Questions for DSS on HUSKY maternity bundles
CT Health Policy Project
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[DSS responses to questions are included in blue text]

It's troubling that DSS is prioritizing this program that carries serious risks of reducing quality and access to care for a population already facing serious challenges and disparities. While the goal may be to reduce those challenges and disparities, most of the focus so far has been on financing and provider concerns. Quality, access, and health equity have not been priorities in development of the program. The main goals cannot be left as "to-be-determined".

DSS respectfully disagrees - quality, access, and health equity are core goals of the program and have been at the forefront throughout the program design process. DSS consciously developed goals at the outset of the program and refined those goals in partnership with stakeholders, including engagement with Maternity Bundle Advisory Council and the MAPOC Women & Children's Subcommittee. The following program goals were established and have been the driving force behind program decisions that have been made throughout the multi-year, stakeholder-informed design and implementation process:

- **Strengthen maternal health in Connecticut Medicaid through improved quality of care**
- **Promote health equity through program design and health disparity reduction targets**
- **Improve health outcomes with enhanced flexibility to deliver person-centered care**
- **Incentivize high quality care through performance-linked quality measures**
- **Increase patient satisfaction with new coverage of community-based, peer resources**
- **Reduce unnecessary costs through greater efficiency and care coordination**

1. What is the plan to monitor and address underservice and cherry-picking of more lucrative patients? These are are natural consequences of provider risk models, especially if the deterrents are weak. The model's risks directly contradict the stated goals of the program to improve access and quality while reducing disparities.
    a. To ensure we don't erode the progress we've made in improving quality and access to care, it is essential to have a robust, evidence-based, well-vetted and tested monitoring system. It must be in place before implementation and have sufficient resources and public reporting to be meaningful.
    b. The concerns about assumed levels of payment for Maternal Fetal Medicine (MFM) specialists in the case rates invites cherry-picking out at-risk pregnant HUSKY members. If practices have no way to pay for specialty care that their patients need, those services are unlikely to be provided. While risk adjusting

the rates could help, it is unlikely to eliminate the incentive to enroll healthier pregnant members.

The program has been designed to incorporate guardrails and protections against underservice and adverse patient selection, while supporting continuous improvement in service delivery and equitable access to care:

- **Performance Year (PY) 1 case rates are built using historical costs and utilization patterns. DSS has a case rate rebasing process to review service utilization and adjust case rates to account for changes in utilization and cost patterns over time.**
- **Reconciliation calculations are risk adjusted for clinical and social risk to ensure that providers are rewarded and not penalized for caring for higher risk Medicaid members with greater social and health needs.**
- **Incentive payments are quality-gated, in which shared savings are contingent upon providers meeting quality performance criteria. If a provider fails to meet Medicaid quality standards, they will be required to submit a quality improvement plan. If there is insufficient improvement in the following year, the provider will be disqualified from receiving incentive payments for that performance year.**

In addition, DSS has identified key access, quality of care, and utilization measures to monitor for underservice and adverse patient selection after the program launches. As part of the underservice monitoring plan, the department will evaluate the measures by provider to identify adverse patterns of change overall. This plan will capture a comprehensive view of maternity care access, quality, and outcomes.

2. How much of payments will be based on quality improvement vs. savings? Will providers who improve quality and access, but do not achieve savings, receive payments? Providers who make long-term investments in quality and access must be rewarded. As I understand the appendix to your October 2024 MAPOC presentation, the answer the first question is No – providers who improve quality will receive no incentives unless they also save money. This doesn't comply with the stated goal of the program that the main goal is to improve quality and reduce disparities.

At the end of the performance year, providers may earn upside-only incentive payments as a bonus for delivering high-quality, efficient care. Providers who generate savings during the performance period will be eligible to receive the incentive payment, which will be distributed based on their quality performance. The incentive payment is distinct from the case rate payment, which DSS designed, based on historical costs and utilization patterns, to ensure that providers are adequately compensated under the new payment methodology. The structure of the case rate payment incentivizes providers to improve access to care by engaging members earlier in the episode and maintaining engagement with the member throughout the episode.

