May 20, 2016

To: Health Care Payment Learning & Action Network
From: American College of Nurse-Midwives
Letter via Email to: paymentnetwork@mitre.org

RE: Maternity Care Draft White Paper

To Whom It May Concern:

On behalf of the American College of Nurse-Midwives (ACNM) I am pleased to submit these comments in response to the Maternity Care Draft White Paper issued by the Health Care Payment Learning & Action Network on April 22, 2016. We hope you find our comments helpful and look forward to your response in the final document.

COMMENTS

Below are our comments on the specific recommendations and questions raised by the draft document. We have numbered them as they appear in the document.

Recommendation 1. Episode Definition

We appreciate the recommendation that low-risk be defined broadly so as to capture larger groups of women. We believe that the types of quality improvement efforts likely to arise from a bundled payment arrangement would be beneficial to many, if not all women, not just those falling into a narrowly defined low-risk category. We support this recommendation.

The goals that a given organization seeks to address should inform the way in which the episode is defined. For example, if a payer wishes to improve the delivery of prenatal care, a bundled payment arrangement may be restricted to that aspect of maternity care. We recommend acknowledging that where a payer wishes to focus improvement on a specific aspect of maternity care, the episode may be defined more narrowly to accomplish that goal.

Recommendation 2. Episode Timing

We appreciate and support the variation in the episode timing for the mother and the infant. As drafted, the recommended timing for the mother ends 60 days post-discharge. Currently approximately one-third of women give birth via cesarean section, a major surgery that entails a significant recovery time, other women may have conditions such as hypertension or postpartum depression that persist beyond the 60 day window. We recommend that the draft acknowledge

8403 Colesville Road, Suite 1550, Silver Spring, MD 20910-6374 240.485.1800 fax: 240.485.1818 www.midwife.org

that for these women, the episode timing may need to be extended to as far as 120 days post-discharge.

Recommendation 3. Patient Population

As noted above, we support the recommendation that the patient population be defined broadly to include as many women as possible. We anticipate that provider organizations agreeing to accept episode-based payments are likely to implement a range of activities that will benefit many women, even those with conditions that would increase their risk and we would want to see as many women as possible benefit from those activities. We believe that sufficient recognition of increased costs associated with higher risk pregnancies should be built into the payment methodology, to encourage providers to include such women in their programs. This is particularly important for provider organizations caring for smaller numbers of women where a small number of patients with outlier costs could offset savings generated with the rest of their patient pool.

4. Services

We strongly support the recommendation that the episode be defined and priced in a way that includes high-value support services that may be less commonly used. Further, as evidence emerges about the value of these types of services or practices evolve to include them, the episode should be revised to reflect that change.

6. Accountable Entity

The draft document indicates that the Work Group "favors clinicians as the preferred accountable entity," and acknowledges that in some cases the interests of clinicians and facilities may diverge. However, the draft then goes on to say that "optimally, accountability would be shared among all involved providers" and that "accountability should be shared between the clinicians and the facility."

We recommend that the draft emphasize the importance of shared accountability among clinicians and facilities. Hospital administration may impact whether certain evidence based clinical practices are allowed in the facility, such as the provision of nitrous oxide during labor, access to vaginal birth after a prior cesarean delivery, or facilitating intermittent auscultation instead of routine continuous fetal monitoring. Clinicians may desire to implement such practices in an effort to improve quality or reduce costs, while the facility may be motivated by liability concerns or the expense associated with staffing or infrastructure changes necessary for their provision. Shared accountability for outcomes and costs should help these two groups find common ground and we recommend that the draft be revised to emphasize the importance of such cooperation. Ideally, accountable entities would be selected based on their ability to engineer real change in how care is delivered, focusing on quality improvement, not just cost savings.

We caution that it can be very difficult for multiple clinician and facility organizations to come together and form the legal structure necessary to accept joint accountability for an entire episode

of care. The challenges in creating these structures, with the potential need to proceed in incremental steps, should be acknowledged in the White Paper.

We believe that the White Paper should encourage payers and the accountable entities to consider structuring care delivery so that the most appropriate provider is available for a given patient. Specifically, accountable entities should be encouraged to discuss the option of midwifery care and birth centers with women who are capable of normal physiologic birth, while simultaneously making sure that smooth transfers of care to higher acuity settings can take place when necessary.

7. Payment Flow

We support the preference for prospective payments. We believe this allows the accountable entity more leeway in deciding how to disburse the money in a fashion that will support its efforts to improve quality and reduce costs. Further, it reduces the individual focus inherent in a fee-for-service environment, which will exist to some extent even in the presence of a methodology relying on retrospective adjustment. Fostering care coordination and group communication will be better accomplished under a prospective arrangement.

We recognize, however, that a prospective payment methodology could result in stinting of care and that it is important to have in place a range of quality measurements to ensure that inappropriate reductions in care, or exclusion of high value, less commonly used services such as doula care or group prenatal care are not excluded from the package offered by the accountable entity.

Because women frequently change providers during the course of their pregnancy, it is important that the White Paper acknowledge that payers and providers will need to come to some sort of agreement about how prospectively given payments will be adjusted when this occurs. We recommend that the draft be revised to include mention of this reality in the section on Payment Flow.

