Table of Contents

State/Territory Name: CT

State Plan Amendment (SPA): CT-24-0007

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

Financial Management Group

November 19, 2024

Andrea Barton Reeves, J.D., Commissioner
Department of Social Services
55 Farmington Avenue, 5th Floor
Hartford, CT 06105-3730

RE: TN 24-0007

Dear Commissioner Reeves:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Connecticut's state plan amendment (SPA) to Attachment 4.19-B of 24-0007, which was submitted to CMS on October 31, 2024. This plan amendment establishes a bundled payment methodology for maternity services.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of January 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Jerica Bennett at 410-786-1167 or via email at jerica.bennett@cms.hhs.gov.

Sincerely,

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 2 4 — 0 0 0 7

2. STATE: CT

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT
(●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
Social Security Act Sections 1905(a)(5), (6), (17), and (21) of the Social Security Act and 42 CFR 440.50, 440.60, 440.165 and 440.166

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 2,015,618
b. FFY 2026 $ 3,102,582

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B, Page 1(a)i(S) through 1(a)i(Y) (NEW)
Attachment 4.19-B, Page 1(a)iii through 1(a)iv
Attachment 4.19-B, Page 2b

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B, Page 1(a)iii through 1(a)iv
Attachment 4.19-B, Page 2b

9. SUBJECT OF AMENDMENT
Implements the Maternity Bundle Program which: 1. Creates episode-based Case Rate payments for a subset of services; 2. Adds doula and lactation support coverage via add-on payments; 3. Rewards efficient, high-quality care with incentive payments if actual total costs are below the target price (expected total costs) and quality performance criteria are met.

10. GOVERNOR'S REVIEW *(Check One)*
(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

12. TYPED NAME
Andrea Barton Reeves, J.D.

13. TITLE
Commissioner

14. DATE SUBMITTED
October 31, 2024

15. RETURN TO
State of Connecticut
Department of Social Services
55 Farmington Avenue – 9th floor
Hartford, CT 06105
Attention: Ginny Mahoney

FOR CMS USE ONLY

16. DATE RECEIVED
10/31/2024

17. DATE APPROVED
November 19, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
01/01/2025

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut

Maternity Bundled Services Payment

I. Overview

Effective January 1, 2025, episode-based payments for maternity care will be established to improve maternal health and birth outcomes. An "episode" is a defined group of related Medicaid-covered services provided to a specific patient over a specific period of time. Additional information regarding episode definitions, quality measurement, service inclusion and exclusion criteria, and risk adjustment are available at the HUSKY Maternity Bundle website at this link: https://portal.ct.gov/dss/health-and-home-care/husky-maternity-bundle/details-of-connecticut-maternity-bundle.

As determined by the bundle accountability methodology set forth below, the "Accountable Provider" will be responsible for both the quality and cost of care delivered to a beneficiary for the maternity episode. The Accountable Provider is the maternity billing provider entity delivering services under the physicians' services benefit category (i.e., services provided by a qualified licensed physician and qualified allied health professionals working under the physician's supervision). Note that services not provided under the supervision of a physician that are provided by or under the supervision of a nurse practitioner, physician assistant, or nurse-midwife are provided under the applicable benefit category for such practitioner.

Episode-based payments, using the Case Rate methodology below, will be made to the Accountable Provider. The Accountable Provider will receive provider-specific, monthly Case Rate payments for a subset of services included in the maternity episode and provided during the prenatal, delivery, and postpartum periods. The Case Rate payment does not change any other reimbursement methodology that is available to nonparticipating providers. Also, applicable fee-for-service (FFS) payments will continue to be made to all participating providers for any Medicaid-covered service outside the scope of the maternity Case Rate.

In addition, Accountable Providers can earn upside only incentive payments when delivering high-quality, cost-effective services throughout the maternity episode. The Department of Social Services (DSS), Connecticut's single state Medicaid agency, will collect and analyze data at the end of the episode of care and conduct a retrospective reconciliation to calculate the incentive payment amount. Accountable Providers can earn incentive payments when the actual total cost of care for the maternity episode does not exceed the target price if they also meet quality performance criteria and comply with under-service prevention requirements. 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 specific Accountable Provider's historical cost.

II. Populations Included in the Episode

All pregnant and birthing Connecticut Medicaid beneficiaries attributed to qualified Accountable Providers, in accordance with the attribution methodology described below, are eligible for the maternity Case Rate, except if the beneficiary meets one or more of the program's exclusion criteria.

