CHCS Center for Health Care Strategies, Inc.

IHA INTEGRATED HEALTHCARE ASSOCIATION

Straw Proposal 8: Value Based Payment for Maternity Services in Fee-for-Service Medi-Cal

Proposed Approach – DHCS would implement value-based payment for maternity services in Fee-for-Service (FFS) Medi-Cal to directly incentivize physicians and private hospitals to reduce medically unnecessary obstetric procedures.

Medi-Cal finances 50% of the births in California. While Medi-Cal has moved many of its beneficiaries into managed care plans over the last several years, over half (62%) of all hospitals births financed by Medi-Cal are paid on a FFS basis; Table 1 below outlines the existing reimbursement methodology in FFS Medical. The other 38% of Medi-Cal deliveries are in managed care and DHCS delegates responsibility to the plans. An overview of FFS Medi-Cal for maternity care is outlined below.

Table 1: Overview of FFS Medi-Cal for Maternity Care

	Physicians	Hospitals		Claims Data: 7/1/13 5/5/14
Fee-for-service **62.2% of Medi-Cal births**	**FFS from DHCS** (Equalized OB Rate: Blended rate for delivery)	**PER DIEM** (based on hospital allowed costs) **24.4% of payments** **17.4% of deliveries**	**Designated Public Hospitals** (21)	**Cesarean** (Average inpatient rate: $6,935) **29.7% of claims** **Vaginal** (Average inpatient rate:$4,489) **70.3% of claims**
		DRG (via hospital specific rate) **75.6% of payments** **82.6% of deliveries**	▪ **Non-Designated Public Hospitals** - District Hospitals (25) ▪ **Private Hospitals** (202) It is important to consider two supplemental payment programs – the Disproportionate Share Hospital Program (DSH) and the Hospital Quality Fee program – and their impact on OB services. Even if the payment rate for deliveries were equalized, there is still a significant financial benefit to perform cesareans compared to vaginal deliveries.	**Cesarean** (Average inpatient rate: $4,588) **32.5% of claims** **Vaginal** (Average inpatient rate: $2,808) **67.5% of claims**

Based on the 2011 DHCS Medi-Cal Birth Statistics Report
Based on Medi-Cal Maternity Rate Setting – June 2014 (internal document from DHCS)

Target Population – Pregnant women in FFS Medi-Cal

Target Providers – Obstetricians and private hospitals with obstetrical programs

Two options for value based payment are described below and can be implemented as one package or separately.

1. **Quality Hospital Incentive Program (Q-HIP) -** A hospital incentive program (DSRIP-like) for private hospitals that ties bonus payments to improvements in maternity care. The current DSRIP program only includes public hospitals, but the majority of OB services are provided in private hospitals. To widen delivery system transformation throughout the state, private hospitals could be included in a new program.

- **Performance Measurement:** There was significant stakeholder input around which performance measures to include in the CalSIM Maternity Care initiative. Provider incentives could be based on performance against and/or improvement on these core measures: (1) Early Elective Delivery, (2) Cesarean Section Rate for Low-Risk Births, (3) Vaginal Birth After Cesarean Delivery Rate, and (4) Unexpected Newborn Complications in Full-Term Babies. Additional information about the CalSIM initiative is available here.
- **Incentive Design:** The funding source for the incentive program would need to be explored.
- **Role of DHCS –**
  - Develop incentive design and program structure
  - Contractually require FFS providers to participate in quality incentive program
- **Example - Washington State Medicaid**
  - The first Medicaid Quality Incentive program in Washington State was passed by the State legislature in 2010 and offered hospitals an incentive to change their behavior
  - Legislation established a Hospital Safety Net Assessment that served as the state share of a federal match program
  - The pay-for-performance initiative required hospitals to meet 5 quality benchmarks- one of which was reducing early elective deliveries before 39 weeks – in order to receive a 1% increase in their Medicaid reimbursement rates
  - The Medicaid Quality Incentive program was a part of larger maternity care collaborative to improve outcomes across the state; the early elective delivery rate dropped from 15.5% to 2.9% between 2010 – 2012
  - To improve maternity care quality, hospitals also implemented numerous other policies including: requiring documentation of medical reason for any patient scheduled to deliver before 30 weeks, prior authorization from chief of obstetrics for any scheduled delivery, and additional provider and patient education.

2. **Prior Authorization ("Hard Stop" Policy):** Requires physicians to receive prior authorization from the chief of obstetrics for any early inductions or cesarean deliveries before 39 weeks gestation without medical indication. Currently Medi-Cal requires prior authorization for all elective medical and surgical inpatient hospitalizations before they are performed. Delivery is the only procedure that does not require prior authorization. This option would align deliveries with all other inpatient hospitalizations by requiring authorization for early elective deliveries. The policy change to require prior authorization based on medical necessity for deliveries prior to 39 weeks would most likely require state legislation. This policy also has the potential to be implemented across all payers thus strengthening the waiver application and facilitate any necessary legislative actions.
   - **Role of DHCS –**
     - Review approval of Treatment Authorization Requests (TARs) to determine implementation feasibility

- State legislation to require prior authorization based on medical necessity for deliveries prior to 39 weeks
- Contractually require FFS providers to receive prior authorization for elective deliveries

- **Example - South Carolina Birth Outcomes Initiative**
  - In 2011, 43 hospitals in South Carolina signed a pledge to end the practice of early elective deliveries for Medicaid participants.
  - State Medicaid and BlueCross BlueShield of South Carolina, the state's largest commercial insurer, both announced in 2013 that they would stop paying for non-medically necessary early elective deliveries; together Medicaid and BCBSSC account for 85% of all births in the state.
  - It is estimated that the initiative reduced unnecessary early-elective inductions by 50 percent, reduced neonatal intensive care unit admissions and saved the South Carolina and the federal government more than $6 million in the first quarter of 2013 due primarily to a decrease in NICU admissions and reduced delivery-related expenses.

Desired Outcome for both value based payment options:

- Promote healthy, evidence based obstetrical care and improve quality for mothers and babies
- Reduce unnecessary costs related to medically unnecessary cesareans
- Create statewide reductions in early elective deliveries (before 39 weeks)

Alignment with other DHCS Initiatives – CalSIM Maternity Care Initiative