California State Innovation Model Initiative (CalSIM)

Maternity Care Initiative for Health Plans and Hospitals

WORKING DRAFT

April 10, 2014

BACKGROUND

The California Health and Human Services Agency (CHHS) received a State Innovation Model (SIM) Design Grant from the Centers for Medicare and Medicaid Innovation (CMMI) to develop statewide strategies that lead to better health, better health care, and lower costs ~ the Triple Aim. CHHS recently submitted California's State Health Care Innovation Plan to CMMI (see Appendix 1) and is awaiting a federal testing grant announcement to apply for implementation funds. In the meantime, CHHS is moving forward with continued planning for this effort.

Within the Innovation Plan the Maternity Care initiative is designed to address issues of high costs and ongoing quality shortfalls in maternity care, with a focus on deliveries and the significant cost and quality concerns that are related to potentially medically unnecessary cesarean sections. Deliveries and related expenses, including high-risk births, rank among the top ten high cost episodes for many large employers for both HMO and PPO insurance products.[1] Despite a variety of efforts to bring down the cost of maternity care, particularly by reducing elective cesarean sections, progress has been slow.[2]

- Today, the average vaginal delivery (facility costs and professional fees) in California costs $11,500 for commercial payers and $4,590 for Medi-Cal, whereas the average cesarean delivery costs $18,800 for commercial payers and $7,451 for Medi-Cal.[3]
- Each year in California an estimated 7,000 early elective deliveries, defined as deliveries greater than 36 and less than 39 weeks gestation, had a scheduled cesarean or induction without medical indication.
- Cesarean section deliveries in California rose from 22 to 33 percent between 1998 and 2008 and now total more than 165,000 per year.[4] While the statewide cesarean delivery rate is 33 percent as of 2012, some outlier hospitals have rates as high as 80.9 percent.[5]
- Moreover, 44 percent of California hospitals do not offer a meaningful Vaginal Birth After Cesarean (VBAC) opportunity for their Medi-Cal patients despite recommendations from the National Institutes of Health Consensus Development Conference, which determined that a vaginal labor trial for subsequent children was a "reasonable option."[6,7]
- There are notable disparities in deliveries. With respect to Medi-Cal patients: non-Hispanic Black women have disproportionately higher cesarean section rates and higher maternal morbidity and mortality rates; while native born Hispanics have significantly lower rates of VBAC than other groups.[8]

PROGRESS TO DATE

There is significant activity underway in California to improve maternity care. For example, hundreds of hospitals participated in the Partnership for Patients, with assistance from six Hospital Engagement Networks (HENs) that help identify and spread best practices in reducing early elective deliveries. The Anthem-funded Patient Safety First Collaborative (PSF) has been working with over 100 California hospitals since 2009 focusing on several patient safety areas, including obstetrics.

In addition, the California Maternal Quality Care Collaborative (CMQCC) has engaged a wide range of stakeholders across the state to improve health outcomes of mothers and newborns through best practices. The CMQCC's California Maternal Data Center (CMDC) supports these

quality improvement (QI) activities by generating perinatal performance metrics for all 252 California hospitals that provide maternity care services. The CMDC receives clinical data from the birth certificate for every birth in California 45 days after the end of each month. In addition, ICD9 codes and additional data are received and linked either with data from the Office of Statewide Health Planning and Development (OSHPD) (for all births, every 6 months with a 9+ month lag) or with data submitted directly by hospitals. Currently, 47 hospitals in California, representing over 28 percent of all births in the state, are submitting data directly to CMQCC. By the end of 2014, anticipated participation in this data collection effort should grow to 100 hospitals representing 55% of births. These data sets are essential to support both internal and collaborative quality improvement activities.

Hospital systems, notably Dignity Health, Sutter Health, and Kaiser-Permanente, are also working with their member hospitals to improve performance. Sutter Health demonstrated a remarkable 83 percent reduction in elective early deliveries in a one-year period within a group of 25 participating hospitals.[9] Similarly, Dignity Health reduced elective early deliveries from 7 percent to 1 percent across their entire health system.[10]

With respect to payment reform, the Pacific Business Group on Health (PBGH) has developed a blended facility payment for maternity care, alongside a physician performance program, which is being piloted with Aetna, Blue Shield, and Cigna in three hospitals and medical groups in 2014. This work builds on a project between the Integrated Healthcare Association (IHA) and PBGH, in which two bundled payment definitions were developed for births.

