HUSKY Maternity Bundle Payment Program

February Provider Forum

Welcome to the HUSKY Maternity Bundle Provider Forum

Please see the meeting's ground rules below:

- This forum will be recorded and posted to the DSS Youtube channel. Meeting materials will also be posted on the DSS Maternity Bundle website.
- If you are not speaking, please mute yourself.
- Please limit use of the Chat for Zoom technical and audio issues only.
- Please use Q&A feature or raise your hand to ask questions.

Agenda

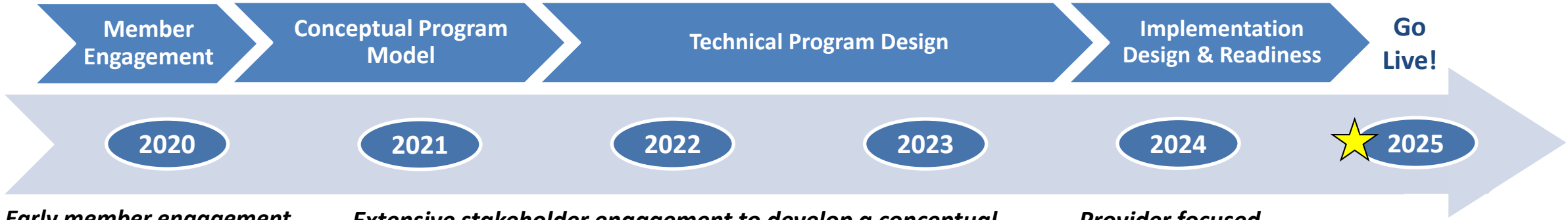
Goals for Today

- **Share program updates** on post-implementation experience to date and upcoming priorities
- **Revisit case rate trigger criteria** reminders and frequently asked questions
- **Review claims payment resources** in preparation for receiving your Case Rate payment
- **Review encounter form reporting** requirements and frequently asked questions
- **Preview provider quality report** and upcoming provider engagement opportunities
- **Answer your questions** regarding the Maternity Bundle program

January 1st, 2025 Program Launch

After several years of extensive stakeholder engagement and program design, DSS launched the HUSKY Maternity Bundle Payment Program on January 1st, 2025!

We appreciate the close engagement of the many stakeholders who helped inform and shape this program, and we plan to continue to work closely with HUSKY Health providers, members, and stakeholders to ensure the program rolls out as designed, to evaluate its performance, and to iterate on the program design accordingly.



Early member engagement to understand experiences, needs, and opportunities

HUSKY member focus groups

Extensive stakeholder engagement to develop a conceptual program model and define the program's technical details

Maternity Bundle Advisory Council (MBAC)
MBAC Doula Subcommittee
MBAC Provider Payment Subcommittee
MAPOC Women and Children's Subcommittee

Provider focused engagement

Provider Forums
DSS Office Hours
1:1 Provider Meetings

Upcoming…

Continued stakeholder engagement and iterative program refinements after PY 1

Early Program Status Update

Following the program's successful launch, DSS is proud to report that the program has not experienced technical issues to date, and the state has been working to ensure that providers feel supported during this transition.

Key Highlights

- **26 maternity practices** successfully transitioned into this program
- **887 Case Rate payments** were made in the program's first payment cycle

Program Experience To Date

- The CHNCT, Inc. Provider Engagement Services team has been offering implementation support to all Maternity Bundle practices.
- Common topics of provider questions include:
  - Signing up for the HUSKY Secure Provider Portal
  - Maternity Bundle Encounter Form
  - Trigger event criteria and other billing scenarios
- DSS has been conducting 1-on-1 meetings to answer provider questions by request.

CHN PES Support: *For any questions related to this program, please email the new Maternity Bundle PES email at* ***maternitybundlequestions@chnct.org*** *or contact your CHNCT, Inc. Provider Engagement Services.*

Upcoming Priorities

With the program now launched, DSS anticipates ongoing stakeholder engagement, program monitoring and reporting, and continuous program improvements to enhance the program in subsequent years.

Stakeholder Engagement	Continuing ongoing collaboration, support, and communication with Medicaid members, providers, and community stakeholders
Program Reporting	Tracking key measures of access and utilization
Provider Reporting	Sharing timely data on quality and cost performance
Program Refinements	Regularly assessing and adjusting program design elements to ensure the program meets evolving needs and goals

Case Rate Payment Reminders

Case Rate Trigger Event Guidance

On January 1st, practices will be eligible to initiate Case Rate payments for second trimester patients.

