbursement requirements of FQHCs' prospective payment system (PPS) make FQHC participation more complex, so initial program design has focused on non-FQHC providers. However, DSS is currently exploring how to implement optional FQHC participation for interested health centers.

   For non-FQHC providers, program participation is determined by the ability to meet the minimum episode volume threshold. The threshold is calculated by using statistical tests and aggregating episode costs based on historic baseline data. The threshold is necessary to establish benchmarks and determine variation of the actual spend of maternity episodes during the performance period.

2. Can patients opt-out?

   HUSKY Health members can choose and change their provider - some of which will not be participating in the bundle.

   2a. Will there be a list or searchable site to determine which providers are not participating in the maternity bundles, and consequently not at financial risk, for patients and the public?

   HUSKY Health will make public the list of providers that are in the program.

3. How will patients be notified that their provider is at financial risk for their care during pregnancy, delivery, and beyond?

   DSS will conduct an information campaign to educate HUSKY Health members about the bundle program and the benefits available through HUSKY Health.

3a. How will the information campaign happen? This was a debacle in PCMH Plus, when a consensus notice developed by DSS and advocates in collaboration, was eroded under political pressure from providers. Members have never been told that their providers are at financial risk and were deliberately misled, including in in-person meetings.
The HUSKY member information campaign is still under development. DSS plans to share more information about the communication plan with the Maternity Bundle Advisory Council and MAPOC Women and Children's Health Committee for feedback as it is developed.

4. What is the methodology and data source to determine the bundle amounts?
Please note the October 2023 correction: The bundle price will consist of ~~a blended rate using statewide and~~ provider-specific utilization history, using Medicaid claims data.
    a. For historic spending – are you using Medicaid utilization and payment rates or commercial/state employee plan rates

DSS will use Medicaid utilization and payment rates.

5. What systems are you using for medical and social risk adjustment?
DSS will apply risk-adjustment based on clinical risk and intends to incorporate social risk factors into the methodology as well. As the Department is still in the design phase, systems for medical and social risk adjustment are still under development and are slated for discussion with stakeholders this Fall.
5a. What risk adjustment system will you use, for clinical risk and for social measures?
DSS plans to risk adjust for the following factors: member demographics, episode subtypes, clinical risk factors, Area Deprivation Index ("ADI" is an area-level measure of socioeconomic factor, which will be used for social risk adjustment), and other supplemental risk adjustors.

6. Are any other states using bundles for Medicaid labor/delivery that include inpatient costs? What is their experience?
Nearly all states include care related to labor and delivery within the maternity bundle. Many programs report decreases in medically unnecessary C-section rates among other benefits of this methodology.

7. What are the cost assumptions/goals? Increased spending on doulas, etc.? Are you expecting cost neutrality or savings? What are the assumptions underlying your goals and where did they come from – other programs, literature?
Cost assumptions remain under development as DSS completes the design phase. Program goals include:
    - Address racial disparities in maternal health and birth outcomes
    - Reduce incidence of unnecessary Cesarean procedures and early elective births
    - Support parity between OB/GYNs and certified nurse midwives
    - Create access to doula services and enhanced lactation supports
    - Align payment models across Medicaid and the State Employee Health Plan

- Create savings for DSS attributable to improved maternal and newborn outcomes

7a. What are the cost assumptions? How will you measure the goals? Are there specific measures/expectations to evaluate the project? How much will the program cost to implement, in total, including outside consultants, CHNCT, and other expenses?

DSS will utilize six key programmatic outcome measures to evaluate progress toward the program's goals and to inform potential program changes needed to promote the highest quality of care for members. Each of the maternal and child health outcome measures was selected based on the recommendations and input of the Maternity Bundle Advisory Council. Given DSS' focus on health equity, DSS aims to reduce racial disparities in each of the outcome measures. The key programmatic outcome measures include:

- NICU Utilization
- Neonatal Opioid Withdrawal Syndrome (NOWS)
- Overall Neonatal Abstinence Syndrome (NAS)
- Adverse Maternal Outcome
- NTSV (Low-Risk) C-Section
- Overall C-Section

8. What proportion of total payments will be based on quality? How are the payments weighted by quality metric and performance level – between total performance and improvement? We need to balance payments to consistent top performers with incentives for lower performers to improve. Medicaid covers a lot of CT births – we can't afford to lose providers.

   Quality metrics and how quality ties to payment are features that remain under development as DSS completes the design phase.

   8a. What are your plans now for ensuring quality improvement and performance, and how much funding is tied to quality? Will the metrics be "easy A's" and process measures that almost all providers already achieve, or will there be meaningful "stretch" metrics that can improve quality and equity for pregnant people and babies? Note: CT Health Policy Project's opinion -- Improving quality, access, and equity is the main benefit of this program to members, and there are multiple competing options to achieve those goals that do not involve the risk to patients of new payment models.

