COLORADO
Department of Health Care
Policy & Financing

1570 Grant Street
Denver, CO 80203

Maternity Bundled Payment Program

FAQs: August 2020

Q: When does the Maternity Bundled Payment Program begin and end?
A: The initial program is two years long with the first year running from Nov. 1, 2020 through Oct. 30, 2021 and the second year running from Nov. 1, 2021 through Oct. 30, 2022.

Q: What other states currently run maternity bundled payment programs for Medicaid patients?
A: Arkansas, Ohio, and Tennessee administer maternity bundled payment programs for Medicaid patients. However, those three state programs are mandatory programs whereas Colorado's program is voluntary.

Q: Which patients are included in the first year of the program?
A: Only Medicaid-enrolled pregnant women with their entire episode of care contained within the first year will be included.

Q: What are the patient exclusions for the program?
A: Patient cases will be excluded for any of the following reasons:

- Patient is dual eligible for Medicaid and Medicare
- Third party liability (TPL) on claim
- No prenatal services supplied to the patient by the provider
- Patient died
- Incomplete episode claims
- No professional claim for delivery
- High-cost outliers
- Emergency Medicaid recipients

Q: Must a provider group provide both prenatal services and deliver the baby for a patient's episode to be included in the bundle for the Principal Accountable Provider (PAP)?

A: Yes, a patient must have their prenatal services provided by a participating obstetric group or health system *and* have their baby delivered by that same obstetric group or health system for the episode to be included in the group's bundle for the program. If one group provides prenatal care and a different group delivers the baby, then the patient's episode is not included in the bundle and does not count toward either group.

Q: What if an emergency forces a patient to deliver at a hospital where their provider does not have privileges? Will the emergency delivery disqualify the episode from being included in the program?
A: The program is retrospectively reconciled after all services have been provided and billed to the Department of Health Care Policy & Financing (the Department). Patients with an emergency delivery at a hospital where the provider does not have privileges will be excluded from the bundle for that provider.

Q: Does the bundle include emergency Medicaid recipients?
A: No, emergency Medicaid recipients are not included in the bundle because they typically do not have their prenatal care paid for by Medicaid.

Q: Which services are included in calculation of the bundled payment?

A: More than 800 CPT codes included in the calculation of bundled payments. A full list of included services can be found at www.colorado.gov/pacific/hcpf/bundled-payments.

Q: Are any services not included in the calculation of the bundled payment?
A: Neonatal services for the newborn and non-maternity care are not included in the calculation of the maternity bundle payment.

Q: Which providers are eligible for participation in the program?
A: Providers or health systems are encouraged to participate in the program if they deliver at least 500 Medicaid-covered births each year for the last two complete fiscal years (2017-2018 and 2018-2019). Physicians and nurse midwives are eligible to participate in the program. Any provider or health system interested in participating should contact the Department to discuss.

Q: Which types of claims will be included in the program?
A: Both professional and facility claims (including fee-for-service claims from the hospital) will be included in the calculation of episode costs. However, shared savings and shared losses will only impact payments to the PAP.

Q: How long is the program commitment for participating providers?
A: Initial participants can choose to commit only to year one of the program but are encouraged to continue participation after the first year.

Q: Does the program include upside risk and downside risk for the provider?
A: In a PAP's first year of participation in the program only upside risk will apply. For PAPs who join in the first year of the program (Nov. 1, 2020 to Oct. 30, 2021) this period will be upside-risk only. Downside risk for initial participants will be implemented on Nov. 1, 2021 for these participants.

Q: How much potential risk will providers be subject to in the program?
A: In a PAP's first year of the program, providers can earn 50% of their realized savings. In a PAP's second year, providers can earn 50% of their savings or forfeit 50% of their losses.

Q: Will providers continue to get paid for maternity services not included in the bundle?
A: Yes, the services included in the maternity episode definition are only used to determine the provider's financial performance and potential savings or losses during the program. Providers will continue to be reimbursed for all covered maternity services and patient benefits will not be altered.

Q: Are high-risk episodes excluded from the program?
A: No, high-risk episodes based on clinical criteria are not excluded. Both vaginal and cesarean section deliveries are included in the program. However, high-cost outliers will be excluded. High-cost outliers include episodes with costs greater than the 99th percentile for specific provider episode cohorts.

Q: How are the acceptable and commendable cost thresholds calculated?
A: Acceptable and commendable cost thresholds will be calculated separately for each participating PAP based on their unique Health First Colorado billing ID or Tax ID. PAPs who are interested in joining will work with the Department to determine which ID to use for their specific structure. Acceptable cost thresholds will be calculated using the average cost for all qualifying maternal episodes over the past two years (excluding high-cost outliers). The commendable threshold is calculated by applying a minimum savings rate to the acceptable threshold. The minimum savings rate was calculated based on the distribution of a provider's episodes to ensure that savings are a result of performance improvements.

Q: Can potential participants see threshold data before committing to the program?

A: Yes, providers interested in participating will have the opportunity to review cost thresholds before committing to participate in the program.

Q: Will acceptable and commendable cost thresholds be recalculated?
A: Thresholds will be recalculated every two years.

Q: If a significant number of new providers have recently joined an obstetrician group or health system (e.g., through an acquisition), how would that affect the threshold calculations, which are based on historical claims?
A: The Department will work directly with interested groups and systems to determine acceptable and commendable thresholds for each PAP. The Department will calculate the thresholds using a consistent method and the best available data for each PAP. For example, in the case of a recent acquisition, the Department may have historical data for the practice that was acquired that could be incorporated into the calculation, if appropriate.

Q: How are patients with a diagnosis of substance abuse disorder (SUD) addressed in the program?
A: Patients with SUD are included. Payment thresholds are calculated separately for patients with and without SUD diagnoses. Patients with a qualifying SUD claim or diagnosis that occurs between six months before the episode and six months following the episode will be included in the SUD payment thresholds.

Q: Will providers be expected to meet certain clinical quality targets?
A: Providers must meet a minimum set of quality targets to be eligible for shared savings for the program.

Q: Will the quality measures be based on claims data or on electronic clinical data?
A: Quality measures will be based solely on claims data for the first year of the program due to operational difficulty in collecting electronic clinical data. The Department will explore opportunities to incorporate electronic clinical data in subsequent years.

Q: Is there a deadline to apply and participate in the program?
A: Practices should express their interest as soon as possible to Trevor Abeyta, Program Lead, at trevor.abeyta@state.co.us. Practices interested in participating can expect to receive predicted acceptable and commendable cost thresholds by Sept. 1, 2020. If practices want to formally participate after reviewing their acceptable and commendable thresholds, they will need to notify the Department formally in writing with a letter of intent before the program start date, Nov. 1, 2020.

Q: How do providers formally apply to participate in the program?
A: Obstetricians or health systems who intend to participate in the program are required to:

- Submit a letter of intent to participate in the program to the following address: Maternity Bundled Payment Program, 1570 Grant St., Denver, CO 80203.
- The letter should outline:
    - The reason for wanting to participate in the program.
    - The number of annual Medicaid covered births the group delivers.
    - The number of annual non-Medicaid covered births the group delivers.
    - If the group is participating in a bundled payment program with any other payers.

Q: How will providers be chosen and how will they be informed if they are accepted?
A: The Department will review all formal letters of intent received and perform an analysis of claims data to verify the criteria listed above are met. The Department will then notify all interested providers in writing regarding the criteria to be a participant in the program.

For more information contact

Trevor Abeyta, Program Lead
trevor.abeyta@state.co.us