If the beneficiary meets one or more exclusion criteria, their episode will be excluded from the retrospective reconciliation (i.e., the incentive payment calculation). In addition, beneficiaries who initially qualify for the Case Rate payment but later meet exclusion criteria will be excluded from the retrospective

reconciliation. The exclusion criteria can be found at the HUSKY Maternity Bundle website referenced above.

III. Episode Accountability Methodology

Each episode will be assigned to an "Accountable Provider", which may be a qualified obstetrics or licensed midwife provider or provider practice enrolled in Connecticut Medicaid from whom the beneficiary seeks maternity care. Payment will be directed to the provider group based on the billing Tax ID. More information about the Accountable Provider can be found at the HUSKY Maternity Bundle website referenced above.

Each episode is initially assigned to the Accountable Provider reporting trigger codes from the earliest encounter claim in the second trimester (14-27 weeks of pregnancy) for purposes of Case Rate payment. Trigger codes are a set of codes, ICD-10-CM, HCPCS or service codes, which formally recognize a beneficiary's eligibility for a Case Rate payment and assigns the beneficiary's episode to an Accountable Provider. A comprehensive list of trigger codes can be found at the HUSKY Maternity Bundle website referenced above.

All pregnant and birthing beneficiaries retain the choice to select and change their provider and care site. Therefore, the Accountable Provider may change if another practice group takes over care for the beneficiary. When a change of care occurs, as determined through the submission of another claim with a trigger code by the practice that takes over care, the episode and Case Rate payment will either be reassigned to the new Accountable Provider or transitioned to FFS payment. Given that the Case Rate is developed based on historical cost and service utilization, the historical pattern of transitions of patient care has been built into the provider-specific Case Rate. Episodes with a change of care will also be subject to a continuous lookback process. The continuous lookback process will identify and recover duplicative payment for non-Accountable Providers in months where multiple Case Rate payments are made. For the retrospective reconciliation, episodes will be assigned to the practice group that reported the most recent trigger code.

All qualified Medicaid providers will participate in the program so long as they meet the expected minimum episode volume threshold, which is calculated on an annual basis. Non-participating providers and practices, such as those who do not meet the minimum episode volume requirement, will be reimbursed FFS with no opportunity to earn incentive payments. More information on the minimum episode volume threshold can be found at the HUSKY Maternity Bundle website referenced above.

IV. Benefits Included in the Incentive Payment Calculation

All Medicaid claim costs for covered services (regardless of the provider who 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. Details about benefits included and excluded from the incentive payment calculation can be found at the HUSKY Maternity Bundle website referenced above.

V. Case Rate Payment Overview

Accountable Providers will receive a provider-specific Case Rate payment, based on historical utilization, for a defined set of services that they provide within the timeframe of an episode. The clinical definition of the episode of care and the defined set of service codes included in the Case Rate payment can be found at the HUSKY Maternity Bundle website referenced above.

All maternity-related services outside the defined set of Case Rate services but provided within the timeframe of an episode will be included within the episode but excluded from the Case Rate and reimbursed through FFS payments. Furthermore, the cost of all maternity-related services provided to the birthing member during the episode, regardless of the specific provider who performed each service, will be included in the incentive payment calculation, even if not provided by the specific Accountable Provider.

Case Rate payments are paid when the individual has an encounter in the second or third trimester with specific trigger codes (see the HUSKY Maternity Bundle website referenced above) to indicate pregnancy (i.e., the minimum service required for the Case Rate). All claims in the first trimester of the pregnancy will be paid FFS and are excluded from the Case Rate. After the minimum service required to pay the Case Rate occurs, all the subsequent claims for services included in the Case Rate will be paid through the Case Rate with no separate payments made. Accountable Providers will continue to submit all encounters as $0-pay claims to document services provided to the beneficiary. Case Rate payments will be part of the retrospective reconciliation process to determine incentive payments. Case Rates will not be rebased more frequently than once every 12 months, based on risk adjustment and trend factors.