To qualify for Case Rate payment, providers must meet the following criteria:

- Perform 30 or more deliveries annually
- Submit a claim with a trigger diagnosis code (outlined in the Code List on the DSS website) 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, which includes Obstetrics and Gynecology (including the subspecialty MFM), Certified Nurse Midwife, Obstetric Nurse Practitioner, and Women's Health Nurse Practitioner.

Reminder: **Effective 1/1/25 - 3/31/25, trigger events *in the 2nd trimester only* will initiate Case Rate payment.**

- This means providers will not receive the Case Rate payment for patients who are in the 3rd trimester or postpartum period for the first three months of the program.
- Effective 4/1/25, trigger events in the 2nd trimester, 3rd trimester, and postpartum period will initiate Case Rate payment.

Case Rate Trigger Code FAQs

Should we bill E & M codes for prenatal visits with a zero-dollar charge?

Answer: No, practices should bill E & M codes for prenatal visits with their usual and customary charges (i.e., without making changes to the service charges).

Once we trigger the case rate payment, should we continue to submit claims for other prenatal visits?

Answer: Yes, DSS recommends that practices bill and submit all claims to document services provided to the HUSKY Health member during the episode.

Will there be any penalties on the case rate payment if the trigger event is not submitted by a doctor?

Answer: No, if an Advanced Practice Registered Nurse, Certified Nurse Midwife, or Nurse Practitioner submits a trigger claim, your practice will still receive the full case rate payment.

Do we only get case rate payments in the postpartum period by submitting trigger events?

Answer: If you're attributed for the patient's care prior to delivery, you will automatically receive the case rate payment, though DSS generally recommends that practices bill to meet the trigger event criteria, when possible, to maintain episode attribution.

What can providers expect for their first Case Rate payment?

Case Rate Payment Logistics

Once initiated, Case Rate payments will be identified and generated at the end of the month, and the expenditures will be included on the existing semi-monthly Remittance Advice (RA) and 835 in the first payment cycle of the month.

Supplemental Payment Report: DSS will also provide a supplemental payment report, which all providers under the Accountable TIN may access through their secure provider portal. This report will contain information to support the Accountable Provider's ability to attribute TIN level payments among its providers/practices.

Claims Payment Example:

1. The practice renders cares for their patient for their second trimester prenatal visit in January.

2. In February, the practice submits a trigger claim for the January date of service (DOS). Next, the January DOS trigger claim will $0 pay, and Case Rate payments for the month of January and February will be generated at the end of February.

3. The practice will see the Case Rate payments for January and February in the first payment cycle in March.

4. Case Rate payment for March (if the provider is still the attributed provider) will be paid in the first payment cycle in April.

For more information about claim payment, please see the Program FAQ.

New Payment Resources

In response to provider requests, DSS has posted the following payment resources on the DSS website on the **Details of Connecticut's Maternity Bundle** page.

- **Sample 835 File** to preview a mock-up 835 file for case rate and incentive payments
- **Billing Example** to show how claims will be processed (either pay FFS or zero pay) under the program

New **835 & Paper Remittance Advice (RA) Examples** to show what the 835 and paper RA will look like for a $0 paid claim and what the paper RA will look like for case rate payments

New **Supplemental Payment Test File** to preview a mock-up of the provider supplemental file that Gainwell will post on the provider's web portal for download.

Encounter Form Reporting

Pay-for-Reporting Quality Measures

Of the program's five pay-for-reporting measures, two measures will be sourced from adjudicated claims information, and three measures will utilize data submitted by OB providers via the CT Maternity Bundle Encounter Form.

Pay-for-Reporting (29%)

Claims Data

CT Maternity Bundle Encounter Form

1 Contraception
(6% doula add-on 7% doula opt-out)

The proportion of mothers with live deliveries that reported contraceptive use within 90 days of delivery

2 Preterm Birth/Labor
(6% doula add-on 7% doula opt-out)

The proportion of preterm births/labors among the total number of live births

3 Doula Utilization[1]
*(6% doula add-on N/A doula opt-out)**

Proportion of births attended by a doula.

4 Breastfeeding[2]
(6% doula add-on 7% doula opt-out)

Assesses the proportion of newborns exclusively fed breast milk during the newborn's entire hospitalization.

5 Behavioral Health Risk Assessment[2]
(6% doula add-on 7% doula opt-out)

Proportion of patients who gave birth and received a behavioral health screening risk assessment at the first prenatal visit of those patients who gave birth and had at least one prenatal visit

[1] 100% Encounter Form submission threshold required for measure reporting/payment.
[2] 90% Encounter Form submission threshold required for measure reporting/payment.