   The table below lists the quality measures with their respective weights for Year 1. Pay for performance measures are subject to financial reimbursement based performance outcomes, and providers will not hold limited risk for penalties at program launch. The five other measures are eligible for pay for reporting, in which financial reimbursement is tied to the submission and reporting of the measure data. Over time, following a continual review of data from program implementation as well as stakeholder discussion for input, DSS may update the quality metrics and status of pay for performance vs. pay for reporting as quality best practices evolve.

The distribution of shared savings is adjusted based on either the overall performance in relation to peer performance (derived from the Performance Tier Score) or the percent improvement over baseline from historical performance (derived from the Improvement Tier Score). DSS will calculate the Performance Tier Score and Improvement Tier Score, and each Score is 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.

Year 1 Quality Measures

Pay for Performance Measures	Pay for Reporting Measures
Cesarean Birth (24%)	Contraception (6%)
Postpartum Care (18%)	Preterm Birth/Labor (6%)
Prenatal Care (12%)	Doula Utilization (6%)
Low Birth Weight (12%)	Breastfeeding (6%)
Maternal Adverse Events (6%)	Behavioral Health Risk Assessment (6%)

9. What feedback/evaluation will you give providers during the year about their performance on costs and quality while they can still do something about it? This is especially important if inpatient and specialty care is included.
   Providers will receive performance reports no less than quarterly that include actionable cost and quality data.
   9a. Please be more specific about the feedback to providers, timing, and potential actions based on the data. Please also describe the process to drive improvement for low-performing providers. Will this information be available publicly for members choosing a provider?
   Provider reporting templates remain in development. DSS plans to share more information with providers and stakeholder once program testing is complete. In Q1 2024, DSS plans to publish historic provider performance reports with insights on quality and cost performance based on 2022 Medicaid claims data. Prior to publishing the historic report, DSS will solicit provider feedback on the reporting templates to ensure providers are receiving meaningful and timely data. After the historic provider performance reports are published, DSS and CHNCT will host a provider forum to help providers understand how to use the data reports to improve their quality of care. As part of the underutilization strategy (which remains under development), DSS is exploring a requirement for low-performing providers to submit a quality improvement plan.

10. What are the included and excluded services referred to in the Appendix slides? I'm assuming the bundle only includes pregnancy-related services. Is that true?
    The maternity bundle will be inclusive of the services required throughout the maternity care experience (i.e., prenatal, labor and delivery, postpartum). DSS aims to tie quality metrics to screenings, care coordination activities, and use of high-value support services to align clinical incentives.

Based on a set of guiding principles, the following table explains the current approach to determining what services are included or excluded.

	Principles
Services included for *Prospective* Payment	• Services provided in-house/directly by the accountable OB/licensed midwife that predictably happen during the course of pregnancy OR that should happen during the course of pregnancy • High-value services, including doulas and breastfeeding support
Services included for *Retrospective* Reconciliation	• Services provided outside of the accountable OB/licensed midwife practice that predictably happen during the course of pregnancy
Fee for Service for Excluded Services	• Services provided by either the accountable OB/licensed midwife or another provider that are uncommon during the course of pregnancy

Note: Under the maternity bundle program, HUSKY Health members will retain full coverage to all Medicaid-covered services and benefits and gain new benefits, including doula care and breastfeeding support. Services "excluded from the bundle" will not have its associated costs of care factored into bundle payment pricing or reconciliation.

10a. Please explain the mechanism for retrospective reconciliation, as there is likely variety in which services are provided in-house vs. outside the practice. Will this vary by which services each practice provides in-house? Does in-house include services provided within providers' affiliated health systems?

To determine shared savings earnings, the data used for reconciliation will include all eligible FFS and Case Rate payments. It will, therefore, capture all relevant maternity services whether they are provided in-house vs. outside the practice. Services provided within providers' affiliated health systems will not be designated as in-house services.

11. Who exactly is at financial risk? The health system, that includes the hospital, or only the practice? Do you expect only practices affiliated with large health systems to be able to absorb this risk? How will the financial risk, and the quality incentives, be apportioned between the system and the practice?
    a. You should monitor that balance to ensure that practices can do the right thing for patients, regardless of cost and to avoid cherry-picking

Maternal health providers practices will be held accountable for financial risk. In at least year one of the program, providers will be eligible for upside/shared savings only (no downside risk), enabling DSS to phase in financial risk over time as providers gain more experience with this program.

11a. How will you monitor the financial pressures place on practices by large health systems? As maternity services in Connecticut have been severely cut by health systems, citing financial losses, this is a critical concern.

DSS has been developing an underutilization strategy to protect and ensure high quality care for members.

