FACT SHEET

**Issue Title:** Alternative Birthing Center (ABC) Reimbursement Methodology Statute Revision

**Background:** Existing law defines an ABC as a clinic that is not part of a hospital, and that provides comprehensive perinatal services and delivery care to pregnant women who remain in the facility for less than 24 hours (Health and Safety (H&S) Code Section 1204 (b)(4)). Existing law outlines the Medi-Cal Fee-For-Service (FFS) rate-setting methodology for ABCs, and requires that the Department of Health Care Services (DHCS) provide Medi-Cal reimbursement to ABCs for facility-related delivery costs at a statewide all-inclusive rate per delivery (Welfare and Institutions (W&I) Code Section 14148.8). The statewide all-inclusive rate per delivery cannot exceed 80 percent of the average Medi-Cal reimbursement to General Acute Care (GAC) hospitals with Medi-Cal contracts, and is based on an average hospital length of stay of 1.7 days.

The ABC providers bill for the all-inclusive delivery service using the local procedure code Z7516. The reimbursement rate methodology for this code is 80 percent of the average contracted rate for GAC hospitals with Medi-Cal contracts, as identified in the California Medical Assistance Commission (CMAC) annual legislative report. The all-inclusive rate per delivery was last adjusted in June 2015 with rates effective July 1, 2014.

Current law requires for the contract between the CMAC and the DHCS be dissolved, effective July 1, 2012, and transfers the CMAC rate-setting responsibilities to DHCS. Assembly Bill 102 (Committee on Budget, Chapter 29, Statutes 2011) also requires that DHCS develop and implement a payment methodology that is based on the Diagnosis-Related Groups (DRG) as specified in W&I Code Section 14105.28. Existing law requires DHCS to provide Medi-Cal reimbursement to ABCs for facility-related delivery costs at a statewide all-inclusive rate per delivery that does not exceed 80 percent of the average Medi-Cal reimbursement rate for all-inclusive deliveries to GAC hospitals with Medi-Cal contracts.

The ABCs are currently a mandated provider type that provides low-risk birthing services to Medi-Cal beneficiaries. On average, there are approximately 200 FFS all-inclusive births within an ABC each year. Along with providing pregnant mothers an alternative to traditional low-risk hospital births, ABCs provide cost-effective birthing services and help to reduce high overall medical costs as compared to low-risk hospitals births.

**Justification for the Change:** This legislative proposal is necessary for DHCS to implement an ABC reimbursement methodology that is based on the Medi-Cal DRG payment system, which replaced the CMAC system.

In addition, this legislative proposal would align existing law to reflect a rate-setting methodology that meets the requirements for the FFS ABC “all-inclusive delivery” service rate. The proposed change would keep the current rate methodology in place until at least
July 1, 2017 or until federal approvals are secured for the new reimbursement methodology. The proposed change will further specify the use of a DRG level-1 based GAC rate within the ABC rate-setting methodology. The proposal would also outline the following: 1) ABC reimbursements will not exceed provider charges made to the general public; 2) federal approvals must be obtained before implementing the revised methodology; and 3) reference to the application of the ten percent provider payment reduction, pursuant to AB 97 (Committee on Budget, Chapter 3, Statutes of 2011).

Additionally, DHCS proposes to: 1) remove certain provider and departmental reporting requirements that are not currently being administered and no longer necessary; 2) add cross-references identifying other provider licensing and oversight provisions, as applicable; and 3) remove the annual legislative reporting requirements in regards to the ABC provider type assessing “cost-effectiveness” and “quality of care.”

The inclusion of ABCs as a provider type eligible for FFS reimbursement in the Medi-Cal program was established in 1988, pursuant to W&I Code Section 14148.8, which was later amended in 2001. The ABC provider type was relatively new to the Medi-Cal program and an optional benefit when the statute was codified. Certain provisions were included to ensure proper “Licensing & Certification” oversight as well as quality assurance reporting requirements detailing the performance of ABC providers in the domains of “quality of care” and “cost-effectiveness.” With the expansion of the federal Affordable Care Act (ACA), effective January 1, 2013, the ABC provider type became a mandatory Medi-Cal benefit. Given the change from optional to mandatory, the additional provider and departmental reporting requirements are no longer necessary to evaluate ABC provider “cost-effectiveness” and “quality of care” per inclusion within the Medi-Cal program. Therefore, DHCS proposes to amend (b) and remove (c) of Section 14148.8, in order to align with current processes and other authorities.