Encounter Form Reporting

Providers should submit a completed Encounter Form to fulfill the program's Pay for Reporting quality measure requirements and to provide information necessary for the doula true up process.

- **Provider Portal Access:** Encounter Forms can be completed by authorized users through the HUSKY Health Secure Provider Portal – Maternity Bundle tab.
- **Submission Deadline:** To be considered in that Performance Year's measure calculations, Encounter Forms must be submitted within 30 days after the end of a birthing person's postpartum period.
- **Save In-Progress Forms:** Encounter Forms may be partially completed and saved prior to completion at the end of the postpartum period; however, they must be submitted to meet Maternity Bundle Pay for Reporting quality measure requirements. Incomplete or saved forms will not meet the Pay for Reporting quality measure requirements.
- **Member Submission Requirement:** As episode attribution may change based on multi-practice billing, DSS recommends that practices submit Encounter Forms for all patients whom they have received a case rate payment for. Your practice can identify patients that you have received case rate payments for through the supplemental payment report, which can be found on the www.ctdssmap.com provider portal.
- **Consultative Care Guidance**: If you are providing consultative care, DSS recognizes that you may not have all information requested by the Encounter Form. DSS recommends that consultative providers still complete the Encounter Form, using the "N/A" answer option to bypass questions that the provider does not have information on.

Encounter Form FAQs

How should we handle multiple births?

Answer: Submit one Encounter Form per delivery event, where a single delivery event can encapsulate multiple births; the questions on the Encounter Form relate to services and events that typically apply to the birthing person, and responses won't differ based on multiple births.

Should we only submit an Encounter Form for live births?

Answer: Measures are calculated based on the rate of services provided to the total number of live birth deliveries. However, to support the doula service true up process, an Encounter Form should be submitted for any patients a practice has received case rate payment for.

For the Substance Use Screening question, does this include alcohol?

Answer: Yes, drug use and alcohol use are included in the Substance Use Screening.

For the Tobacco Use Screening question, does this include Tobacco, E-Cigarettes and Vaping or Tobacco only?

Answer: The Tobacco Use Screening encompasses traditional tobacco products, e-cigarettes, and vapes.

If the baby is being fed breastmilk from a bottle or a donor, does this count as breastfeeding?

Answer: The question "*Was the newborn exclusively fed breast milk during the newborn's entire hospitalization?*" is specific to birthing person/baby contact breastfeeding.

Provider Quality Reports

Quarterly Quality Reports

As part of this program, participating providers will receive quarterly data reports to assist in monitoring their performance on the program's quality measures.

- DSS anticipates providing the **first data report in April**, acknowledging that data from the first quarter of the program will be limited.
  - Practices should expect to receive this report by email from their designated CHNCT, Inc. Provider Engagement Services representative.
- DSS also plans to host a **provider forum in April** to support providers in understanding their quarterly quality data report.
  - For more guidance on the quality report, you may email the new Maternity Bundle PES email (maternitybundlequestions@chnct.org) or contact your practice's PES representative.

