COLORADO
Department of Health Care Policy & Financing

303 E. 17th Ave. Suite 1100
Denver, CO 80203

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New Maternity APM: Model Design Townhall Questions & Answers

This document summarizes:

All stakeholder questions received during Colorado Department of Health Care Policy & Financing's (Department) stakeholder engagements (Town Halls) on May 29, 2025, June 3, 2025, and June 10, 2025.

Below each item, the Department has provided an *interim* response.

Important Note: There are several stages of policy development and implementation. Any responses in this document represent a snapshot of the Department's position as of September 2, 2025 and should not be read as final policy determination.

Where can I find policy changes and updates on the New Maternity APM?

Department's New Maternity APM webpage:
https://hcpf.colorado.gov/maternity-alternative-payment-model

Provider Types and Participation

This section addresses which providers are eligible to participate in the model and how inclusion is being determined.

Are Midwives, Doulas, and freestanding birth centers included as providers of the New Maternity APM?

- **Midwives** are included as eligible providers in the New Maternity APM.
- **Doulas** with a Medicaid provider ID employed by a participating group may share in savings, as payments are made at the Tax Identification Number (TIN) level and distributed by practices. The role of independent doulas is still under discussion.
- **Freestanding birth centers** are being evaluated. The Department is actively exploring how the APM could meaningfully support and engage them in the future.

Which providers are included in the New Maternity APM?

- Colorado Medicaid-enrolled providers who deliver prenatal care, labor and delivery services, and/or postpartum care are eligible to participate in the New Maternity APM.

What criteria does the Department use to determine whether a provider type is included or excluded from the model?

- A range of provider types are eligible to participate in the model. However, inclusion may depend on specific criteria such as attribution rules, patient volume thresholds, and other pending programmatic methodology requirements that are dependent on the three perinatal phases (prenatal, labor and delivery, and postpartum). These thresholds help ensure fairness and validity in evaluating provider performance.

Does the New Maternity APM apply to Federally Qualified Health Centers (FQHCs)?

- Yes, the program applies to Federally Qualified Health Centers (FQHCs). The model is structured around three perinatal phases—prenatal, labor and delivery, and postpartum—with the following implications for FQHCs:
    - **Prenatal phase**: FQHCs may be eligible for shared savings. However, their eligibility in the payment methodology will depend on how the prenatal payment mechanism is structured, acknowledging FQs already are encounter-based.
    - **Labor and delivery phase**: FQHCs are not eligible for shared savings in this phase, as only delivering facilities are included.
    - **Postpartum phase**: FQHCs are eligible to receive postpartum incentive payments.

PMPM Structure, Risk Adjustment, and Shared Care Scenarios

This section addresses how the possibility of the PMPM model would be structured, how risk adjustment is applied, and how the model handles shared care scenarios and provider assignments.

How is the prospective per-member-per-month (PMPM) different from the maternity bundled payment?

- This likely refers to the OB global payment, a bundled model that covers prenatal care, delivery, and the postpartum visit, usually paid after the postpartum visit. This can delay payment for care provided much earlier. Our proposed PMPM provides predictable, upfront payments. Stakeholders have shared that this approach better supports early investment in prenatal services, staffing, and patient support.
- Core prenatal services would be covered under the PMPM, while additional services would continue to be paid on a fee-for-service basis.

Does the PMPM work similarly to a capitation payment? How are members assigned to providers, and what if the provider isn't seeing the assigned patient?

- Yes, the PMPM is similar to capitation. It’s a prospective payment based on member volume, projected from historical volumes. We're still finalizing how members will be attributed to providers related to PMPM historical volumes. In common practice, the number of members being paid per month will be stable within a rate and member counts adjustment cycle, regardless of the actual number of members a provider sees in a given month.

Since PMPM is prospective, what’s the notification process to receive the payment?

- The notification process is still being discussed. We’re working through how and when providers will be informed of assigned members and upcoming payments to ensure clarity and predictability before the PMPM is issued. In common practice regarding PMPM payments, providers receive a fixed amount on a monthly basis until the PMPM rate changes, which will be communicated to providers in advance.

What if the provider seeing the member isn't being paid for the member?

- Since the PMPM will be based on historical volumes, a provider will receive a PMPM based on their previous case load. PMPM payment is not member-specific. For a given month, the number of members being paid is fixed, which means that some providers will be paid more than the actual number of members they see that month, while others will be paid less than the actual number of members they see that month. However, a reconciliation process will be performed periodically to help ensure the PMPM can be adjusted to account for any changes in volumes.