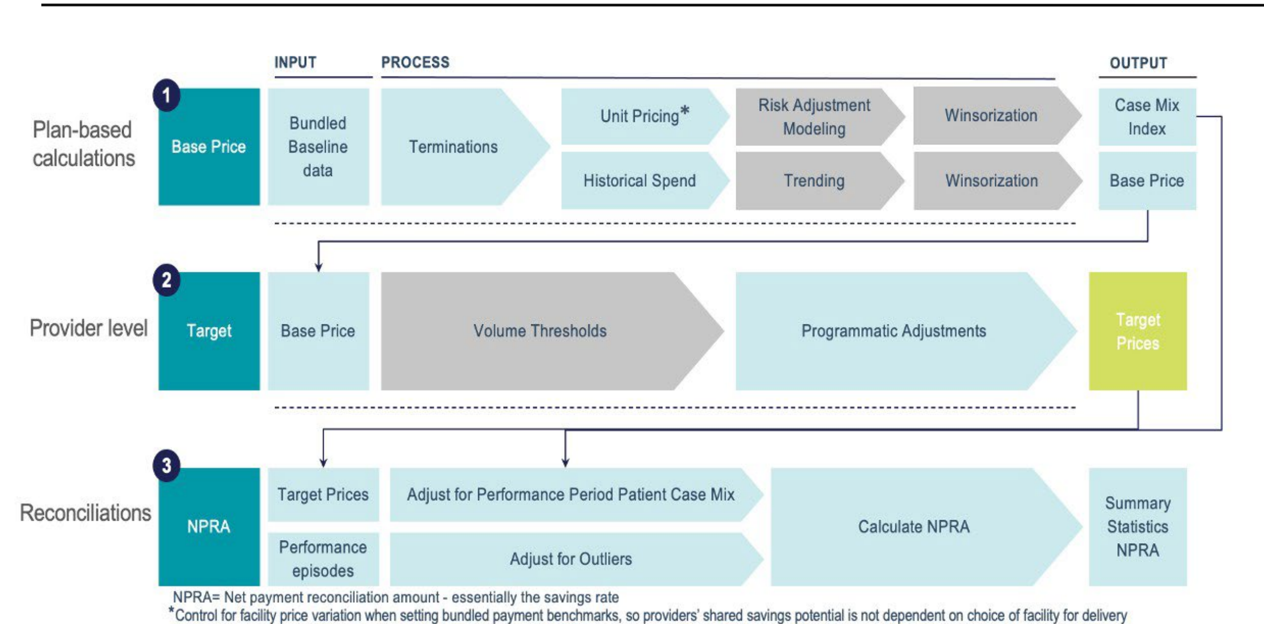
Additionally, doula and lactation support services provided by or under the supervision of the Accountable Provider entity will be made as an add-on payment to the Case Rate. Descriptions of doula services and lactation supports can be found at the HUSKY Maternity Bundle website referenced above, and the add-on rates for doula and lactation support services are posted to the same DSS website. The add-on payment will be calculated by taking the total available add-on funding budget divided by the estimated number of Case Rate payments. Historical data will be used in future years to determine payments for these services. The add-on payment for doula and lactation support services will be provided prospectively and excluded from incentive payment calculations. In addition, the doula services will be subject to a retrospective true-up process.

VI. General Pricing and Reconciliation Methodology

Risk-adjusted episode base prices for the maternity bundle payment program will be developed using historical claims from the year prior to each Performance Year as defined below. The base price encompasses the costs of maternity services provided during and included in the maternity episode (i.e., services reimbursed by the Case Rate and maternity services paid in accordance with the reimbursement methodology applicable to the non-Accountable Providers). These data are then utilized to create episodes and then applied in the following process (Figure 6.1) to develop the base price for each individual episode type.

Figure 6.1 Pricing Process

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut



1. **Apply member inclusions and exclusions**

   To ensure complete and accurate episodes are used for pricing, a set of exclusion criteria was applied to remove episodes and members from the pricing process as specified above (See Section II. Populations Included in the Episode).

2. **Standardized episode cost**

   The financial amount used in pricing is the Medicaid allowed amount under the methodology approved in accordance with the applicable section of the Medicaid State Plan for each service. For inpatient hospital services, where price variation between providers is defined by factors, such as DRG base rates, price-standardized allowed amounts were applied to remove differences in prices or rates among providers. These were then summed up for each individual episode to get the total standardized episode cost, which is used as the predicted outcome in the risk adjustment model.

3. **Winsorize outliers**

   To ensure that episodes with unusually high costs or incomplete episodes that otherwise meet the inclusion criteria do not influence the final episode price, winsorization was applied to the cost of the outlier episodes. Winsorization is the transformation of statistics by limiting extreme values in the statistical data to reduce the effect of outliers. Total allowed amounts for episodes below and above the 5th and 99th percentiles, respectively, were reset to those thresholds.