Preview of Quarterly Quality Reports

Mercer Performance Measure Rate Overview

Last Update: 07/30/2024

Measure Descriptions

Measures & Weights

Methodology

Fiscal Year

Measure

Measure Group

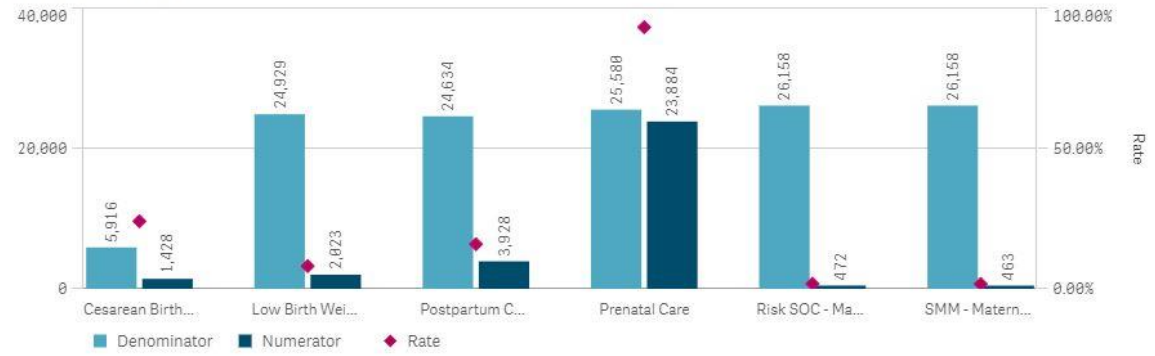
TIN

Provider Name

Included Providers

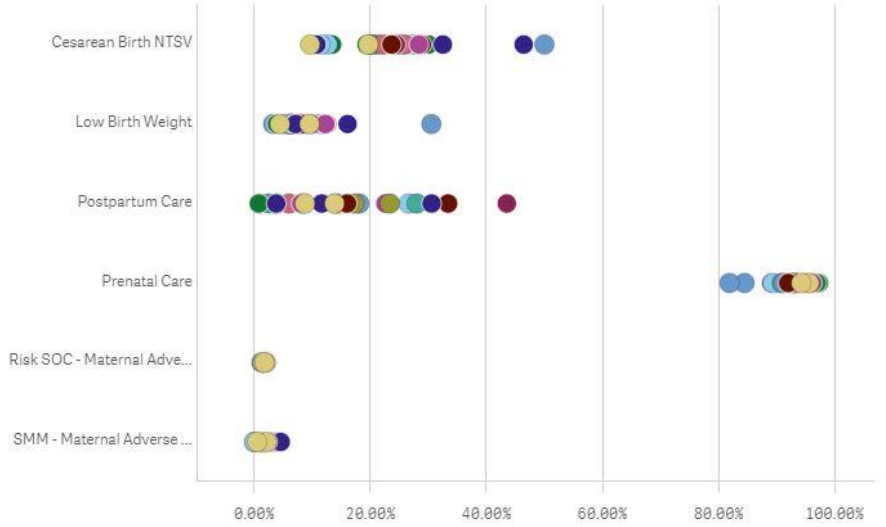
During quarterly data updates, low case numbers can affect the measures not meeting the thresholds. The exact quality scores will be produced annually during the reconciliation calculation.

Measure Rate Detail



Rate Distribution by Measure & Fiscal Year

Provider Distribution By Rate & Performance Measures



Preview of Quarterly Quality Reports

*DSS will only require practices that receive the doula care add-on payment to report on the doula utilization measure. This measure will not appear on the dashboard for practices that have opted out.

[1] 100% Encounter Form submission threshold required for measure reporting/payment; [2] 90% Encounter Form submission threshold required for measure reporting/payment.

Program Resources

For more information about this program, DSS has created the following program resources, which can be found at the **DSS Maternity Bundle Website**. Updated or new resources are highlighted below.

Category	Program Resource
Program Overview	• **Program Overview** with a glossary of key terms • ***Updated* Program FAQ** based on frequently asked questions raised during provider forums and office hours • **Video Resource Guides** about the MB Program, Case Rate payment, and incentive payment
Technical Details	• **Program Specifications** containing all technical details pertaining to the program • ***Renumbered* Code List** containing the list diagnosis trigger codes, case rate codes, case rate termination codes, and reconciliation codes • **Sample 835 File** to preview a mock-up 835 file for case rate and incentive payments • **Billing Example** to show how claims will be processed (either pay FFS or zero pay) under the program • ***New* 835 & Paper RA Examples** to illustrate sample $0-paid 835s/paper RAs and Case Rate-paid paper RAs • ***New* Supplemental Payment Test File** to preview a mock-up of the provider supplemental file
Quality & Reporting	• **Sample Encounter Form** for data submission on select Pay-for-Reporting measures • **Quality Measures Reference Guide** for general guidance on the program's quality measures and reporting requirements
Doula Integration	• **Resources, form templates, and model policies** that doulas/practices may use and customize when partnering together

CHN PES Support: For any questions related to this program, please email the new Maternity Bundle PES email at **maternitybundlequestions@chnct.org** or contact your CHNCT, Inc. Provider Engagement Services.

Questions?

Appendix: Program Details

Maternity Bundle Program Overview

Under this program, Medicaid obstetrics or licensed midwife practices will be responsible for both the quality and cost of care provided during the “maternity episode” or “maternity bundle.”

Program Start Date: January 1, 2025

Eligible Providers: Maternity practices who deliver 30 or more births per year

Maternity Episode: An episode of care describes the total amount of care provided to a patient during a set timeframe. In this program, the maternity episode covers care through the prenatal, labor & delivery, and postpartum periods.

