Connecticut Medical Assistance Program Provider Bulletin 2024-44
Policy Transmittal 2024-17 November 2024

Andrea Barton Reeves, J.D., Commissioner

Effective Date: January 1, 2025
Contact: See below

TO: Physicians, Advanced Practice Registered Nurses (APRNs), Physician Assistants (PAs) and Certified Nurse Midwives (CNMs)
RE: Maternity Bundle Payment Program

The Department of Social Services (DSS) is implementing the HUSKY Health Maternity Bundle Payment Program on January 1, 2025, pending federal approval from the Centers for Medicare & Medicaid Services (CMS). Through this program, DSS will transition to an episode-based payment model for maternity care reimbursement. This payment model aims to create and align incentives for maternity providers to manage high quality care and costs during the perinatal period, with an emphasis on reducing health disparities and improving the HUSKY Health member's care experience.

The maternity episode includes services across the full perinatal period, spanning 280 days before the anticipated date of delivery to 90 days after the date of delivery. For providers who are eligible to participate, each episode will be assigned to an "Accountable Provider", which will be an obstetrics or licensed midwife provider, or provider practice enrolled in the Connecticut Medical Assistance Program (CMAP) from whom the HUSKY Health member seeks maternity care. The Accountable Provider will be responsible for both the quality and cost of care delivered to a HUSKY Health member in a maternity episode.

All services in the first trimester of the pregnancy will be paid fee-for-service (FFS). Starting in the second trimester, Accountable Providers will receive monthly Case Rate payments for a subset of services provided during the prenatal and postpartum periods. In addition, Accountable Providers may also receive a Case Rate add-on payment for doula care and/or lactation supports, two new high-value services associated with positive maternal and infant health outcomes. Practices may opt out of receiving the doula care add-on payment prior to the beginning of the performance year.

At the end of the performance year, DSS will conduct a retrospective reconciliation for all attributed episodes to calculate upside-only incentive payments. Accountable Providers can earn incentive payments when the actual total cost of care for attributed maternity episodes does not exceed the target price, which is the expected total cost of care based on a blend of the statewide average cost for maternity care and the specific provider's historical cost. For Performance Year 1, the target price blend will comprise 50% of the statewide average cost and 50% of the provider's historical cost for deliveries incurred between 1/1/2024 to 12/31/2024. Providers will be eligible to share up to 50% of savings, and the distribution of incentive payments will be adjusted based on quality performance.

Performance Year Time Period

Each Performance Year will be twelve months. The first Performance Year will begin on January 1, 2025, and end on December 31, 2025.

Member Eligibility

Pregnant and birthing HUSKY Health members will be included in the program if they are attributed to a participating provider. See Member Participation section of the FAQ on the DSS website **here** for more information.

Provider Eligibility

Physician/Physician groups specializing in obstetrics, Advance Practice Registered Nurse (APRN)/APRN groups, and Certified Nurse-Midwives/Nurse Midwife groups that meet the minimum episode volume threshold of 30 deliveries in the past 12 months will be automatically enrolled in the program. See the *Accountable Provider* section of the 'Maternity Bundle Program Specifications' document on the DSS website **here** for more information about provider eligibility, including provider types and specialties.

Case Rate Payments:

A subset of services will be reimbursed through monthly Case Rate payments. For more details on services included in the Case Rate, see the *Case Rate Codes* in the "CT Maternity Bundle Code List Master" document and the *Service Inclusion & Exclusion Criteria* section of the "Maternity Bundle Program Specification" document on the DSS website **here**.

Case Rate Trigger Event Criteria

To qualify for Case Rate payment as an Accountable Provider, eligible providers must meet the following trigger event criteria:

- Perform 30 or more deliveries annually.
- Submit a claim with a *trigger diagnosis code* (outlined in the "CT Maternity Bundle Code List Master" document on the DSS website **here**) **and** one of the following Evaluation & Management (E&M) codes 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215.
- Submit a claim with a qualifying place of service location: 11 (office), 19 (off-campus outpatient hospital), or 22 (on-campus – outpatient hospital)
- Bill as a qualifying maternity bundle specialty type: 328 - Obstetrics and Gynecology (including the Maternal Fetal Medicine subspecialty), 095 - Certified Nurse Midwife, 091 - Obstetric Nurse Practitioner, and 122 - Women's Health Nurse Practitioner.

For the first quarter of Performance Year 1, effective 1/1/2025 - 3/31/2025, trigger events in the 2nd trimester only will initiate Case Rate payments (i.e., providers will not receive Case Rate payments for patients who are in the 3rd trimester or postpartum period for the first three months of the program). Subsequently, effective 4/1/2025, trigger events in the 2nd trimester, 3rd trimester, and postpartum period will initiate Case Rate payments.

Please note that, for practices who do not currently bill using these criteria, this will represent a billing practice change. For example, practices that typically use global code should be aware that the use of global code will not qualify as a trigger event. Although the trigger event criteria do not need to be met for each claims submission (i.e., it is only required to initiate or reclaim the Case Rate payment), practices should bill to meet the trigger event criteria, when possible, to maintain episode attribution.

To avoid unintentional changes in episode attribution, providers who perform consultative services or obstetrical emergent care should avoid billing claims with trigger event diagnosis codes and E&M codes listed above when possible.