4. **Risk adjustment**

   Predictive models were developed to predict the cost for each episode. The model uses the standardized episode cost as the predicted outcome. Risk factors were then tested and clinically validated to capture the clinical risk of the individual patient and the effect on the episode of care cost. Risk factors include member demographics, episode subtypes, clinical risk factors (e.g., comorbidities), social risk factors

(i.e., Area Deprivation Index), and other supplemental risk adjustors. More detail about risk adjustment can be found at the HUSKY Maternity Bundle website referenced above.

A regularized regression model was implemented with cross-validation techniques. The model parameters were tested rigorously and optimized. The model performance was assessed using industry standard statistics, such as R-Square and mean absolute percent error.

5. Base price

There are several elements involved in defining the base price. The following steps are the process for calculating the base price:

a. For each Accountable Provider, the trended, winsorized, and average total episode cost was summed up into the provider historical price. The provider historical price includes costs for delivery, prenatal, and postpartum services from the Accountable Provider and other providers.
b. The provider risk factor was calculated as the average risk factor, including both health and social determinants, for winsorized pregnancies that the Accountable Provider was responsible for.
c. The provider risk adjustment factor was calculated as the Accountable Provider's average risk factor divided by the statewide average risk factor, which includes pregnancies for all Accountable Providers.
d. The risk adjusted provider historical price was the provider historical price divided by the provider risk adjustment factor.
e. The provider base price was calculated as the price that each accountable performance period experience was measured against for calculating incentive payments and costs after risk adjustment. Each Accountable Provider's own risk adjusted historical price makes up a portion of their provider-specific target price, blended with the statewide historical price, which is the average historical price across all Accountable Providers, weighted by all deliveries attributed to an Accountable Provider.
f. Base prices will be updated annually following this process.

6. Target Price and Incentive Payment Reconciliation

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. DSS will allow for a claims run-out period before conducting the reconciliation process. Once the claims run-out period and reconciliation process are complete, Accountable Providers will receive payment no more than 270 days after the end of each Performance Year. The data used for the reconciliation will include all eligible FFS and Case Rate payments, all of which are made via the Department’s MMIS, for each particular Performance Year. These payments are only made on behalf of birthing members. Other payments made to Accountable Providers are not included in this reconciliation. The incentive payment calculation is in addition to the Case Rate rebasing process.

The first Performance Year will be the twelve months beginning on the initial effective date of this section in the Medicaid State Plan (i.e., January 1, 2025). At the incentive payment reconciliation, each Accountable Provider’s target price is calculated by multiplying the base price by their specific performance period risk adjustment factor. The Accountable Providers’ performance period risk adjustment factor is calculated using data from the performance period episodes. Providers with increased patient risk in the performance period will subsequently have their target prices adjusted accordingly.

Finally, the Accountable Provider's gross savings will be calculated as the sum of the target prices for the eligible episodes less the total aggregate performance period FFS payments for the eligible episodes. See Table 6.2 for illustration. Providers will be eligible to share a portion of savings based on quality performance.

Table 6.1 Base Price Example

Provider	Historical Price	Risk Adjustment Factor	Risk Adjusted Historical Price (50%)	Statewide Historical Price (50%)	Base Price
Provider A	$1,200	1.10	$1,091	$1,100	$1,096
Provider B	$1,100	1.00	$1,100	$1,100	$1,100
Provider C	$1,000	0.90	$1,111	$1,100	$1,106

Table 6.2 Risk Adjusted Price and Reconciliation Example

Provider	Base Price	Performance Risk Factor	Target Price	Performance FFS	Net Saving or Loss
Provider A	$1,096	1.05	$1,150	$1,100	$1,150 - $1,100 = $50
Provider B	$1,100	1	$1,100	$980	$1,100 - $980 = $120
Provider C	$1,106	0.98	$1,083	$1,100	$1,083 - $1,100 = -$17

VII. Quality and Incentive Payment Methodology

Specific details pertaining to the quality measures, quality scorecard calculations, and methodologies for distributing incentive payments based on quality performance can be found at the HUSKY Maternity Bundle website referenced above.

1. Quality Measures

Incentive payments are contingent upon Accountable Providers meeting the established quality performance criteria. The quality slate comprises a mix of pay-for-performance measures, in which the Accountable Provider's performance level determines the financial reimbursement or penalty, and pay-for-reporting measures, in which financial reimbursement is tied to the submission and reporting of the measure data. For Performance Year 1, pay-for-performance measures are subject to financial reimbursement only (resulting in a portion of savings based on quality performance).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut

---

2. Quality Scorecard Calculations

Quality scorecards are derived using baseline data to set quality performance targets against which performance during the live program is measured. Scores are derived from the baseline period and the performance period in the same way, and both are normalized to the ranges found in the baseline period.