In commercial HMO products, IHA included maternity metrics in its Value Based Pay for Performance program, which currently applies to physician organizations. Data collection is being tested in 2014 for the maternity quality measures included in this proposal with CMQCC scoring data submitted by health plans and IHA reporting these results back to health plans and physician organizations. Furthermore, the results are incorporated into the Value Based Pay for Performance incentive payment calculations which participating health plans use to reward physician organizations.

OBJECTIVES and TARGETS

Expert stakeholders and the State team identified three objectives for improving Maternity Care performance through a coordinated multi-payer effort.

1. **Reduce rates of early elective deliveries (< 39 weeks) to below 3 percent by the end of 2017.** According to experts, as a result of significant focus on this area in recent years, 40-50 percent of California hospitals are close to the target.
2. **Reduce cesarean section rates overall by 10 percent, from 33.2 percent (2012 actual) to 30 percent by the end of 2017.** The quality improvement focus will be on reducing low-risk, first birth deliveries cesarean section rates, the largest portion of primary cesarean births, with a targeted reduction from a statewide average of 27.7 percent to 23.9 percent (the Healthy People 2020 target for this measure).
3. **Reduce repeat cesareans by incentivizing an increase of vaginal births after delivery (VBACs), where safe and appropriate, from 9 percent to 11 percent by the end of 2017.**

ACTION STEPS

1. Effective January 2015 state purchasers[11] and select large employers and their health plans will encourage and eventually require hospitals from which they purchase maternity care to report appropriate and timely data to the California Maternal Quality Care Collaborative (CMQCC) in order to publicly report maternity outcomes and support quality improvement activities.
2. State purchasers and select large employers will note participating hospitals in their provider directories.
3. State purchasers and select large employers and health plans will implement a Value Based Purchasing program.
4. State leadership and others will include a review of cost and quality associated with the maternity initiative in an annual review of state and regional performance.
5. Provider quality improvement technical assistance will be made available through CMQCC or other similar organizations.

DATA SUBMISSION

A uniform set of performance measures will be used to track performance at both the health plan and provider level. Appendix 2 includes the detailed specifications.

Appendix 3 contains a visual display of current data submission and time to report related to deliveries versus the proposed approach. Three of the four maternity measures can be calculated by CMQCC using patient discharge data combined with the California birth certificate data that CMQCC receives from the state. CMQCC receives birth certificate data for every birth in California approximately 45 days after the end of each month, and is able to link the birth certificate data with discharge data and produce the measures within a few days if discharge data is submitted by the hospitals directly. This creates essentially real-time reporting with benchmarks, available to hospitals online with links to extensive QI analyses to support quality improvement efforts. The exception is the measure on early elective deliveries; hospitals report that measure separately to the Joint Commission at the overall hospital level (i.e., no breakdown by payer or product), so reporting at the level of health plans, medical groups, or purchasers is currently not possible.

The discharge data used to partially generate these reports is already submitted by hospitals to California's Office of Statewide Health Planning (OSHPD) or to the Joint Commission, so there is no additional burden associated with data collection other than more frequent creation of the file. Importantly, there is a significant time lag for data released by OSHPD or the Joint Commission, usually over 12 months elapsing between the event (delivery) and the release. Accordingly, requiring hospitals to report the Discharge Diagnosis files directly to CMQCC will expedite availability of the measures for payment and quality improvement purposes without creating additional data collection burden. Currently approximately half of all births in California are reported directly to CMQCC in this manner. Additionally, as CMQCC would have patient level data, measures at the level of the provider, health plans, medical groups, and purchasers could be calculated.

Health plans will have the option to use the CMQCC results to determine incentive payments or to provide more granular information, for example by employer, to determine payouts. In the case of Value Based Pay for Performance, data submission includes designation of both the hospital and physician organization and results can be reported at both levels.

VALUE BASED PAYMENT INCENTIVES

Value based payments will be implemented by the health plans, building on the momentum established by the combination of data collection and measurement outlined above and supported by the available quality improvement resources. A portfolio of payment options has been developed by California stakeholders, and health plans will be required to implement one of these options or some variation most suitable to the specific health plan and provider contract. Plans will be expected to revise their hospital and provider contracts to require participation in the selected value based payment initiative(s) upon contract renewal or effective January 1, 2016.

A. PPO PLAN PAYMENT INCENTIVES

For PPO plans, the initial payment model of the Value Based Purchasing program will be a split-blended payment (one payment to hospitals and another to physicians). Ultimately, the goal is for health plans to pay hospitals and physicians a single, episode payment, or bundled case rate.