Case Rate Payment Details

Once initiated through the submission of a claim with a trigger event, Case Rate payments will be identified and generated in the first claim cycle of the month for the previous month. Case Rate payments are made to the Accountable Provider at the Taxpayer Identification Number (TIN) level. All payments for the TIN entity will be made to the Medicaid (AVRS) ID that received the most revenue in the prior year. Practices have the option to specify a different Medicaid ID to direct payment to, by request to the practice's Community Health Network of Connecticut, (CHNCT) Incorporated's Provider Engagement Services representative.

The Case Rate payments will be included on the existing semi-monthly Remittance Advice (RA) and 835 in the first payment cycle of the month. The RA will display the Case Rate payment, Client ID, Client Name, and From DOS (which will always be the first day of the month). The 835 will report the Case Rate in the PLB segment. The PLB03-1 field (Adjustment Identifier) will indicate LS – Lump Sum. The PLB03-2 field (Reference Identification) will be populated with an internal tracking number. It will be prefaced with a value of MB (maternity bundle).

In addition, services included in the Case Rate that are zero paid will be identified on the RA with EOB code 9950 'Service Is Covered By Monthly Maternity Bundle Case Rate Payment', and the 835 will contain CARC code CO245 and RARC M15. For the full list of services included in the Case Rate, please see the *Case Rate Codes* in the "CT Maternity Bundle Code List Master" document on the DSS website **here**.

Incentive Payments:

The maternity episode includes services provided between 280 days prior to anticipated delivery to 90 days postpartum. Services included in the episode, regardless of the provider who performed the service, will be included in the incentive payment calculations during reconciliation. For more details on services included in the episode, see the *Reconciliation Codes* in the "CT Maternity Bundle Code List Master" document and the *Service Inclusion & Exclusion Criteria* section of the "Maternity Bundle Program Specification" document on the DSS website **here**.

Quality Methodology

The distribution of incentive payments will be adjusted based on the Accountable Provider's quality performance to incentivize and maintain accountability for high-quality care and maternal and infant health outcomes within the program. Comprehensive details about the payment model's quality component, including the list of quality measures, can be found in the *Quality Methodology* section of the " Maternity Bundle Program Specification" document on the DSS website **here**.

Incentive Payment Details

Once the claims run-out period and reconciliation process are complete, Accountable Providers will receive the incentive payment no more than 365 days after the end of each Performance Year. Similar to the Case Rate payment, the incentive payment for the Accountable Provider TIN will be made to the Medicaid (AVRS) ID that received the most revenue in the prior year, and practices may specify a different Medicaid ID to direct payment to, by request to the practice's CHNCT, Inc.'s Provider Engagement Services representative.

Incentive payments will be included in the 'Non-Claim Specific Payouts' section of the existing semi-monthly Remittance Advice (RA) and 835. The 835 will report the Incentive Payment in the PLB segment. The PLB03-1 field (Adjustment Identifier) will indicate LS – Lump Sum. The PLB03-2 field (Reference Identification) will be populated with an internal tracking number. It will be prefaced with a value to be determined and communicated at a later date.

DSS will also provide a supplemental payment report, which the Accountable Provider may access through their secure provider portal. This report will contain the following information to support the Accountable Provider's ability to attribute TIN level payments among its providers/practices: the Client ID, Last Name, First Name, Middle Initial, Practice ID (TIN), Payment Provider AVRS ID, Accountable Provider AVRS ID, Case Rate Month/Year, Case Rate Amount, Expenditure/Recoupment indicator (E, R) and Transaction #.

Billing and Claims Submissions

Accountable Providers should bill and submit all claims to document services provided to the HUSKY Health member during the episode.

All claims in the first trimester of the pregnancy will be paid FFS. For these claims, while they will not be reimbursed by the Case Rate, the cost of the services provided to the HUSKY Health member during the episode will be included in the incentive payment calculation.

In the second or third trimester, the Case Rate payment may begin by billing a claim that meets the trigger event criteria. After the trigger event(s), Case Rate payments will be made in the first claim cycle of the month for the previous month, and the trigger event claim and all subsequent claims that bill services included in the Case Rate will be zero-paid. Services that are excluded from the Case Rate will continue to be reimbursed FFS.

For example, if an Accountable Provider initiates the Case Rate payment and bills non-Case Rate services, DSS will both (1) provide the Case Rate payment and $0 pay all Case Rate codes and (2) reimburse the non-Case Rate codes through FFS payment.

Posting Instructions: Policy transmittals can be downloaded from the Web site at www.ctdssmap.com.

Distribution: This policy transmittal is being distributed to providers of the Connecticut Medical Assistance Program by Gainwell Technologies.

Responsible Unit: For questions related to the HUSKY Maternity Bundle Payment Program, please contact:

Fatmata Williams RN, BSN, MPH, C.H.E.S
Director of Integrated Care Unit
Division of Health Services -DSS
Email: fatmata.williams@ct.gov
Phone: 860-242-5181

For questions regarding claims and billing should be directed to the Provider Assistance Center - Monday through Friday from 8:00 a.m. to 5:00 p.m. at: 1-800-842-8440.

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