3. Distribution of Incentive Payment Earnings

The distribution of incentive payments is adjusted based on either the overall performance in relation to peer performance or the percent improvement over baseline from historical performance. Providers will receive payment in accordance with their highest earnings tier between the two methodologies.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut

(ii) Naturopaths – The current fee schedule was set as of January 1, 2012, and is effective for services provided on or after that date. The fee schedule for naturopaths is published at this link: http://www.ctdssmap.com (select "Provider," then "Provider Fee Schedule Download," accept the terms and conditions, and select the applicable fee schedule). Rates are the same for private and governmental providers.

(iii) Nurse practitioners – 90% of physician fees as referenced in (5) above, except for physician-administered drugs and supplies and services rendered by certified registered nurse anesthetists, which are reimbursed at 100% of the physician fees. For qualifying providers and services, maternity services provided by nurse practitioners are paid in accordance with the Bundled Payment for Maternity Services detailed in (5) above.

Nurse practitioner groups and individual nurse practitioners are eligible to participate in the Person-Centered Medical Home (PCMH) initiative detailed in (5) above under Physician's Services. Nurse practitioner services within PCMH practices run by nurse practitioners are authorized by Section 1905(a)(6) (services by other licensed practitioners). Nurse practitioners working in a physician group or a solo physician practice are eligible to participate in the PCMH initiative as part of the physician group or solo physician practice under the Physician's Services section of the State Plan.

(iv) Dental Hygienists - 90% of the department's fees for dentists as referenced in (10) below).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut

(v) Licensed behavioral health practitioners to include licensed clinical social workers, licensed marital and family therapists, licensed professional counselors, and licensed alcohol and drug counselors. The fee schedule for licensed behavioral health practitioners is published at this link: http://www.ctdssmap.com (select "Provider," then "Provider Fee Schedule Download," accept the terms and conditions, and select the applicable fee schedule). The agency's rates were set as of November 17, 2021, and are effective for services on or after that date. Rates are the same for private and governmental providers.

(vi) Physician assistants – 90% of the department's fees for physicians, as referenced in (5) above, except for physician-administered drugs and supplies, which are reimbursed at 100% of the physician fees. For qualifying providers and services, maternity services provided by physician assistants are paid in accordance with the Bundled Payment for Maternity Services detailed in (5) above.

Physician assistants working in a physician group or a solo physician practice are eligible to participate in the Person-Centered Medical Home (PCMH) initiative detailed in (5) above under Physician's Services as part of the physician group or solo physician practice under the Physician's Services section of the State Plan in Section (5) above.

(vii) Acupuncturists - 100% of physician fees as noted in (5) above. The current fee schedule was set as of October 1, 2021, and is effective for services provided on or after that date. The fee schedule for acupuncturists is published at this link: http://www.ctdssmap.com (select "Provider," then "Provider Fee Schedule Download," accept the terms and conditions, and select the applicable fee schedule). All governmental and private providers are reimbursed according to the same fee schedule.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

(17) Nurse-mid wife services - are paid using the physician fee schedule at 100% of physician fees, as referenced in (5) above. For qualifying providers and services, maternity services provided by nurse-midwives are paid in accordance with the Bundled Payment for Maternity Services detailed in (5) above.

(18) The Medicaid Hospice rates are set prospectively by CMS based on the methodology used in setting Medicare Hospice rates, which are adjusted to disregard the cost offsets attributable to Medicare coinsurance amounts. Hospice payment rates are also adjusted for regional differences in wages, using indices published in the Federal Register and daily Medicaid hospice payment rates announced through CMS's memorandum titled "Annual Change in Medicaid Hospice Payment Rates—ACTION". COVID-19 vaccines and their administration are paid off of the physician fee schedule at 100% of physician fees, as referenced in (5) above, regardless of whether the individual is otherwise receiving services from the hospice provider. The hospice fee schedule is published at this link: http://www.ctdssmap.com (select "Provider," then "Provider Fee Schedule Download," accept the terms and conditions, and select the applicable fee schedule). All governmental and private providers are reimbursed according to the same fee schedule. For clients living in a nursing facility, the per diem nursing facility rate will equal 95% of the rate for that nursing home under the Medicaid program.