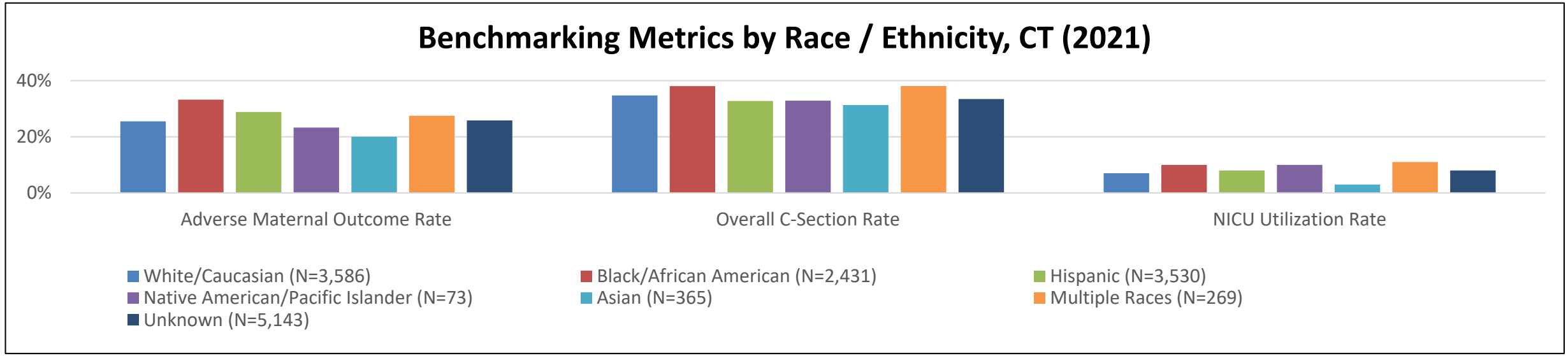
Program Goals:

- **Strengthen maternal health** in CT Medicaid with enhanced flexibility to deliver person-centered care
- **Promote health equity** through program design and health disparity reduction targets
- **Improve health outcomes** and higher 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

Starting Point: Disparities in Maternal and Infant Health

Despite efforts to incentivize improved care and health outcomes under the current FFS model, DSS saw a **rise in adverse maternal outcomes, C-section utilization, and NICU utilization** among HUSKY Health members between 2017-2021.

- In 2020, Connecticut Medicaid's overall c-section rate (33.3%) was the highest in New England and 7th highest in the United States[1]
- Connecticut has the 8th highest Neonatal Abstinence Syndrome (NAS) rate per 1,000 births in the country[2]
- Additionally, DSS observed substantial racial health disparities. For example, Black/African American members have the highest Adverse Maternal Outcomes rate and the highest Overall C-Section rate.

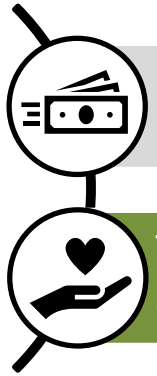


Sources: 1: Health Care Cost Institute (June 2022) 2: CT NAS Data Visualization (Sept 2020)

Data Source: CT DSS Data, provided by CHN

Episode-Based Payment Model

The launch of the Maternity Bundle Program supports the transition from a FFS payment model to an episode-based payment model for maternity care.



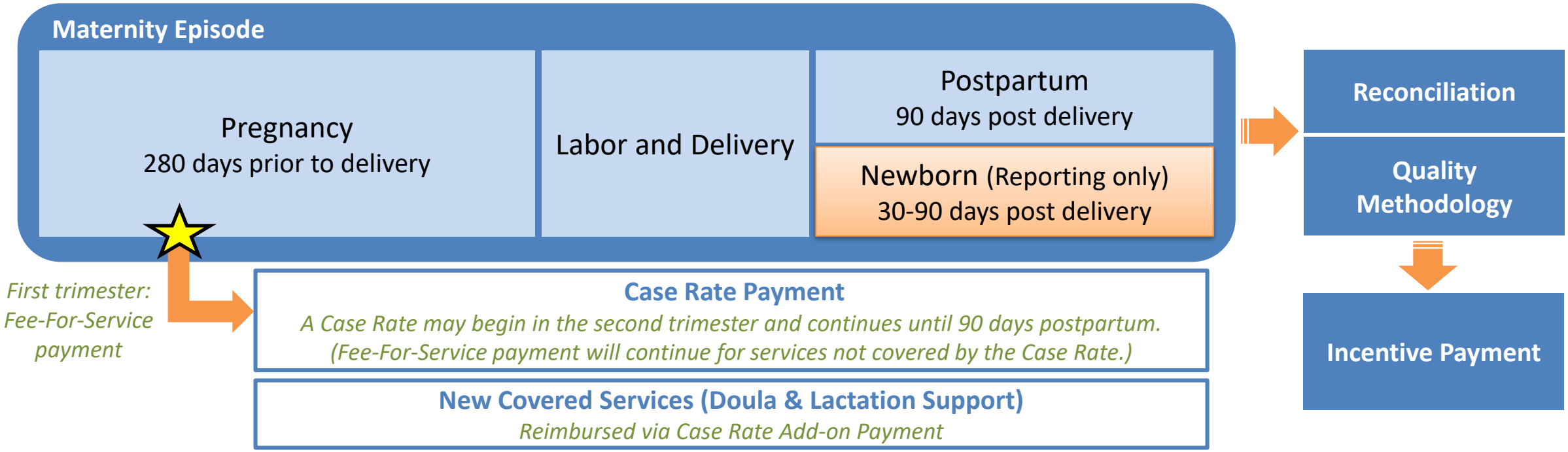
The current FFS system rewards providers for the **volume of services provided, regardless of quality or outcomes.**