For PPO plans, a variety of blended payment approaches which offer a single payment for "birth" rather than separate payment levels for vaginal and cesarean births will be available. Participation in the reporting of the four identified quality measures will serve to protect against unintended consequences.

1. Preferred Option: Split Blended Payments

Split blended payments involve two blended payments: one to physicians and one to the hospital. In each case a single payment amount is paid, whether the delivery is vaginal or via cesarean. A blended payment is sometimes used in California for professional fees, but is uncommon for the payment of the inpatient portion of the delivery. This approach is being piloted by Aetna, Cigna and Blue Shield with PBGH.

2. Combined Blended Payments (Episode, or Bundled Payment)

Combined blended payments, often referred to as bundled payments, cover both the physician and hospital component of a delivery in a single payment. These can either be basic (including only the physician and inpatient services for a vaginal or cesarean delivery), or comprehensive, which would include both the delivery costs and the broader range of care associated with newborn and maternal outcomes (e.g. neonatal care). The specifications for both of these versions of combined blended payments have been defined by the IHA and PBGH and are available the following link: www.iha.org.

3. Other variations of the Blended Payment Method

Some health plans may have existing value based payment methods for maternity care (e.g., ACOs, proprietary incentive plans). If these existing value based payment

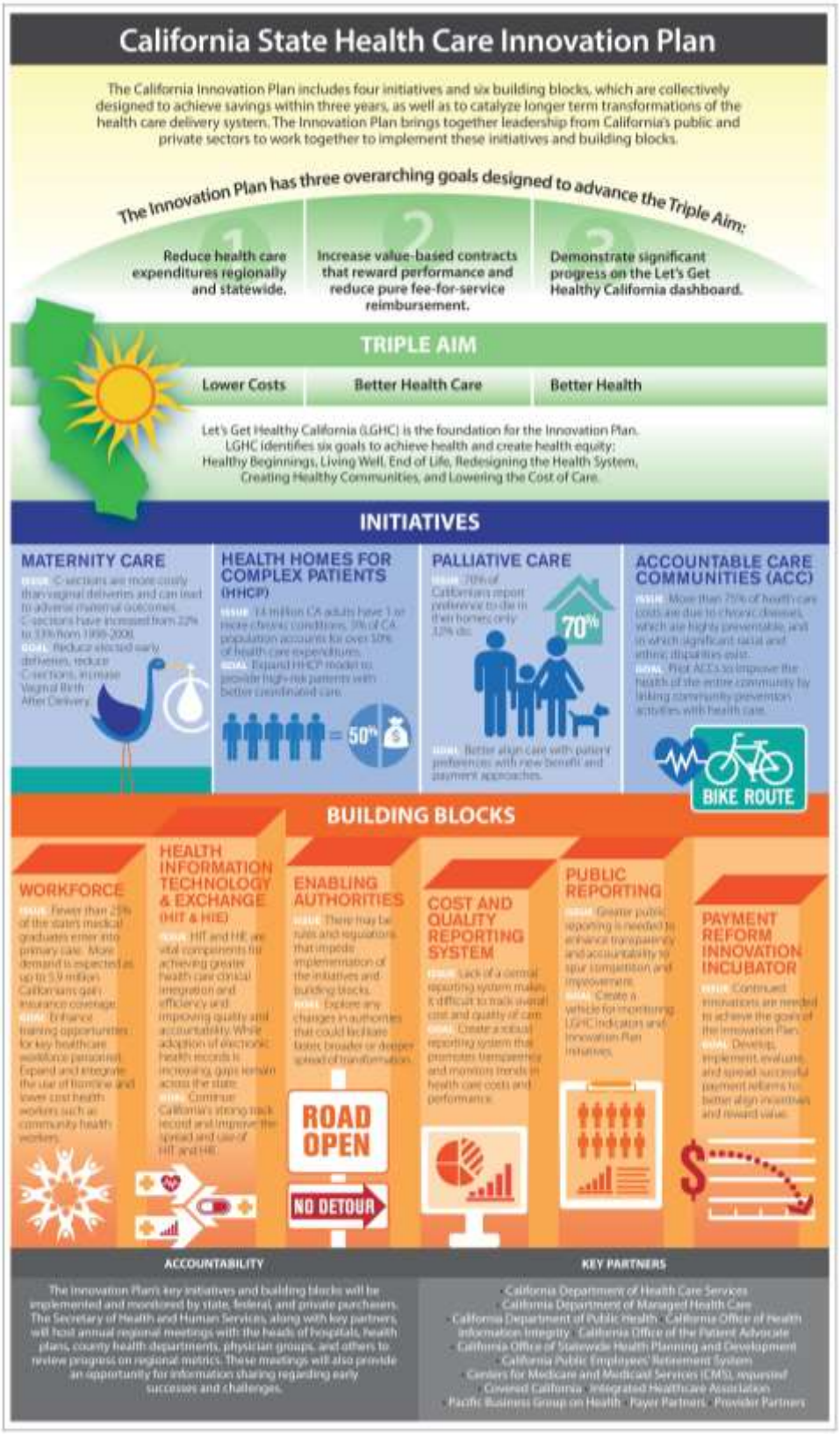
plans are linked to the four quality metrics listed in Section IV.A. (Performance Measures), they will be considered for approval under this program.

