COLORADO
Department of Health Care Policy & Financing

New Maternity Alternative Payment Model (APM) Design Review Team
Session 6 – Payment Model
Meeting Minutes

August 22, 2024
7:30-9:30 am MT via Zoom

- **Facilitator**: Suman Mathur, Francois de Brantes, Kathleen Le, Katey Ortlieb
- **Scribe**: Kimberly Phu
- Purpose and Goals:
    - Understand the importance of identifying payment mechanisms that support the achievement of outcomes at each phase of the perinatal journey
    - Discuss various payment mechanism options for the new Maternity APM and the pros, cons, considerations at each phase of the perinatal journey
    - Understand how reconciliation occurs in different payment scenarios

Key Decisions or Takeaways

1. DRT members noted that an overall challenge with a fee-for-service (FFS) payment mechanism is separate billing for services which may create additional burden and difficulty in tracking outcomes that are reliant on multiple services. DRT members also raised payment delays related to global billing and inability to account for team-based care and wraparound services as challenges to a FFS model. Further, under a FFS model there is no incentive for providers and hospitals to improve quality, for example by avoiding C-sections when they are paid more for C-sections than vaginal deliveries.
2. DRT members raised concerns with the possible downside risk of a shared savings model. A member also noted that shared savings and FFS together may both disincentivize and incentivize overutilization of care. However, for specific measures such as Cesarean-section (C-section) rates, a blended payment model that reimbursed equally for vaginal birth and Cesarean birth can improve outcomes. As with many APMs, there must be a balance between cost and quality and unintended consequences, such as providers "cherry picking" healthier patients to avoid adverse outcomes.
3. DRT members noted that per-member-per-month (PMPM) or a prospective payment model may better support metrics, such as reducing low-risk C-sections since equitable payment is given for the procedure and is dependent only on the outcome. However, DRT members noted concerns around how a PMPM would transfer during a transition in care and accountability of providers throughout the perinatal journey.

Agenda

1. Welcome and Updates
2. Level-Setting: Perinatal Journey and Aligning Outcomes and Payment
3. Payment Mechanism Descriptions and Examples
    a. Fee-For-Service (FFS)
    b. Shared Savings
    c. Prospective Payment (PMPM)
4. Looking Ahead

Meeting Minutes

1. Welcome and Update

Suman Mathur called the meeting to order and welcomed participants.

Diego Pons, interpreter for our session today, reminded folks that to support interpretation, please speak at a slower pace and refrain from using acronyms.

Suman reviewed the Department of Health Care Policy and Financing's (HCPF) mission, as well as today's agenda and meeting objectives. She then introduced the Maternity APM team and additional HCPF members team joining today's call, including Melanie Reece. Suman led the DRT through an introduction, asking what is your favorite thing you've read, listened to, or watched recently?

Suman reminded the group that meeting minutes for DRT Session 5 were sent on Monday, August 25. DRT members should review the minutes and email the Stakeholder Engagement team at HCPF_VBPStakeholderEngagement@state.co.us by end of day Friday, August 23 with any proposed changes, for example correcting misinterpreted comments.

She then provided an overview of the remaining DRT schedule.

2. Level-Setting: Perinatal Journey and Aligning Outcomes and Payment

Francois de Brantes provided a level-set of the perinatal patient journey, including the prenatal, labor and delivery, and postpartum and newborn care phases. He emphasized the importance of looking at the entire perinatal journey in phases as there are different goals and outcomes at each phase. Further, the birthing person may change care teams and there are different members of the care team involved throughout the phases, therefore accountability can change.

- A DRT member asked whether nurse home visitors are considered community-based organizations, stating they need to be included in the postpartum phase.
    - Francois responded yes, the Maternity APM team has been thinking about home-visitation programs and their important role in perinatal care.

Francois then provided an overview of three payment mechanisms and noted they are not mutually exclusive. These include:

- Fee-for-service (FFS): Providers are reimbursed for each service they deliver. Each service has a defined cost, which is then billed to the patient or their insurer upon service delivery. Providers are reimbursed regardless of the outcome.
- Shared Savings: Goals incentivize providers to excel in care delivery. Providers receive shared savings payments when they exceed performance targets based on quality and cost thresholds set prior to performance period. Providers are paid retrospectively, after quality and cost calculations are completed.

- Per Member Per Month (PMPM): This model incentivizes efficient and effective care delivery. Upfront payments to manage care for a defined set of patient procedures. Typically, providers receive a preset fee (i.e., PMPM) for a complete episode of care.

Melanie Reece noted that providers do and can bill for all the additional services for higher risk pregnancies, so they do get paid more.

Kathleen Le then overviewed how quality is linked to these payment mechanisms. Payment for meeting quality measures would be made through shared savings, PMPM, or other payment models. FFS is not linked to the quality model; this does not mean providers do not receive FFS payments, rather the code set may not be linked directly to quality.