The maternity bundle episode-based payment model **holds maternity care providers responsible for both the quality and cost of care** provided during the maternity episode.

Key Program Components	Value
Provider-specific **"case rate" payments**	Encourage flexibility in care delivery and incentivize early engagement with members, enabling practices to provide right care at the right time
"Incentive" payments (shared savings bonus payments)	Providers who meet quality performance standards and lower costs relative to a target benchmark are eligible to share in savings – creating an incentive to reduce unnecessary costs and improve efficiency
New coverage of **doula and lactation support** services	Enhance patient-centered care through access to high-value, peer-based services
Quality measures	Ensure high-quality care and improvements in care
Social and clinical risk adjustment	Rewards providers who care for Medicaid members with greater social and health needs

Maternity Episode

An episode of care describes the total amount of care provided to a patient during a set timeframe. In this program, the maternity episode includes services across all phases of the perinatal period, spanning 280 days before birth to 90 days postpartum.



Maternity Episode Services

See the full list on slide 23.

Pregnancy

- Monthly prenatal visits
- Routine ultrasound
- Blood testing
- Diabetes testing
- Genetic testing
- Doulas
- Care navigators
- Group education meetings
- Birth education classes
- Preventive screenings (chlamydia, cervical cancer, etc.)

Labor & Delivery

- Vaginal delivery
- C-section delivery

Postpartum

- Breastfeeding support
- Depression screening
- Contraception planning
- Ensure link from labor and birth to primary and pediatric care occurs for birthing person & baby

Accountable Providers

Ambulatory maternity providers who have the greatest role in delivering obstetric care will be designated as the episode's accountable provider.

Accountable Providers

- Ambulatory maternity providers (i.e., qualified licensed physicians, nurse practitioners, and nurse-midwives) who have **the greatest role in delivering obstetric care** will be designated as the episode's Accountable Provider.
- Accountable providers must meet a **minimum volume threshold of 30 or more deliveries annually** to participate.
- Accountable providers will be transitioned from the existing OB Pay for Performance (OBP4P) program to the Maternity Bundle Program.

Non-Participating Providers

- FQHCs and providers who perform fewer than 30 deliveries annually will be ineligible to participate in the program and will be paid according to their current payment methodology.
- Non-participating providers may still opt to participate in the OBP4P program.

Case Rate Payments

DSS designed the maternity bundle's case rate payment to give providers greater flexibility in how they deliver care and increase investment in maternity care providers.

- **Case Rate Payment Overview:** **DSS will make monthly "case rate" payments** for a subset of services, which includes the majority of prenatal, labor and delivery, and postpartum care that a birthing person receives. Each practice's case rate is based on historical second trimester, third trimester, delivery, and postpartum professional claim expense for historically attributed episodes.
- **Rate Development:** DSS anticipates that the case rate payment will provide an **opportunity for providers to earn additional revenue**, adding an estimated $6 million in expenditures annually. DSS rigorously developed the case rate payments based on each practice's historic utilization and FFS billing. DSS also tested case rate payment through the program's historic simulation and a separate fiscal impact analysis.
- **Program Monitoring:** **DSS will monitor changes in member access, practice revenue, and billing patterns** after program implementation to ensure that the roll-out of case rate payments occurs as designed and to preserve HUSKY Health members' access to care.
- **Rate Rebasing:** **DSS will rebase the case rates** no more than once annually to account for changes in risk mix or service delivery over time.

Doula and Lactation Supports

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.

DSS is utilizing a dual approach to provide and fund access to doula services in Medicaid:

1. **Paying through the maternity bundle**
   Maternity bundle providers have the option to partner with doulas, who will receive payment through the bundle.

