
Bree Collaborative | Perinatal Bundled Payment Model Workgroup

October 27th, 2020 | 9:00-10:30

Virtual

Present

Rita Hsu, MD, FACOG, Obstetrics and
Gynecology, Confluence Health

Dale Reisner, MD, Obstetrics and Gynecology,
Swedish Medical Center

Ginny Weir, MPH, Bree Collaborative

Alex Kushner, Bree Collaborative

Beth Tinker, PhD, MPH, MN, RN, Health Care
Authority

Mike Barsotti, MD, Neonatologist, Providence
Medical Group Hospitalists

Josephine Young, MD, Premera Blue Cross

Mandy Weeks-Green, Senior Health Policy
Analyst, Officer of the Insurance
Commissioner

Molly Firth, MPH, Patient Advocate

JD Fischer, Manager, Value-based Purchasing,
Washington State Health Care Authority

Tami Hutchison, Signify Health

Vivienne Souter, MD, Medical Director, OB
COAP

INTRODUCTIONS

Ginny Weir, MPH, Bree Collaborative, opened the meeting and those present introduced themselves and gave their background.

GENERAL DISCUSSION

Ms. Weir explained to the group that the goal of this meeting would be to finalize the document before sending it to the larger Bree Collaborative for approval for public comment.

- Rita Hsu, MD, FACOG, Obstetrics and Gynecology, Confluence Health, brought up the issue of how the bundle will distinguish which events are related to birth when treating a newborn (within our 30 day coverage period) who comes back in for care.
 - The group agreed that it would make sense to look at other bundles that have done this successfully to decide what is related to the perinatal event and what is not. In other words, what is excluded?
- Related to the above discussion, Tami Hutchison, Signify Health said that, other than trauma, her practice does not have exclusions for perinatal coverage. However, they also have stop loss and loss caps in place.
 - Congenital malformations terminate a coverage episode and move the birth to fee for service.
 - Ms. Weir: we want to add language that says when an episode is terminated—episode is terminated when congenital malformation is found or twins or higher order multiples are found.
 - Josephine Young, MD, Premera Blue Cross clarified that sometimes congenital malformations do not affect the baby in the first 30 days, so do we always want to terminate the episode?
 - Other members argued that it is cleaner to terminate the bundle episode in this instance, especially because we do not want to incentivize providers not to see babies with congenital malformations. And additional expenses for non-impactful malformations are going to be low.
 - Dr. Hsu added that excluding malformations from the bundle would help smaller rural clinics accept the bundle as well.

Action Item: Ms. Weir to follow up with Mike Barsotti, MD, Neonatologist, Providence Medical Group, to generate a list for the appendix of major congenital malformations.

- Related to the discussion on what types of care should be excluded from the bundle for the baby, Dr. Young and Dr. Barsotti recommended looking at claims data in the first month of life for babies as a way to help decide what is excluded.
- The group discussed language to add on a perinatal bundle for patients who have Opioid Use Disorder (OUD) or substance use disorder. Ms. Hutchison argued that these parents should not be excluded from a bundle, but they will need their own custom-tailored bundle (or to have a different price set for the bundle).
 - Ms. Hutchison also recommended making OUD screening a mandatory quality gate to incent screening and proper diagnosis.
 - Language was added addressing OUD patients and stating that the price and pathway for a perinatal bundle for this population should be different than the bundle described by this workgroup.
- Vivienne Souter, MD, Medical Director, OB COAP, asked about including language around preventing unnecessary Newborn Intensive Care Unit (NICU) admissions. Dr. Barsotti talked about hypoglycemia: there are strict guidelines in Washington now to help decrease NICU admission through the use of oral gels.
 - In terms of hyperbilirubinemia there is little to do to prevent it in the first few days of life. It is also a symptom, not a cause, and so there are many underlying issues that could cause it to happen. Hyperbilirubinemia is too broad of a category to make a statement about it and the etiology is too broad.
 - There are, however, things that you can do to decrease the amount of hyperbilirubinemia, and this should, in turn, help decrease the need for the NICU.
 - The group could consider creating pathways to help those with less experience manage hyperbilirubinemia in the hopes of reducing NICU rates. Nothing was decided on to be added at this time.
- Ms. Weir: it would be helpful to explain loss caps and retrospective versus prospective bundles, and to add a general discussion of what payment looks like for the bundle.
 - Ms. Hutchison mentioned that there will be payor specific implementation decisions that have to be made.
- Dale Reisner, MD, Obstetrics and Gynecology, Swedish Medical Center spoke about the need to give providers the bundle money for patients regardless of whether bundled patients are transferred—the group does not want to disincentivize transferring.
 - The HCA does not cover transfer from a higher level to lower level of care. Beth Tinker, PhD, MPH, MN, RN, Health Care Authority, added that changing this would require a change to the WAC.
 - The sticking point for the state on this was the high cost of transfer.
 - The group decided that this could be something that is solved after the public comment period.

Action Item: Dr. Reisner to do some research on the issue of covering patients who are transferred and get back to the group.

- Under the clinical pathway section of the document, removed language from Newborn, 2-5 days of birth, and 30 days of birth sub-sections that reads “A physical examination that includes”.
- Within 30 days of birth bullet: removed “Within” from title.
 - Changed “10-14 days” bullet to “7-14 days newborn screening”.
 - In the Hepatitis B immunization bullet, added clarification that this could be dose number two.
- “Immunization counseling” added under the “Newborn” bullet and “30 days of birth” bullet to allow for the fact that parents may decline vaccines. Added that immune counseling should recommend Hep B.
- The group discussed the language under the “Pediatric visit scheduled” bullet in the Quality Metrics section. Should language be added about designating a primary care provider (PCP) for the baby?

- The group agreed that hospital providers need to assist in encouraging parents to choose a PCP for the baby and help ensure the scheduling of an appointment.
 - It is hard to mandate that this appointment be kept, and it is also hard to track compliance.
 - Attendees discussed that it is the responsibility of the pediatric clinic to follow up on newborn appointments that are no shows.
- The group decided to keep this bullet and add in language about referral and transfer of information. It now reads: "Pediatric visit scheduled or referral process initiated. Developed by the workgroup. Percentage of newborns with first pediatric visit scheduled or referral to pediatric care made prior to leaving inpatient care or if delivery occurred outside of the inpatient setting, while the obstetric care provider is present in the delivery setting including transfer of pediatric discharge information."
- Molly Firth, MPH, Patient Advocate, brought up the 2-5 days requirement for having a follow up appointment. She was discharged after her baby and it was hard to get into the clinic within 5 days with both mother and child.
 - **Ms. Weir to add language about taking into account when the gestational parent is discharged.**

CLOSING COMMENTS

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