Bree Collaborative | Perinatal Bundled Payment Model Workgroup
August 25th, 2020 | 9:00-10:30
Virtual

Present

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
Blair Dudley, Pacific Business Group on Health
Ginny Weir, MPH, Bree Collaborative
Alex Kushner, Bree Collaborative
Beth Tinker, Health Care Authority
Tami Hutchison, Signify Health
Mike Barsotti, MD, Neonatologist, Providence Medical Group Hospitalists
Josephine Young, MD, Premera Blue Cross
Brian Simmerman, MD, General Pediatrician, Providence Health
Andrew Busz, Policy Director, Washington State Hospital Association
Bat-Sheva Stein, RN, MSN, Washington State Department of Health
Sarah Doxey, Director, Providence Health
Edna Maddalena, Program Manager, Washington Chapter of the American Academy of Pediatrics
Mark Schemmel, M.D., Obstetrics and Gynecology, Providence Health

INTRODUCTIONS

Ginny Weir, MPH, Bree Collaborative, opened the meeting and those present introduced themselves, their background, and told others in attendance what—in their opinion—would be the best and worst outcomes for this group's work.

- Rita Hsu, MD, FACOG, Obstetrics and Gynecology, Confluence Health, said that the best outcome would be to incentivize collaboration. However, she worried that rural areas might not have the resources for collaboration; this could lead to patients in rural areas having more limited access. Other members of the group echoed these points.
- Other thoughts and concerns that were voiced in this opening:
    - Best outcome would be cost containment.
    - One challenge will be the large gap in coordination of care between child and mother.
    - One attendee worried about pediatrician reimbursement—they are already paid lower than other doctors.
    - Bundle could add financial risk for patients.
    - Pediatricians may be skeptical of the bundle and will want to know the math behind it.
    - One attendee expressed a desire for the adoption of an episode definition that would be consistent across all payers.

GENERAL DISCUSSION

Ms. Weir asked the group to think about step-down care reimbursement—an issue that came up and was unresolved last meeting.

- The issue is that, if an infant is transferred from the birthing hospital to another hospital, they could potentially run out of total days of insurance coverage. Medicaid will not pay for transport to a lower level of care, and there are also often issues with the accepting hospital receiving any payment at all. This leads to birthing hospitals not bothering to send newborns back to a more local area.
    - A challenge here is that it is hard to prove that a transfer to a local area is medically necessary; some view transfers as being done for purely social and monetary reasons (however, we know those can also impact health outcomes).

- This is a problem for poorer patients in rural areas who have to drive into a city rather than getting the care closer to home.
    - One possibility is to change the WACs so that the language does not hinge on "medical necessity".
    - The group can also use the argument of social determinants of health: being in a more socially appropriate area would lead to better health results for mother, baby, and family.
    - Ms. Weir will think with Beth Tinker, Health Care Authority, about how to change the WAC language.
    - An attendee pointed out that, in newborn care, 90% of the volume is in level 1 care, but 70% of the cost is in level 2 or higher care. Stepdown can play a significant role in bringing down total costs.
- Ms. Weir pivoted to including pediatric care in the bundle. What would it take to include 30 days of pediatric care in the bundle?
    - One attendee asked if there are examples of states doing this successfully?
    - Tami Hutchison, Signify Health, said that there are many states doing global maternity episodes that include the newborn in the episode definition. She added that there are some misperceptions about how risk is managed and where risk lies—everything is contracted through OB and everyone gets paid as they would in a regular FFS world.
        - Signify is currently working with 6 states on Medicaid global maternity episodes for 2021. The reason to include newborns in the episode definition is that this has the most chance of improving quality and reducing cost. NICU placement for the baby is very important for reducing total cost.
- Ms. Weir asked what the mechanics of including the newborn would look like.
    - Possibility to include an incentive metric around coordination between the OB and pediatrician.
    - Another attendee mentioned that the perfect model for this would be a family practice doctor who does OB.
        - Another attendee added that these family practitioners do not typically take care of the highest risk patients.
- The group agreed that the ultimate goal of the bundle is to improve the quality of care—this takes priority over reductions in cost.
- The group discussed the possibility of mapping out each decision point and how care diverges based on those decisions. This map would show all the trigger points for decisions but would not define how providers have to decide.
    - An attendee recommended mapping out the care pathway for the newborn before creating a bundle payment.
- Ms. Weir summarized that a big issue for the group is care coordination around the newborn.
    - Ms. Hutchinson added that episodes of care are done to incent care coordination. The key is in identifying whether to insource or outsource the resources needed for an episode of care.
- Ms. Weir, in response to a question from the group, said that the timeline would be, ideally, to finish revisions by the end of the calendar year.
- Mike Barsotti, MD, Neonatologist, Providence Medical Group Hospitalists, spoke about what the role of the pediatrician would be given that the OB is in charge of the bundle.
    - Pediatricians would be responsible for some of the maternal education around the newborn and would be responsible for some of the follow up for the first 30 days.
    - They would potentially also be involved in risk-assessment for depression or SUD in the mother. Then there would be a handoff to the neonatologist if the baby turned out to be ill.
        - Multiple others agreed with this assessment.
- The group discussed the lack of a link between the EHR data of the OB and the pediatrician. Doctors will still have to sign release of information forms—this is a barrier to good communication.

    - If the pediatrician is involved in screening for postpartum depression, it is hard to get that info to the OB.
- The group discussed the integration of support/community services in the model. This may not be something that is in scope for the bundle to address.
- Ms. Hutchison spoke about the importance of quality metrics and establishing an episode price.
    - An ideal program would have incremental quality metrics to which incentive and gain sharing payments are tied.
        - One of these, for example, would be depression screening (also substance use disorder screening).
    - Ms. Weir asked about quality metrics around coordination of care if someone screens positive for things like depression.
        - Ms. Hutchison: you do not want to duplicate the incentive alignment properties of the episode itself—the incentives of the episode should encourage quality coordination.

Action Item: Ms. Weir to follow up with Dr. Barsotti on language to articulate where responsibility lies within episodes.

CLOSING COMMENTS

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