In all cases the performance measures need to be linked to incentive payments based upon improvement and/or attainment of targets against these measures. The intent is for health plans to pass savings to purchasers, but also to use savings to reward hospitals and physicians and to offset the costs of quality improvement efforts and reductions in payments from prior fee for service arrangements.

B. HMO PLAN PAYMENT INCENTIVES

IHA's Value Based Pay for Performance (P4P) Program is currently in place for commercial HMO health plan products representing over 9 million covered Californians, and includes the quality and appropriate resource use measures for maternity care previously outlined. The existing program design includes bonus payments by health plans paid to physician organizations. Plan participation in the maternity component of Value Based P4P is deemed sufficient to meet the value based payment incentive requirement.

Appendix I: CalSIM Infographic



Appendix 2: Performance Measure Specifications

Detailed specifications are available in the IHA Pay for Performance Measurement Year 2013 Manual, pages 212-223 .

Early Elective Delivery Measure. This measure is currently reported by hospitals to the Joint Commission and to CMS in numerator/denominator form. It can also be reported to CMQCC at the patient level so that it can be benchmarked, made available in a timely manner, and provide more granular performance results (by provider/payer/purchaser).

Cesarean Section Rate for Low-Risk Births

This measure is based on the measure developed by CMQCC, endorsed by NQF and adopted by the Joint Commission, LeapFrog Group, and HP 2020. The measure reports the percentage of deliveries to nulliparous women with a term, singleton baby in a vertex position (NTSV) that is delivered by cesarean section. CMQCC has further streamlined it to enable reporting by provider, payer or purchaser.

Vaginal Birth After Cesarean Delivery Rate

This measure was developed by CMQCC and measures the rate of vaginal deliveries to women with evidence of a prior cesarean section.