Overall, DSS has designed this program to incentivize long-term investments in quality of care, access to care, and efficient care management. Examples of such investments include engaging with members earlier and more frequently, expanding access to doula and lactation support services, and promoting greater care coordination. Evidence demonstrates that these investments lead to improved health outcomes and quality of care.

3. Please provide more detail on the quarterly, actionable information sent to providers. This is especially true for care delivered outside the practice. It must be delivered as close as possible to when care is delivered to ensure they can address problems. Answered payment/metrics in appendix to DSS presentation 10/2024 questions below not answered and a new one based on the appendix
    a. Patients should be able to access the quality and access providers' performance information, ideally early in pregnancy when they are choosing where to get care.
    b. Please also provide more detail on Quality Improvement Plans required of lower performing providers. These plans should be provided to patients with opportunities to comment on gaps. Based on the appendix to your October 2024 presentation to MAPOC, a PIP will only be triggered for providers who are in the lowest levels of performance AND improvement. Paperwork, in the form of drafting a PIP, is all that's required to get year 1 savings, which may be substantial given the weak incentive structure. After two years of double failures, a provider may not receive savings payments from that year, but could be eligible again the year after.
    c. Is it true, that providers under the 55th percentile of quality performance will receive half the savings they generate? That's a very poor incentive model – where even the worst performers get half the savings they are able to generate. That worst performer could get up to 90% of the savings they generate if they have only a 10% increase in improvement – which isn't hard to do when you are starting at the bottom.
    d. If I understand it correctly, even though it may not be the intention, this system is built to encourage skimping on quality and access to boost profits.

DSS respectively disagrees that the program is built to encourage skimping on quality and access to boost profits. Every payment model has a upside and downside to it. The traditional fee-for-service payment model both encourages increased access to services with the risk of overservice. Monthly case rates encourage a focus on high value care delivery with a risk of underservice. DSS recognizes the risk and, as noted above, the program has been designed to incorporate guardrails and protections against underservice and adverse patient selection, while supporting continuous improvement in service delivery and equitable access to care.

After the first quarter, DSS will distribute provider-specific, quarterly reports to give practices timely and actionable information on their quality performance throughout

the performance year. The reports will include a mix of claims-based and encounter form data for the program's 5 pay-for-reporting and 5 pay-for-performance measures. DSS recognizes the importance of timely, actionable data and has consciously designed the provider reports to enable providers to receive data as quickly as possible. To ensure the provision of frequent and timely reports, the quality reports will capture a rolling 12-month period, enabling DSS to begin distributing data as early in the program as possible, as opposed to waiting for a full year of data to be collected.

Quality improvement plans will be required of Accountable Providers who fall into the lowest tier for both the Performance Earnings Tier and the Improvement Earnings Tier. The quality improvement plan gives practices the opportunity to identify and reflect on areas for improvement and to propose strategies to positively address areas for improvement. Once the plans have been submitted, they will be reviewed; plans that do not adequately address opportunities for improvement will not be approved. If the Accountable Provider consecutively maintains low quality performance in the following year, the provider will be ineligible for the incentive payment of that performance period. This policy was designed in acknowledgement that providers who make long-term investments in quality and access should be rewarded. However, as the program progresses, the department will monitor this policy and make necessary program refinements as needed.

In addition, providers who fall into the lowest tier for both the Performance Earnings Tier and the Improvement Earnings Tier will only be eligible to receive 25% of their shared savings. During reconciliation, all savings generated will be shared between the provider (50%) and the state (50%). Of the provider's portion of shared savings, the distribution of incentive payments will subsequently be adjusted based their quality performance.

4. Will you monitor the impact of bundled payments on health systems to prevent more birthing center closures?

Yes, DSS plans to monitor and review the impact of the Maternity Bundle Program to ensure that the program is effectively supporting access to care and sustainability, including the continued operation of birthing centers. Overall, the department is committed to monitoring outcomes and making adjustments as needed to support Medicaid's maternal health care system.

5. Please provide more information on patient satisfaction surveys and how they will be used in achieving the goals of improved quality and access to care. Given that patient satisfaction surveys often lag behind claims, it is especially important to consider how to link them to quality-based payments.

