Bree Collaborative | Perinatal Bundled Payment Model Workgroup
July 28th, 2020 | 9:00-10:30
Virtual

Present

Molly Firth, MPH, Patient Advocate
Rita Hsu, MD, FACOG, Obstetrics and Gynecology, Confluence Health
Janine Reisinger, MPH Director, Maternal-Infant Health Initiatives Washington State Hospital Association
Dale Reisner, MD, Obstetrics and Gynecology, Swedish Medical Center
Judy Zerzan, MD, Chief Medical Officer, Washington State Health Care Authority
Blair Dudley, Pacific Business Group on Health
Ginny Weir, MPH, Bree Collaborative
Beth Tinker, Health Care Authority
Amita Rastogi, MD, MHA, FACHE, VP Commercial Lines, Episodes of Care Medical Director, Signify Health
Tami Hutchison, Signify Health
François de Brantes, MA, Senior Vice President of Commercial Business Development, Signify Health
Mike Barsotti, MD, Neonatologist, Providence Medical Group Hospitalists
Vivian Souter, MD, OB COAP

INTRODUCTIONS AND APPROVAL OF MINUTES

Ginny Weir, MPH, Bree Collaborative, opened the meeting and those present introduced themselves, their background, and what brings them to the meeting today.

REVIEW 2019 BREE BUNDLE

Ms. Weir began a discussion of achieving dyadic care through considering whether and how to add care for the newborn up to 30 days post-delivery. Those present discussed:

- Being a supporter of dyadic reimbursement when all goes well but that issues can exist in utero that are not evident with any factors having to do with the mother and figuring out who is at risk and how to fix that is challenging.
- Simpler and more appropriate to target term delivery and look at outcomes from those.
- Need to build in a look-back for cases that are really complicated that have nothing to do with the care that is given or the mom's preexisting conditions.
- Operating off the assumption that the newborn is healthy, and delivery has done well is problematic.
    - When you look at the pathway that the care takes if the baby is not healthy some is related to the prenatal care but some is not related to prenatal care.
    - As you open that up it gets complicated. Lots of studies that say if mom is not doing well baby will not do well. If we are going to do this we need to look at term healthy babies first.
    - We need pediatric providers here on the phone as well.
    - This is a pediatric discussion going forward. Will run up against an inpatient outpatient construct – neonatologist, family medicine, they may be employed by the hospital or not.
- Discussion needs to distinguish two things, outcomes and how these initiatives create a focus on measurement of outcomes and the payment or the cases
    - Payment – lots of cases that are quite expensive because of the outcome and the health of the baby. For Medicaid, almost all of that creating a relatively simple technique, stop loss or winterizing that caps the cost at ~$70,000. All of the cases have an automatic cap. Creates the right level of financial protection for all providers involved in the care. Limit exposure to the risk.
    - Metrics – if you only include the full-term baby you won't have a big impact on the outcomes for a population. Some providers object to being accountable for every baby that comes out and their health and subjected to significant financial costs.
- Being appreciative of simple financial models.

    - Having an outlier status answered to with a cap is simple.
    - We need to decide what our goal is. Is it to improve outcomes and quality or is it to save money. Worry about the scope of this if we include 23 week preterm infant and the care that the dyad requires and try to scope that the ask for a 40 week is so different. Different physiologies and different needs.
- Signify Health has implemented maternity bundles in Texas and New York. Pediatric outliers are not as big an issue as one would think, less than 1% who go over the stop loss. What is important is when the newborns are part of the bundle, the focus becomes on early intervention before 14 weeks of pregnancy, trying to reduce low birth weight. Has big impact in stopping smoking, diet, etc and reducing c-section rates.
- Within a bundle, looking at a cost savings perspective, that small population that needs that intense care would have more funding come to them through the shared savings approach. There are things that can happen prenatally to reduce possibility of NICU. Getting to a better place of appropriate NICU utilization.
- Concern that bundles like this start to impact maternity care access. Many counties have no maternity care access. Geographically remote counties have difficulty with access. One cost outlier would cause them to lose too much money and not want to provide care. Many of these patients do not have resources.
- Tremendous benefits of dyadic care. If we were only to include term babies is an equity piece. Disproportionately impacts minority patients. The care that can happen because of coordination. Depression and anxiety can sometimes have lifetime impacts on infants also substance abuse. Critical importance of that relationship between the infant and the parent.
- Revised bundle would include the first 30 days of the baby's life not the first year. Then it becomes a pediatric issue.
- We can't discuss cost but having pediatric providers involved in this discussion is important as is defining how the payment gets dispersed between the providers.
- Unreasonable for the obstetric care provider to be financially responsible for poor quality care that the pediatrician does or does not do.
- Ideal is to extend postpartum Medicaid for a year. In the first 30 days there is a lot that can be done.
- How to divide payment and how to differentiate retrospective and prospective models. In prospective model there is a preestablished price for the episode and whoever the accountable entity is has to divide the reimbursement. Most programs are initially retrospective which eliminates the issue of a provider having to pay other providers. The model establishes the target price prospectively and providers continue to be paid just as they are today. On a quarterly basis there is a retrospective lookback to see whether the target price was exceeded or missed.
- NICU level can be designed before delivery and in models that excluded NICU level 4, more babies than needed were but in a NICU level 4 which drove up the cost of maternity care. Better to include all and do a stop loss.
- Administratively linking the obstetric care provider and the pediatric care provider
    - Can help with the maternal mental health front as well. If there is a chance for additional screening in a pediatric visit for anxiety/depression. That information transferring from the pediatric provider
    - The bundle doesn't solve for all these communication issues – it offers and incentive
- Issue of large diversity in newborn care such as a baby born at 23 weeks and one born at term.
    - Is one month enough time to get any kind of outcome for differences.
    - Need to think about equity of access to this coordinated care. Anyone who is excluded loses the benefit of the dyad.
- Discussing what happens financially when baby has to be transferred to a higher level of care then back to a lower level of care (step down care)

    - Federal legislation that if the baby needs to higher level and then returns the home community the hospital does not get reimbursed. You can be reimbursed from a lower to higher level of care but not the other way.
    - Tami will look into the issue. Very low birth weight babies are unexpected.
- How to include opioid use disorder treatment as an integrated service
    - Need to keep this separate not as part of the bundle.
    - Issue of addressing substance use disorder and other issues that coincide with a global maternity episode is a conversation many providers, plans, and states are having but need to separate clinical outcomes and how the episode is administered.
    - The options for administering substance use disorder include creating a modifier to the episode for moms with a history of substance use disorder, standing up two different episodes, excluding the services, or excluding the people.
- Desire to focus on the majority of women who deliver at 37 weeks and above and expanding to more high-risk groups if that is successful coupled with desire to have clinical impact on populations that need more care.

Next steps: Include pediatricians in next meeting August 25th.

CLOSING COMMENTS

Ms. Weir thanked all for attending. The meeting adjourned.