

January 28, 2015

Jennifer Kent
Director
California Department of Health Care Services
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

SUBJECT: 1115 Medi-Cal Waiver Maternity Care Provider Incentive Program

Dear Director Kent:

On behalf of Private Essential Access Community Hospitals (PEACH), representing California's community safety net hospitals, thank you for the opportunity to submit our recommendations on the Department of Health Care Services' (DHCS) proposal to develop a value based payment for Maternity Care in Medi-Cal Fee-for-Service. As outlined in the Waiver Provider Incentive workgroup in the "Straw Proposal 8: Value Based Payment for Maternity Services in Fee-for-Service Medi-Cal" DHCS has outlined some ways in which an incentive program could be implemented for maternity services provided to Medi-Cal Fee-for-Service beneficiaries.

Our members provide 38% of the Medi-Cal Fee-for-Service deliveries in the state and we are supportive of DHCS further exploring incentives tied to maternity care. We agree that there is merit in exploring the measures outlined in the California Health and Human Services Agency CalSim Maternity Care initiative including those tied to core measures around (1) Early Elective Delivery (2) Cesarean Section Rate for Low-Risk Births (3) Vaginal Birth After Cesarean Deliver Rate and (4) Unexpected Newborn Complications in Full-Term babies.

In addition, we are appreciative of DHCS' efforts to include private safety net hospitals within the scope of the Waiver. While the current DSRIP program only includes Public Hospitals, Private Safety Net hospitals are crucial partners in providing all Medi-Cal beneficiaries the full range of needed services, and are critical providers of obstetrical services within the Medi-Cal Fee-for-Service system.

Any such incentive program should be exactly that, an incentive program, and we encourage the department to think creatively as to how state funds could be used to draw down additional federal funds, either thru the use of State General Fund or thru the State's Shared Savings approach. As included in the Department of Healthcare Services Diagnosis Related Groups May 4, 2012 presentation, reimbursement to private hospitals for deliveries is 26% below the cost of providing such services to Medi-Cal Fee-for-Service beneficiaries. With no significant rate increases since 2010, that gap between payment and cost continues to widen.

We are concerned that many stakeholders involved in the discussion are unaware as to why current payments are higher for Cesarean Sections than for Vaginal Deliveries under the current payment system. Any further stakeholder discussions should make it clear that at its core, the APRDRG payment system is designed to pay more for inpatient services that use more hospital resources. This is reflected in the APRDRG assignment for C-Sections that reflect that an average length of stay is three days while the average length

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of stay is two days for a vaginal delivery. While the payment amount is more to the hospital providing the C-Section, the cost to the hospital is also greater and therefore we believe that it is a misnomer that the current system incentivizes more costly procedures.

It should also be noted that ultimately the decision to perform a C-Section is a decision made by the doctor in consultation with the patient. While we are supportive of further exploring an incentive program for hospitals, the Department should not lose sight of these factors outside of the hospital's control. In addition, studies referenced in the California Health and Human Services CalSim report suggest that there is racial and ethnic differentiation when it comes to the method of delivery. This issue should be explored further in the development of an incentive program.

We would be supportive of Incentive Payments that are based around the following three principles:

- Incentive Payments should start with Pay for Reporting on Maternity Care Measures (this has been a common principle used by many other payers prior to implementing "Pay for Performance Initiatives")
- After Payment for Reporting Measures are established, Pay for Performance Incentives should be based on an established benchmark of quality measures and those hospitals meeting or exceeding the benchmark should be eligible for an incentive payment
- After Payment for Reporting Measures are established, Pay for Performance Initiatives should be made for those hospitals showing an improvement in Maternity Care measures year over year

We are not supportive of DHCS further pursuing a Prior Authorization process for deliveries as outlined in the "Straw Proposal 8". Our hospitals are already reporting that an eTAR backlog of greater than 45 days exists in many cases, and obtaining a prior authorization to delivery is unrealistic.

Thank you for your consideration of our comments and recommendations. PEACH looks forward to continuing to partner with the Brown Administration and the Department in our collective efforts to ensure all Californians, especially our most vulnerable, low-income communities have access to better coordinated and higher performing delivery systems of whole-person care. Please feel free to contact me at (916) 446-6000 should you have any questions.

Sincerely,



Catherine K. Douglas
President and CEO

CC: Diana Dooley, Secretary, California Health and Human Services Agency
Mari Cantwell, Chief Deputy Director of Health Care Programs,
California Department of Health Care Services