3. Payment Mechanism Descriptions and Examples

Fee-For-Service

Kathleen then provided an overview of the FFS model. Advantages of FFS include timeliness and familiarity. Disadvantages include overutilization, fragmented billing, and lack of an outcome focus. Other considerations are delays related to global billing and that FFS does not incentivize improved quality performance. Kathleen then provided an example of payment under a FFS model. She acknowledged there may be existing challenges and limitations with FFS in each phase of the perinatal journey.

Suman then led the group through discussion, asking what are some challenges in achieving prenatal phase outcomes through FFS?

DRT members raised the following challenges related to FFS:

- Separate billing is a challenge as many outcomes would likely be comprised of different services and care, so there is burden for providers in trying to track all services that lead to these outcomes.
- Payment delays related to global billing have been prohibitive for providers.

DRT members asked the following questions:

- What is meant by timeliness to prenatal care?
    - Suman responded that this is a quality metric discussed in earlier sessions. Melanie elaborated that this measure focuses on getting patients seen in the first trimester.
- Would this be related to FFS under the global code and is the prenatal depression screening and follow up measure included under the global code? The DRT member noted that they have heard it is challenging to screen for perinatal depression when there is a behavioral workforce shortage and therefore lack of follow up.
    - Melanie responded that depression screening is paid as a separate service.
- How would a FFS model pay for wraparound services, such as nutrition or case management? Some outcomes, such as low birth weight, can be impacted by

wraparound services. The DRT member also asked how FFS would pay for innovative approaches to prenatal care, such as group care?
    - Suman responded this is one of the limitations of FFS and why HCPF is looking to see where other payment mechanisms could be layered in.
    - Another DRT member noted that this is where regional accountable entities (RAEs) have a vital role in care coordination, health related social needs, behavioral health, etc.

Additional comments made related to the prenatal phase include the following:

- A DRT member stated there needs to be clarity on whether Healthcare Common Procedure Coding System (HCPC) codes would be used to achieve incentives or if screening codes, such as 96127 would achieve the same results.
- A DRT member raised an issue specific to the timeliness to care measure. They noted that while the system should account for patients who started care elsewhere (and therefore, providers and systems are not penalized for perceived late entry), many individuals, such as newcomers from Latin America, arrive in late pregnancy with no prenatal care which skews numbers for systems that serve these populations.
    - A DRT member responded that there are diagnosis codes for insufficient antenatal care, and these should be used and taken into account so providers and systems are not unfairly penalized.

Suman led the group through the next discussion question, asking what are some challenges in achieving labor and delivery phase outcomes through FFS?

- A DRT member said that many of these outcomes take health care team collaboration and system support which is a challenge under FFS. Many programs are large and support systemic approaches to care.
- A DRT member noted that if primary and repeat C-sections, compared to normal spontaneous vaginal delivery (NSVD) and vaginal birth after cesarean section (VBAC), are reimbursed more highly, there is no incentive for providers and hospitals to avoid C-sections.
- A DRT member stated that rural locations that do not offer VBAC would be affected by the desired outcomes.
- A DRT member noted that wraparound and supportive services can contribute to these outcomes and should be considered and made sustainable.
- A DRT member stated that under global billing, transitions of care are disincentivized. They elaborated that it will be important to make sure that every provider/hospital receives reimbursement for care they provide for labor, not just the provider "catching" the baby.
    - A DRT member responded that this is related to an earlier conversation around C-section rates and that resource utilization for labor is big (room occupation, provider and nurse time, etc.) and vaginal births should be valued more highly.

Suman led the group through the last discussion question for this section, asking what are some challenges in achieving postpartum phase outcomes through FFS?

- A DRT member noted that 365 days is a long time to wait for payment so HCPF should consider splitting payments into segments.

Shared Savings

Katey Ortlieb provided an overview of the shared savings model. Advantages include improved patient outcomes and cost savings. Disadvantages include delayed payment, financial risk, and complex implementation. Other considerations are that a new program could be upside risk only and there is familiarity with this model as it is what is used in the Current Maternity Bundled Payment Program. Katey then provided an overview of payment under the shared savings model. She noted the timeline for payment is longer as there is a minimum 12-month baseline period, a 4-month period for thresholds to be set, 12-month performance period, 3-month claims-runout period and to account for the postpartum period, and 2-3 months for reconciliation where performance is compared to the thresholds. The shared savings model does account for outliers. Only providers with average episode costs below the commendable threshold would be eligible for shared savings. The amount of shared savings varies and is dependent upon things like quality measures.

- A DRT member noted their practice would be less likely to participate if there was downside risk in the model.
- A DRT member asked whether the cost thresholds would be set at the practice, individual provider, or regional level?
    - Ke Zhang responded that in theory, it can be any of those. The current program is set at a practice level based on Medicaid IDs.
- A DRT member noted that there is a study showing Minnesota's success with a blended payment model that reimbursed equally for vaginal birth and Cesarean birth. C-section rates went down. However, the program was torpedoed despite its success because of objections from providers and systems who wanted to be paid more for C-sections nonetheless. They noted reimbursement equity should be included in the program and provided the following resources:
    - https://pubmed.ncbi.nlm.nih.gov/29912840/#:~:text=With%20the%20goal%20of%20reducing,payment%20regardless%20of%20delivery%20mode)
    - Why the C-Section Rate Is So High - The Atlantic

Suman then led the group through discussion, asking how does shared savings support or not support the ability to achieve prenatal, labor and delivery, and postpartum phase outcomes?

