CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

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Toby Douglas
Director
California Department of Health Care Services
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Subject: Comments on Value-Based Payment for Maternity Services in Fee-for-Service Medi-Cal Proposal

Dear Director Douglas:

The California Hospital Association (CHA) appreciates the opportunity to provide comments on the California Department of Health Care Services' (DHCS) 1115 Waiver Renewal proposal to 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. We welcome further discussion about the draft proposal's opportunities and challenges. More than 250 hospitals in California provide labor and delivery services, from small rural hospitals to large academic medical centers. These hospitals and their physician partners deliver more than 500,000 babies each year. CHA, through our work with the recently formed Hospital Quality Institute (HQI), is committed to improving maternity care outcomes. Maternity care has been a top priority for voluntary quality improvement efforts for the last several years, and HQI is building upon the great success of the Patient Safety First (PSF) initiative funded by Anthem Blue Cross and the California Hospital Engagement Network (CalHEN) to continue to drive improvement. Since 2012, these two initiatives have focused on reducing early elective deliveries (EED) prior to 39 weeks. Looking ahead, the CalHEN and PSF will continue to build on the success of the EED work and broaden the focus of decreasing OB-related harm by addressing low-risk, first-time pregnancy with single baby in vertex position cesarean sections, as well as preeclampsia and hemorrhage.

CHA looks forward to working with DHCS to develop quality improvement initiatives that align with current public reporting and payment reform efforts already underway, and that build on the tremendous success hospitals have achieved through their own voluntary efforts. We agree there is more work to be done and look forward to continued efforts to help shape and ensure a successful initiative.

The draft proposal focuses on achieving improved outcomes in maternity care through Medi-Cal managed care plans, noting the potential for components of the proposal to be implemented across all payers. **CHA urges the state to make additional information available for stakeholder input. Key to achieving our goals is alignment – between payers and providers, as well as between physicians and hospitals. Alignment across all programs, public and private, is critical to keeping hospitals and physicians engaged in a common set of shared goals. Multiple competing initiatives will detract from a focused effort to drive improvement more rapidly.**

We have organized our comments in the general framework of the Jan. 23 discussion document titled *Straw Proposal 8: Value-Based Payment for Maternity Services in Fee-for-Service Medi-Cal* and offer additional comments for consideration as this process moves forward. We look forward to additional discussions.

Progress to Date
CHA appreciates the opportunities for improvement that lie in nearly every aspect of our health care system, and specifically in maternity care. Significant investments have been made in public reporting and quality improvement efforts in this area over the past several years. In California, hospitals have led the way through voluntary efforts to reduce OB harm through both the CalHEN and PSF initiative. The results show great improvement in a short period of time.

Objectives and Targets
Because of the tremendous work underway in a number of voluntary quality improvement efforts noted above to reduce EEDs — low-risk, first delivery C-section rates, and improving vaginal births after cesarean delivery (VBACs) — we encourage the state to reexamine the proposal's goals. The available data does not yet recognize the important work to date, and we believe examination of more recent data over a 12-month period may provide more insight into the meaningful improvements that have already been voluntarily made. These improvements should be accounted for when setting statewide goals going forward. We recognize that a number of measures are already being publicly reported utilizing 2012 data and that this is an important starting point. However, the EED measure is not yet publicly reported, but will soon be available on the Centers for Medicare & Medicaid Services' (CMS) *Hospital Compare* website, and should be considered when examining the initiative's goals and objectives.

In addition, we understand these goals are statewide and caution against universally applying them to individual hospitals. It is critically important that when looking at state- and provider-level objectives, we ensure accountability is appropriately assigned. For example, as detailed below, we have some concerns regarding a measure of hospital performance that would focus on reducing repeat cesareans by incentivizing vaginal births after cesarean delivery. On a statewide basis, we agree this is an important goal, but there are evidence-based guidelines for ensuring this type of care is provided with the highest quality and safety and, therefore, requires tremendous resources that may or may not be available at every labor and delivery hospital across the state.

Quality Hospital Incentive Program (Q-HIP)
The proposal outlines, as one of two options for value-based payment that can be implemented, either together or separately, a Quality Hospital Incentive Program (Q-HIP) for private hospitals that ties bonus payments to improvements in maternity care.

<u>Performance Measurement</u>
The draft proposal outlines four hospital quality measures that could be required for reporting, based on California's State Health Care Innovation Model (CalSIM) Maternity Care initiative. Generally, CHA supports public reporting of maternity measures to better inform patients about the potential variation in care; however, this proposal would create duplicative reporting requirements. We offer more specific comments on the measures below:

- *Early Elective Delivery (EED):* CHA supports the efforts underway to publicly report this measure. We believe the vast majority of our hospitals are currently reporting through their Joint Commission (TJC) vendor, and that those vendors are reporting data on behalf of hospitals to CMS. CHA has previously raised concerns to the state regarding the current CMS data collection methodology required for use by inpatient prospective payment system hospitals for reporting to the inpatient quality reporting program. CMS does not require patient-level data collection, as it was deemed too burdensome. However, this also limits CMS' ability to accurately validate the data. CHA has requested that CMS review the data submitted through the CMS web portal and compare it to hospital data supported at the patient level through a hospital's TJC vendor

submission. When data is publicly reported on this measure, it is our hope that the variation in data collection mechanisms does not significantly change the results, and if variation is present, steps should be considered to ensure its accuracy and reliability.