2. **Paying fee-for-service**
   DSS anticipates implementing direct Medicaid reimbursement of certified doulas as a separate but parallel doula payment pathway.

In addition, DSS will also provide coverage of lactation support services through the maternity bundle.

- All maternity bundle providers will receive payment through the bundle.
- The new high-value services shall be provided under the supervision of the maternity bundle providers and within both the scope of the provider's overall services and the provider's plan of care for each beneficiary.

Maternity Episode Services

Services included in the maternity episode will be subject to a retrospective reconciliation to calculate the incentive payment amount.

Included Services	Excluded Services
➢ OB/licensed midwife Professional Services ➢ ***In-house*** OB/licensed midwife Professional-related hospitalization costs (Inpatient, Outpatient, and ED) including professional delivery fees ➢ OB/licensed midwife Professional-related Behavioral Health Evals, including screening for depression and substance use ➢ Screenings (general pregnancy, chlamydia, cervical cancer, intimate partner violence, anxiety) ➢ ***In-house*** OB/licensed midwife imaging ➢ ***In-house*** labs and diagnostics ➢ Prenatal group visits ➢ Care coordination activities ➢ Any of the above services provided via telehealth • *If performed outside the participating Accountable Provider:* OB/licensed midwife imaging & labs • Birth Centers and hospital costs related to maternity care • Specialist/Professional Services related to maternity (e.g., anesthesia) • General Pharmacy related to maternity	• Pediatric Professional Services • Neonatal Intensive Care Unit (NICU) • Behavioral Health & Substance Use services • Long-acting reversible contraception (LARC) • Sterilizations • DME (e.g., blood pressure monitors, breast pumps) • High-cost medications (specifically, HIV drugs and brexanolone) • Hospital costs unrelated to maternity (e.g., appendicitis) • Other Care, including Nutrition, Respiratory Care, Home Care, etc. • Maternal Oral Health services

Key: ➢ Services reimbursed and included in the Case Rate.
• Services reimbursed Fee-For-Service

Incentive Payment

Accountable providers can earn incentive payments when total cost of care is lower than the target price, if they also meet quality performance criteria and comply with under-service prevention requirements.

- If episode costs are below the "target price" (the target benchmark), providers will receive a retrospective (i.e., at the end of the bundle) "incentive payment" (shared savings) based on their quality performance.
- This program is upside only, which means providers can only earn incentive payments as a bonus for delivering high-quality, cost-efficient care; there are no penalties if the provider's costs exceed the target price.

Target Price

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 provider's historical cost.

Historical Price

- Calculate the average standardized* episode cost of all services by provider TIN.
- Winsorize outliers — set the total episode cost thresholds between the fifth and 99th percentile.
- Trending — utilize DSS' institutional knowledge regarding fee schedule changes, etc..

** Standardization includes applying standard fee schedule by diagnosis related group and severity level. This process will be used for inpatient hospitals and some other services, if applicable.*

Risk Adjustment Factor

The historical year's risk adjustment factor, integrated with the Area Deprivation Index (an area-level measure of socioeconomic factor) will be used to risk adjust the historical price.

State-wide Historical Price (50%)

Risk Adjusted Historical Price (50%)

Risk-neutral historical price by provider TIN

Base Price by Provider

Base Price by Provider

Performance Year Risk Factor

Risk adjustment factor of the performance year

Target Price by Provider

Quality Measures and Weights

This program has ten quality measures: five are pay-for-performance measures and five are pay-for-reporting measures.

Pay-for-Performance (71% Total)

1 Cesarean Birth (24%)

The proportion of live babies born at or beyond 37.0 weeks gestation to women in their first pregnancy, via cesarean birth.

2 Postpartum Care (18%)

Measures rate of timeliness of postpartum care for the maternity bundle project.

3 Prenatal Care (12%)

Measures the timeliness of prenatal care for the maternity bundle project.

4 Low Birth Weight (12%)

The proportion of infants with the International Classification of Diseases codes for light for gestational age, small for gestational age, low birth weight, or intensive care units care for low birthweight infants on newborn records among all births.

5 Maternal Adverse Events (6%)

The proportion of deliveries > = 20 weeks gestation with any of 21 maternal morbidities plus maternal mortality occurring during the delivery hospitalization, risk-adjusted using claims data.

Pay-for-Reporting (29%)

6 Contraception

(6% doula add-on
7% doula opt-out)

The proportion of mothers with live deliveries that reported contraceptive use within 90 days of delivery

7 Preterm Birth/Labor

(6% doula add-on
7% doula opt-out)

The proportion of preterm births/labors among the total number of live births

8 Doula Utilization[1]

(6% doula add-on
*N/A doula opt-out)**

Proportion of births attended by a doula.