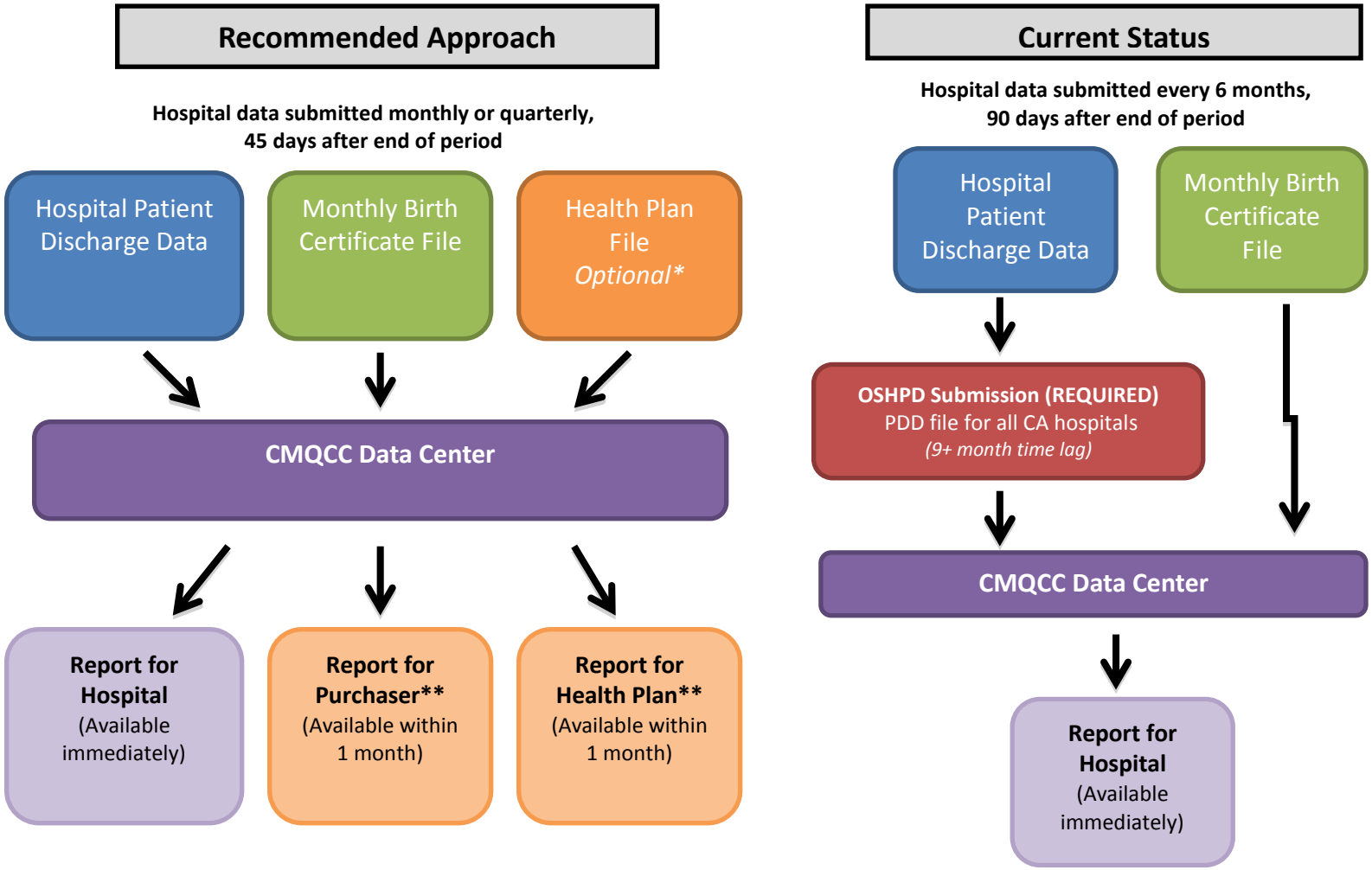
Unexpected Newborn Complications in Full-Term Babies

This "balancing" measure was developed by CMQCC and is NQF endorsed. It measures the rate of unexpected newborn morbidity in full-term newborns without pre-existing conditions, and is included to ensure that efforts to reduce the rate of cesarean sections and increase the rate of vaginal birth after cesarean delivery do not adversely affect the newborn complication rate.