Specifically, DHCS proposes to remove Medi-Cal caseload requirements, as they are no longer necessary because ABCs are currently a mandated provider type (W&I Code Section 14148.8 (b)(1) has been revised). The proposed language would accurately reflect ABCs as a mandated Medi-Cal provider type. The reference to H&S Code Section 1204.3 is included in order to cite other ABC provider regulatory provisions. This is necessary to maintain consistency and “clean up” statutes that need to be in alignment in regards to ABC oversight and certification standards.

W&I Code Section 14148.8 (b)(2) has been revised to incorporate: 1) a non-substantive capitalization of the title identifying the Comprehensive Perinatal Services Program (CPSP), 2) referencing a citation to CPSP related regulatory provisions in W&I Code Section 14134.5, and 3) removing the language regarding “If not currently certified, the facility shall be certified with the first year of operation,” given this requirement is also codified in W&I Code Section 14134.5. These changes will align the statute with current processes and provisions.

W&I Code Section 14148.8 (b)(3) has been revised to include “Licensed Midwives” as direct-care service providers within ABC facilities. This policy has been added to the Medi-Cal program in recent years, so it is important to identify in order to maintain consistency within Section 3.1-A of the Medi-Cal State Plan, and other areas of policy alignment.
W&I Code Section 14148.8 (b)(4) is being revised to clarify that ABCs must be certified by either the National Association of Childbearing Centers (as previously identified), “or at least equivalent standards as determined by the state department” given there are now equivalent associations rewarding similar certification standards.

The removal of W&I Code Section 14148.8 (b)(5-7) is needed to align with the removal of the annual legislative reporting requirements identified in subdivision (c). ABCs are now a mandatory provider type, which makes the “cost-effectiveness” and “quality of care” data reporting requirements for ABCs no longer necessary. The provisions in current (b)(5) are mirrored in other areas of the H&S Code Section 1204.3, and the provisions in (b)(6) and (b)(7) are specific to the reporting requirements in (c).

DHCS proposes to remove certain “provider-oriented” reporting requirements identified in W&I Code Section 14148.8 (c) since the “cost-effectiveness” and “quality of care” to Medi-Cal beneficiaries has been established through the mandated ABC provider type, which also follows the licensing and certification standards upheld by the California Department of Public Health. The additional reporting requirements are not required for Licensing and Certification or other Benefits-related provisions, and would be burdensome for DHCS to continue given: 1) the legislative report has not been completed to our knowledge, 2) there is no current process for providers to process the requirements set forth and report data, and 3) the ABC provider type has become an official Medi-Cal provider participant per ACA requirements.

Current subdivision (d) is proposed to: 1) become the new (c) due to the proposed deletion of the current provision (c); and 2) revised to extend a permanent “Provider Bulletin Authority.” The new authority would allow DHCS to administer the article by means of provider bulletins published on the Medi-Cal web page issuing further guidance and policy clarification to the ABC provider community regarding reimbursements.

Current subdivision (e) is proposed to become the new (d) due to the proposed deletion of the current provision (c) and realignment per the provisions in order.

DHCS proposes to add subdivision (e) to further clarify that no part of this article will be implemented without receiving the necessary approvals from the Centers for Medicare and Medicaid Services.

Summary of Arguments in support:
- Revising the current ABC rate-setting methodology to 80 percent of the DRG Level-1 in order for DHCS to be in compliance with existing law.
- The change to the reimbursement methodology for “statewide all-inclusive rates per deliveries” would result in an increased rate for ABC providers.
- The change would codify the use of licensed midwives to be utilized at ABC facilities consistent with the California State Plan.
- The change to remove or amend certain “provider-oriented” and “departmental-oriented” reporting and certification requirements would reflect updates in the administration of ABCs and align policies with other areas of law.
Estimate Issue #: PC 140. Alternative Birthing Center Reimbursement. 50% Title XIX / 50% GF (42601010001/0890) ACA Optional Expansion funding identified in PC 193 Funding Adjust —ACA Opt. Expansion. By amending the W&I Code to reflect a reimbursement rate that is 80 percent of the Level-1 DRG payment, the reimbursement rate would increase from $1,723.05 to $1,975.74, providing an additional $252.69 in reimbursement to ABC providers. The annual estimated fiscal impact resulting from this methodology change would create an insignificant cost increase of $50,000 Total Funds ($25,000 General Funds) to DHCS.