What happens if a Health First Colorado (HFC) member loses HFC coverage?

- The model includes three phases—prenatal, labor and delivery, and postpartum. If a member loses Health First Colorado coverage, providers may still receive payment for any phases that were completed while the member was enrolled. This helps ensure providers are compensated for care already delivered, even if coverage changes during the episode.

How will the model adjust for providers seeing more high-risk patients (e.g., more preterm births or low birth weight)? Or seeing patients who need more support (e.g., have chronic health conditions or social challenges)?

- We are exploring a risk adjustment methodology to potentially account for various member risk levels at the individual provider level and incorporating additional maternity-specific risk factors into the methodology to account for the unique needs of the population. In addition, we plan to stratify quality measures by race and ethnicity to better understand and address disparities.

Encounter Billing and Fee-for-Service

This section addresses questions about the relationship between the possibility of an encounter-based billing and traditional fee-for-service, including how different care settings and visit types (e.g., telehealth) may be reimbursed.

With encounter billing, how will the Department ensure providers do not overuse prenatal visits unnecessarily?

- The Department is committed to supporting evidence-based prenatal care. Encounter billing will be aligned with clinical guidelines to encourage appropriate visit schedules. We're also exploring ways to monitor utilization patterns to ensure visits reflect patient needs, not volume, while trusting providers to deliver care based on best practices.

Would encounter payments require monthly billing separate from FFS billing?

- No, encounter payments wouldn't require separate monthly billing. For each visit, providers would submit an encounter claim with the appropriate codes to identify the service provided (similar to fee-for-service billing).

Outcomes and Performance Measures

This section focuses on how clinical and equity-focused outcomes will be measured, how they will be tracked, and how those measures will influence payment or incentives.

How will data points be collected?

- Claim data would be the major source of data points for the Department. We also use some data collected by other state agencies, such as birth certificate data from the Colorado Department of Public Health & Environment (CDPHE).

How will the patient experience during labor and delivery be measured? Will it evaluate respectful or culturally responsive care during delivery?

- Improving patient experience across all stages of the perinatal journey is a core goal of the program. We plan to first define patient experience and identify nationally recognized tools that measure key elements such as respectful, culturally responsive care and transitions between providers, then to deploy this survey tool during initial program years to capture feedback throughout pregnancy, delivery, and postpartum.

Who pays the incentive payments—HCPF, RAEs, or some other funding source?

- HCPF will be the one providing the incentive payments for the New Maternity APM. It is also possible, although not yet finalized, that RAEs may be involved in the provider payment process.

Postpartum Care

This section focuses on how postpartum care—including care transitions, shared responsibility, and reimbursement—is handled under the model.

Will providers still be reimbursed for labor management if a patient is transferred to another facility for delivery?

- Even outside of the APM, providers are reimbursed for any services they deliver according to the Colorado Medicaid fee schedule. If a provider manages labor but the patient is transferred before delivery, they will still be paid for the care they provided.

Is postpartum follow-up tied to the delivery facility or the prenatal provider?

- Postpartum follow-up is tied to the provider who sees the member for their postpartum visit. This could be the same provider who delivered prenatal care, the delivery provider, or a different provider entirely, whoever delivers the postpartum care.

How will the model ensure providers are compensated for postpartum care if the patient misses follow-up visits due to barriers outside the provider's control?

- If a postpartum visit doesn't occur, the provider would not receive payment. However, the postpartum incentive payment is designed to encourage outreach and support efforts that help more members return for care.

Does the model support follow-up care for birth-related complications or chronic conditions diagnosed postpartum?

- When a member comes in for a comprehensive postpartum visit, providers can address both birth-related complications and any chronic conditions identified after delivery. The model is designed to support this kind of whole-person care during the postpartum period.

Does the model account for extended postpartum needs beyond 60 days, particularly for high-risk or medically complex patients?

- The program focuses on the first 60 days postpartum, which is a critical period for monitoring complications and sequelae related to pregnancy and delivery. While the model does not currently extend beyond 60 days, Colorado Medicaid will continue to cover postpartum coverage for a year after a member's pregnancy ends.

How will the APM model address transitions in care when patients change providers between delivery and postpartum follow-up?

- The program recognizes the importance of smooth care transitions and is interested in identifying tools, such as checklists or care coordination supports, that can help providers and patients navigate these handoffs across the perinatal journey. This is an area we're actively exploring and eager to learn more about.

For more information, contact:

Kathleen Le at Kathleen.Le@state.co.us

Department of Health Care Policy and Financing (HCPF)