- A DRT member noted that thresholds are important to consider. While expecting iterative improvement upon your own baseline can work, it can create challenges in some instances. For example, a provider who is at the 95th percentile baseline and not receiving payment unless they're at the 97th percentile. These models can also create inequities among providers around expectations. Conversely, regional thresholds can create equity challenges due to differences in patient population and therefore unintended consequences related to patients served.

    - A DRT member commented that relatedly, there is still confusion around baseline data and whether the practice, provider, or system would make the decision on that data component.
    - Francois thanked folks for their comments, noting that adjusting for patient characteristics is essential. Specifics around methodology are not defined, but the concept is important. He elaborated that the baseline measurement is done using 12-24 months of historical data there would be both regional, statewide, and national benchmarks that are all taken into consideration when establishing the threshold.
    - A DRT member elaborated that a hybrid model combining FFS and shared savings would be in opposition. For example, these models together would both disincentivize and incentivize overutilization of care and therefore "come out in the wash".
- A DRT member asked whether there is any concern that the commendable threshold could disincentivize the provision of necessary care and whether there would be a cost floor.
    - Suman posed the question to the group as this feedback is what we would like to hear from folks on the call.
    - Ke responded that these are concerns; every APM has potential for providers to game the system and shared savings can reduce necessary services. However, there are ways to mitigate risks. For example, providers are still responsible for patient outcomes. Episode definition is another way to mitigate risk, for example, by identifying which codes are included and necessary. In addition, each phase has different levels of unnecessary services built in. For example, additional services and costs may be appropriate for the prenatal phase but may reduce unnecessary costs in the labor and delivery phase. Overall, these concerns will still exist by nature of APMs.
    - Katey elaborated this is why it's important to combine cost and quality in the model to maintain a balance.
    - The DRT member noted that overall, this could lead to cherry-picking patients which is the challenge of APMs and should be carefully considered.

The group then took a 5-minute break before reconvening.

<u>Per Member Per Month (PMPM)</u>

Francois provided an overview of the PMPM model. Advantages include stabilization and incentivized coordination. Disadvantages include risk of underpayment and lack of flexibility. Considerations around this model include provider practice size impacting preset payments. Francois noted that prospective payments can be partial, blended with a FFS model, or 100%. Francois walked through an example of payment where a practice takes a 50% prospective payment, PMPM.

Suman then led the group through discussion, asking how shared savings supports or does not support the ability to achieve prenatal, labor and delivery, and postpartum phase outcomes.

- A DRT member noted that more time is needed to learn about these models to provide valuable feedback. They suggested sending follow up feedback through email.

DRT members asked the following questions related to a PMPM model:

- Would members with Medicaid through Cover All Coloradans be included in the APM?
    - A DRT member responded yes, the only distinction of Cover All Coloradans is that it is a program for people without documentation, but it is still Medicaid.
- Would the PMPM transition between providers if a care transition occurs, for example one month to one practice and one to another?
    - Francois responded that the state of Connecticut is doing something similar. They have a monthly payment paid to practices during the prenatal phase and there are mechanisms in place that would transition the payment depending on the incidence in which the pregnant person switches practices.
- Would quality/achievement of outcomes impact the PMPM rate? If not, is quality incorporated into this model?
    - Ke responded that the way the quality model holds providers accountable is different than shared savings. Shadow billing is still required so HCPF will see how many services are provided and what the rate would be. The quality model must be met to keep the difference between the PMPM received and FFS shadow billing amount. Providers may need to pay this back, which is the risk associated with the model, but HCPF may choose not to reinforce that downside risk. Ke elaborated that PMPM rates are not typically adjusted, and that the provider maintains the rate throughout the year.
- Would all provider types be subject to PMPM payments when providing care to a postpartum patient or would it only apply to the perinatal team?
    - Francois responded that it could apply to all provider types.
    - The DRT member elaborated that when it comes to quality, there is often a warm handoff between the OB/GYN and primary care provider. They asked whether the delivering provider is subject to the quality threshold in the postpartum phase.
        - Francois responded that while the OB/GYN's work may be done, there is still the remaining care team and that is still up for discussion.
- A DRT member noted that related to earlier discussions around C-section rates, a PMPM model would better support reducing low-risk C-sections as opposed to incentivizing it.
    - Ke responded that a PMPM could mitigate the choice between C-section and vaginal delivery because the rate is the same for all members in your panel that month. This creates room for the care team to decide (when a choice is present). From a provider perspective, they might have an incentive to be more efficient.

Ke overviewed a comparison of the three different payment mechanisms and encouraged folks to review and follow up with the Stakeholder Engagement Team with any thoughts or questions.

4. Looking Ahead

Suman wrapped up the meeting by providing next steps.

- There will be an optional office hours held on August 29.
- The final DRT session will be on Thursday, September 12.
- DRT members can also email the stakeholder engagement team at HCPF_VBPStakeholderEngagement@state.co.us.