DSS is still working on efforts to integrate patient satisfaction surveys into the program's quality monitoring and improvement strategy for Year 2 or later. One of the

main challenges is identifying validated surveys that effectively capture the patient's full perinatal care experience from prenatal through postpartum care. Many existing surveys tend to focus only on specific points during the perinatal period, rather than offering a comprehensive view of the entire care journey. As we recognize the importance of linking patient satisfaction to quality-based payments, the department will continue to explore what surveys can be used to collect HUSKY member feedback that is actionable and aligns with program goals to improve patient satisfaction, quality of care, and access to services.

6. Regarding doula services –
    a. Given the scarcity of doulas, will DSS require clear policies from practices regarding which patients get access to these services? It is very important to ensure that the policies are adhered to and that there are no biases that could increase disparities.
    b. How will DSS adjust for the savings from doula services provided outside practices? This is a serious problem in PCMH Plus as providers can, and routinely do, refer patients with significant care management needs to the Intensive Care Program (ICP). As ICP is funded by the state, practices reap the resulting considerable savings of keeping people with chronic conditions well. They also did not need to build internal care coordination capacity that they were paid to create. The state paid twice for these services and the savings went to providers.

In preparation for the doula integration through the maternity bundle, DSS worked with Primary Maternity Care and Health Equity Solutions to create several doula integration policies, resources, and templates. Based on feedback from doulas and maternity practices, DSS is enabling broad flexibility to give doulas and providers time to adapt to the new model, manage service availability, and explore ways to integrate these services into their care delivery models. DSS encourages providers to use this initial year to establish appropriate guidelines and processes that align with the goal of providing high-quality, accessible care for all patients. DSS will monitor doula utilization and will consider program refinements if disparities in access occur.

DSS has established a reconciliation process for doula care services to ensure that there is no double payment for doula services. Accountable Providers who receive doula care add-on funding must document and report on doula services provided. DSS will supply each practice with a list of fee-for-service (FFS) doula claims and require each practice receiving add-on payments to verify and attest that no FFS doula claims were made for beneficiaries tied to the add-on payment. In turn, DSS will reconcile the doula service add-on payment against actual doula services provided in the specified period. If actual doula services provided exceed prospective doula payments, DSS will provide additional payment to yield balance; conversely, if prospective doula payments exceed actual doula services provided, DSS will recoup the commensurate amount of extra payment to yield balance.

Comments

- It's good to hear that FQHCs will not be covered by the program in the foreseeable future. Their very complex payment model makes balancing incentives to improve access and quality while protecting patients and taxpayers very difficult.
  DSS form

- It's disappointing that all eligible providers will be forced into the program and at the same time.
  - Not all providers are currently performing at a level sufficient to safely manage in a provider risk model. Provider risk should be earned.
  - While a non-voluntary model reduces opportunities for gaming the system, it doesn't allow for patients to choose providers who are not at financial risk, even upside-only, for their care.
  - Piloting the program over time would allow for learning as it progresses and halting the experiment if it is causing harm.

DSS is committed to monitoring and evaluating the program over time and will make iterative updates to the structure of the program to be responsive to program performance and learnings.

- Using each provider group's historic spending level as the basis for case rate payments locks in and perpetuates inefficiency and provision of low value care. DSS should have a plan to move to a case rate based on a fair assessment of what it costs to provide high quality maternity care.

DSS will rebase the case rates to account for changes in service delivery and cost patterns over time. In addition, after the conclusion of each Performance Year, DSS will determine each Accountable Provider's target price and perform a reconciliation for all eligible episodes to calculate incentive payments. The target price is a blend of the Accountable Provider's risk adjusted historic price and the statewide historical price, which is the average historical price across all Accountable Providers, weighted by all deliveries attributed to an Accountable Provider. The target price serves as a lever to incentivize efficiency and a reduction in the provision of low value care amongst historically less efficient providers.

Thank you for your work to improve HUSKY maternity care and this opportunity to ask questions. If there are any questions or feedback, please send to andrews@cthealthpolicy.org

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