The White Paper could acknowledge that it is possible for some state Medicaid programs, which constitute the most important payer for maternity services, to provide bundled payment. When this occurs, it may be helpful to both providers and commercial payers in the state to use the same or a similar approach. For the providers, it ensures that their behavior across their entire patient population can be consistent, which eases their practice operations. For payers, it ensures that providers don't try to cost shift between them, although it may be more complicated for those payers who operate in multiple states and wish to use a single approach across their entire service area.

8. Episode Price

The draft White Paper recommends pricing the episode based on a combination of provider and region specific costs. The White Paper recognizes that there can be significant variation in these costs between regions and among providers in the same region, which argues in favor of a rate based on regional and provider specific data. We support a blended approach.

We are concerned that long term success of episode pricing based on past performance may be unsustainable. Typically in these approaches to payment, a benchmark is set based on data from a prior period of time. The accountable entity then seeks to better the benchmark during its performance period. Assuming the accountable entity continues in this arrangement, benchmarks for subsequent performance periods will be based on a *prior performance period*. Thus, the accountable entity is put in the position of perpetually attempting to best its own past performance. At some point, appreciable gains in quality or cost reduction are likely to be very minimal. If the accountable entity is held to standard of constantly improving performance, at some point participation in this arrangement becomes untenable. Payers and accountable entities seeking to enter such a reimbursement methodology for the long term should carefully and regularly review evidence and best practices to identify where they lie and how to price the episode to sustain that level of performance, rather than continuously attempting to reduce payments over time to the point where it becomes impossible to deliver optimal care.

Finally, we support the inclusion of costs for historically underused services in the episode price.

9. Type and Level of Risk

We support the inclusion of risk adjustment methodologies into the payment mechanism. Providers should be given opportunity to comment on or give input into the risk adjustment methodology used in determining their payments and should be given assistance to understand how their patient population would be scored by the selected risk adjustment methodology.

In addition to discussing approaches to risk adjustment, the draft White Paper reviews the use of upside and downside financial risk. The White Paper mentions the approach of using a transition to downside risk arrangements, however, it is not clear when such an approach may begin. It would be very helpful if the paper could point readers to situations in which the mechanism or state of affairs that triggers a transition to downside risk has been identified.

We are concerned that methodologies for determining up and downside risk may impact clinicians and facilities differently, which may create unusual dynamics and incentives. Payers and accountable entities should think carefully about how risk structures are implemented to ensure that they encourage cooperative behavior between clinicians and facilities.

10. Quality Metrics

We strongly support the use of quality metrics that have been endorsed by a nationally recognized body such as the National Quality Forum, or by large, multi-stakeholder groups.[1] We also support the recommendation that preference be given to alignment of measures across programs to reduce the reporting burden.

We strongly support the recommendation that quality information be used to communicate and engage with patients. Patients need to understand the meaning and impact of these data and be

---

[1] See for example, Frayne, D. J., et. al. "Consensus Statement: Health Care System Measures to Advance Preconception Wellness," *Obstetrics & Gynecology*, vol. 127, no. 5, pp. 863-872.

able to access them before making critical choices about their providers and birth setting. These data should be publicly available to prospective as well as current patients.

2. Data Infrastructure

In order to accurately attribute economic and quality performance, payers must be able to precisely determine who the rendering provider is for the services included in the episode of care. Currently, many payers reimburse certified nurse-midwives (CNMs) and certified midwives (CMs) (as well as many other provider types) at some percentage of physician rates. Because of this payment differential, the services of these providers are often frequently billed under the number of a physician or group practice because when done so, they are reimbursed at the physician rate. This practice, known as “incident to billing” is a policy of the Medicare program that has been adopted by many other payers. Incident to billing obscures the actual rendering provider. As a result, it can be impossible to use administrative data to accurately attribute performance among providers.

According to CDC data, CNMs and CMs attended 8.33% of all births during 2014. In some states, this number was over 20%, making them significant providers of maternity care. If their performance is obscured in claims data, it will not be possible to establish an accurate value-based purchasing program at the provider level.

We strongly recommend that the White Paper be revised to encourage payers to reimburse CNMs and CMs at the same level as physicians. This removes the financial incentive for incident to billing, recognizes the demonstrated professionalism of these providers and is a matter of basic fairness. Second, we recommend that payers establish billing requirements to identify the actual rendering provider so that their systems will capture this crucial data.

Moving Forward: Priorities for Supporting Maternity Care Episode Payment

We are concerned about the potential impact of episode based payments on rural settings where it can be very difficult to establish a group of accountable providers who can provide the full range of needed services. As payers seek to transition their provider networks to episode based payment, they should take into account the varying abilities of provider groups to provide the entire bundle based on the presence or absence of various specialties in their areas. It may be much easier for an urban professional to refer a patient out to a maternal fetal medicine specialist, or for a woman with a normal pregnancy to find a birth center. The absence of these provider types will curtail the ability of rural providers to render the most cost effective care. This should be taken into account when determining both the content of the episode as well as the resources made available to the accountable entity.

CONCLUSION

We thank you for the opportunity to comment on the draft White Paper. Should you have any questions regarding our comments, please reach out to me directly.

Sincerely,

/JSB/

Jesse S. Bushman, MA, MALA
Director, Advocacy and Government Affairs
240 485-1843
jbushman@acnm.org