12. Are you ensuring that private equity and other outside funders are not funding/directing the new arrangements?
    DSS has no direct engagement with outside funders or private capital. Maternal health providers must meet CMAP enrollment criteria to participate.
    12a. We respectfully urge DSS to monitor the impact of this new payment model for attracting outside investors, especially those seeking short-term profits. As stated above, maternity and birthing services are already at risk in Connecticut.
    As noted above, DSS has been developing an underutilization strategy which aims to protect members against unintended impacts, such as underservice and adverse member selection.

13. How will patients be attributed to the practice?
    a. Prior care site, how much prenatal care do they have to get from the practice (or at all)
       A bundle is triggered as soon as they have at least one claim for a prenatal care service during the first or second trimester. The goal is to improve access to timely prenatal care, but providers and the birthing person will not be penalized for a patient receiving care later in the pregnancy. Any member who does not seek care until the third trimester will be excluded from the bundle.
    b. Can patients choose a site they haven't seen before (maybe they couldn't get in or want to change from their previous providers)
       Yes, patients retain the choice to select the provider and care site of their choice.

14. Do you intend to share the risk with pediatricians when you begin including newborns in the bundle? Is this where DSS intends to stop? This feels like a slow march back to capitation.
    Newborn care is defined as services for the newborn from birth to 30 days following discharge from the facility. In Year 1, the bundle will include reporting only to participating maternal health providers for newborn care for the first 30 days. Pediatricians will not be responsible for financial accountability. The inclusion of newborn care in reporting will support tying the impact of prenatal care to post-birth outcomes, including NICU utilization.
    14a. Please give more detail on your plans to include newborn care in the bundle. As pediatric practices will not be at financial risk, the hope of using maternity bundles to improve the health of infants is attenuated. Please consider adding accountability only for pediatric birth outcomes that are linked in evidence, either strong evidence in the literature or linked in individual patient cases, to good prenatal care as a quality measure for payment or penalty to the maternity provider.
    DSS plans to develop and share more details about the inclusion of newborn care within the bundle after an evaluation of the overall Program Year 1, including newborn care data, and after further discussion with stakeholders once the program is live.

15. I would move patient experience of care up to the quality list from "Consider adding"? It is critical both for the data, and for providers to understand that part of their compensation is dependent on their patients' experience. This should be through a gold-standard survey such as CAHPS, not a doctor-centered survey. This is especially true when adding non-doctor providers to the team.
    DSS agrees that patient experience is a critical quality measure to collect and is currently evaluating the Pregnancy Risk Assessment Monitoring System (PRAMS) Survey as a potential tool. DSS has been working with Yale CORE to evaluate the best approach to build a quality measure for patient experience throughout the perinatal episode.
    15a. What is the status of including a patient-centered experience measure and how much accountability/funding will be attached to this measure?
    The addition of a validated patient-centered experience measure remains under development.

16. What time are the advisory meetings listed in the appendix? Who is on the Advisory Committee?
    The Maternity Bundle Advisory Council meetings typically take place on the 3rd Tuesday of every month at 11am. Committee attendees include HUSKY Health members with birthing experience, legislators, community-based advocates and organizations, providers (OB providers, certified midwives), and doulas. Stakeholder engagement efforts also include ad hoc subgroup meetings with doulas and providers to allow for additional time for design discussions. These meetings are streamed via the CT DSS YouTube Channel and recorded there.

17. What is the attachment point for the bundle over which providers are no longer at risk?
    The specific point at which highest cost bundles would be excluded remains under development as DSS completes the design phase.
    17a. What is the attachment point, or is provider risk unlimited?
    DSS is currently engaged in program testing to determine the specific point at which the highest cost bundles would be excluded, so this work remains in development. Please note that providers will be eligible for upside/shared savings only (no downside risk) in Year 1.

18. How will you monitor for underservice and cherrypicking? What data sources will you use – do you have enough information/data to identify underservice or cherry-picking
    a. This is critically important and probably needs a separate document/presentation

    DSS will use at least Medicaid/CHIP data and additional details will be laid out as part of the ongoing design process.
    18a. This is extremely important. What are your plans to ensure patients get all the care they need, and everyone has access? Please describe your plans for robust monitoring. Your plans for this should be publicly developed, in detail, with lots of input from stakeholders. It should also be developed early in the process, long before implementation. The risks are very high in this population – it is critical to get this right.

Underservice and cherry-picking protection was extremely weak in SIM, the benchmarking plan, and PCMH Plus plan development. Despite lots of input, sometimes invited, from consumers and advocates, the eventual plans were driven by the providers who profit from the new models, resulting in no protection for members.

DSS has been developing an underutilization strategy to monitor and protect against underservice and adverse member selection. More details will be provided to providers and stakeholders to solicit input after program testing is complete.