Appendix 3: Process & Timeline for Maternity Measures

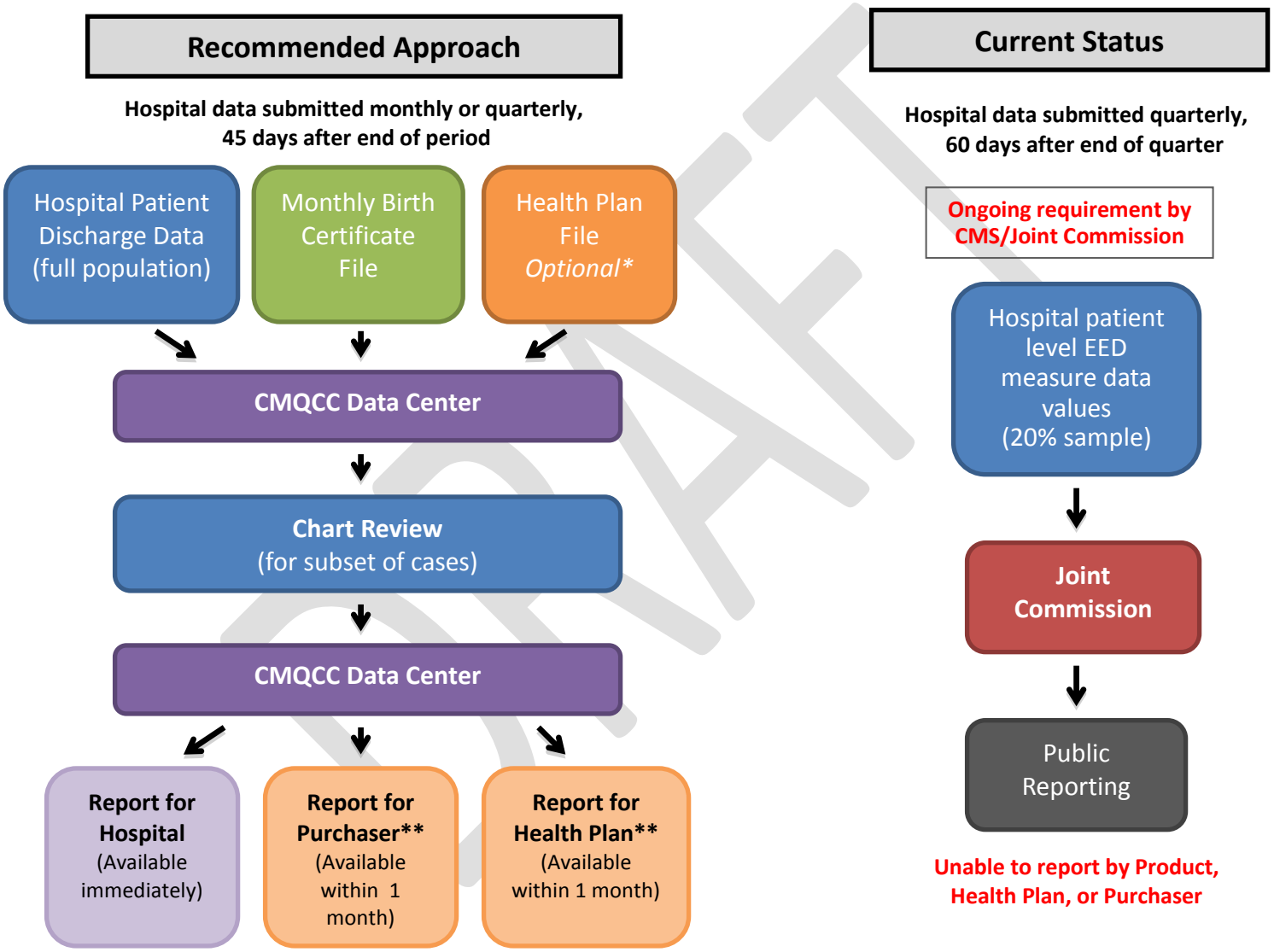
PPO & HMO PLANS

Cesarean Section for Low-Risk Births
Vaginal Birth After Cesarean Delivery Rate
Unexpected Newborn Complications in Full-Term Babies



* Optional – Dictated by Purchaser or Health Plan
**Contingent on Health Plan File; without it, results would be by hospital by product (Commercial/Medi-Cal/Self Pay and Managed/Traditional options), across plans and purchasers

Special Process & Timeline for Early Elective Deliveries (EED) Measure
PPO & HMO PLANS



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** Contingent on Health Plan File; without it, results would be by hospital by product (Commercial/Medi-Cal/Self Pay and Managed/Traditional options), across plans and purchasers

Endnotes

[1] Personal Communication with Pacific Group Purchaser. *Top 10 High Cost Episodes By Purchaser,* 2013.

[2] Oshiro, Bryan et al. "Decreasing Elective Deliveries Before 39 Weeks of Gestation In An Integrated Health Care System." *Obstetrics & Gynecology* 113, no. 4, (2009): 804-11; Bryan Oshiro et al. "A Multistate Quality Improvement Program to Decrease Elective Deliveries Before 39 Weeks of Gestation." *Obstetrics & Gynecology* 121, no. 5, (2013): 1025-31; The Ohio Perinatal Quality Collaborative Writing Committee. "A Statewide Initiative to Reduce Inappropriate Scheduled Births At 36 0/7 – 38 6/7 Weeks' Gestation." *American Journal of Obstetrics and Gynecology 202, no. 243 (2010): e1-8.*

[3] Main, Elliot et al. *Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Quality,* 2011.

[4] Ibid.

[5] Personal Communication with Elliot Main. *The California Maternal Data Center (CMDC) slide deck,* California Maternal Quality Care Collaborative, July 24, 2013.

[6] Main, Elliot et al. *Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Quality,* 2011.

[7] National Institutes of Health Consensus Development Conference Panel." National Institutes of Health Consensus Development Conference Statement March 8-10, 2010." *Obstetrics & Gynecolog*115, (2010): 1279-95.

[8] Main, Elliot et al. *op.cit.*

[9] Zavoral, Gary. *Sutter Hospitals Pilot Initiative for Healthier Newborns,* 2013.

[10] Dignity Health. *Dramatic Reduction in Early Elective Deliveries: Dignity Health prevents NICU stays for 70 newborns, saves $1 million in less than a year,* 2013.

[11] State purchasers include CalPERS and Covered California; details for the Medi-Cal program are still under discussion.