9 Breastfeeding[2]

(6% doula add-on
7% doula opt-out)

Assesses the proportion of newborns exclusively fed breast milk during the newborn's entire hospitalization.

10 Behavioral Health Risk Assessment[2]

(6% doula add-on
7% doula opt-out)

Proportion of patients who gave birth and received a behavioral health screening risk assessment at the first prenatal visit of those patients who gave birth and had at least one prenatal visit

[1] 100% Encounter Form submission threshold required for measure reporting/payment.
[2] 90% Encounter Form submission threshold required for measure reporting/payment.

Quality Methodology and Scoring

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

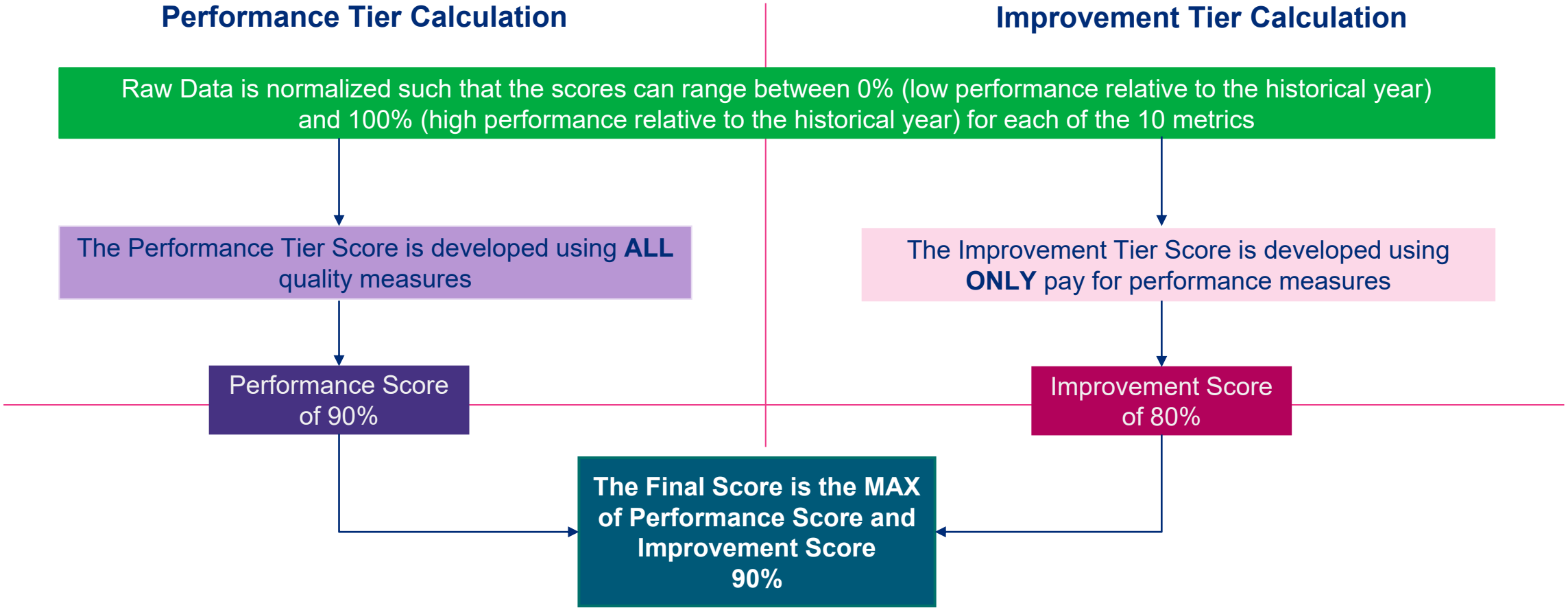
Overall Performance	Performance Earnings Tier	Performance: % Shared Savings
< 55th Percentile of peer group	F	50%
55–60th Percentile of peer group	D	60%
60–70th Percentile of peer group	C	70%
70–75th Percentile of peer group	B	80%
75–80th Percentile of peer group	A	90%
> 80th Percentile of peer group	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%

Quality Methodology Example

The distribution of incentive payments will be adjusted based on the accountable provider's quality performance. The example below illustrates how DSS will produce the final quality score.



Quality Gate Check

- Accountable providers who fall into 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.
- In the subsequent year, if an accountable provider consecutively maintains quality performance in Tier F for both tiers, the provider will be ineligible for the incentive payment that year.