The CalSIM Maternity Care initiative would require this data — as well as data on the other measures — be reported through the California Maternal Quality Care Collaborative (CMQCC), an *additional* repository that may further introduce data variability in this measure. Please see our additional comments below regarding data collection.

- *Cesarean Section Rate for Low-Risk Births:* The PSF initiative, comprised of more than 180 participating hospitals in California, is focusing its efforts on reporting and improving performance on low-risk, first-time pregnancy with single baby in vertex position cesarean sections. CHA supports the inclusion of this specific measure as part of the maternity care initiative, as it is the measure currently being publicly reported. We believe this measure is more specific in driving important quality improvement efforts in this area.

- *Vaginal Birth After Cesarean Delivery Rate (VBAC):* CHA recognizes the important quality improvement efforts associated with this measure. With that said, we believe a number of important considerations must be discussed before a final recommendation is made for its inclusion in public reporting and value-based payment design.

  As you are well aware, the risk of uterine rupture may be increased in women who select a trial of labor after cesarean section delivery. This risk has been estimated at 0.7 percent for women with low transverse incisions and up to 1.8 percent with two or more cesarean deliveries (American College of Obstetrics and Gynecology [ACOG] Practice Bulletin #115, August 2010). The risks of complication from uterine rupture include brain death or damage to the baby as high as 25 percent, need for hysterectomy at 20 percent, need for transfusion at 30 percent and bladder injury at 7 percent. While the overall risk of uterine rupture is low, the damage, as outlined, can be catastrophic.

  Therefore, recommendations in the attached ACOG bulletin state that a trial of labor after previous cesarean delivery should be undertaken at facilities with sufficient resources and that have staff (obstetric, pediatric, anesthetic and operating room staffs) *immediately available* to provide emergency care. Respect for patient autonomy supports that patients should be allowed to accept increased levels of risk; however, patients should be clearly informed of the potential increase in risk and management of the alternatives.

  While we support the concept of increasing the rate of vaginal birth after cesarean, many smaller and mid-size hospitals will have neither the staff nor the resources recommended in this standard of care document, and as such, the quality reporting of this measure at zero may lead to a misinterpretation of the quality of care provided at that facility. In addition, the CalSIM Maternity Care initiative does not detail whether or not the measure is currently National Quality Forum (NQF)-endorsed. At a minimum, CHA asks that any measures used for public reporting have NQF endorsement.

  At a bare minimum, should this measure proceed in public reporting, we urge the state to include whether VBAC is available at the hospital, as currently reported on calqualitycompare.org:

  VBAC Routinely Available (Yes or No)

> *Some hospitals will not provide "vaginal birth after C-section" (VBAC), usually because they do not have the necessary medical personnel needed to respond immediately to a VBAC attempt that does not go well. This measure is shown to help consumers understand whether a facility does routinely offer vaginal birth after prior C-section. A hospital showing "yes" delivers at least 5% of babies vaginally among mothers that previously had a C-section.*

This issue becomes far more acute as we move to its inclusion in a set of measures to determine payment. **We believe hospitals that do not provide VBAC services based on standard of care recommendations will be unfairly penalized under a value-based payment design that includes this measure. Therefore, we believe only hospitals that provide VBAC services should be required to address this measure under a value-based payment design contract.**

- *Unexpected Newborn Complications in Full-term Babies:* This measure is not currently publicly reported. We understand this measure would be used in conjunction with the VBAC measure and, therefore, our concerns noted above remain relevant. We believe additional discussion is warranted before including this measure in public reporting and payment reform.

As previously noted, NQF endorsement is of critical importance to hospitals before a measure is publicly reported. Furthermore, the way hospital performance is described and displayed on a website or through written material is important for patient understanding as well as performance improvement. **CHA is concerned the current methodology used to depict hospital performance on these measures on the calqualitycompare.org website is not suitable for public reporting under the CalSIM Maternity Care initiative.**

Until a few years ago, CHA supported the important work of CHART. However, in 2012, the CHA Board of Trustees withdrew its endorsement of CHART due in large part to the lack of transparency and stakeholder consensus on the new scoring methodology used to characterize hospital performance on many of the measures on its website. **CHA does not support the current methodology used to rank provider performance on calqualitycompare.org due to the lack of transparency and ability to differentiate between ratings from measure to measure.**

Finally, we anticipate that some may argue that a maternity care composite measure would be much more ideal for public reporting and payment reform than individual measures. **CHA would not support the inclusion of a maternity care composite at this time.** First, they are inherently complex. Second, we are not aware of a maternity care composite that is NQF-endorsed. Jumping too quickly to a composite measure would be premature.

Incentive Design

The state's proposal references as an example the Washington State Medicaid incentive program that established a Hospital Safety Net Assessment that served as the state share of the non-federal match. This initiative required hospitals to meet five quality benchmarks in order to receive a 1 percent increase in their Medicaid reimbursement rates. California hospitals are committed to continuing their leadership in developing and implementing transformational efforts to improve care delivery at a lower cost with higher quality; however, we believe it is necessary for the state to make appropriate investments in the Medi-Cal program. **CHA is not supportive of any assessments being placed on providers to fund the state's share of the non-federal match.**

California's Medi-Cal program ranks nearly last in the nation when it comes to funding health care for Medicaid patients. On a statewide aggregate basis, the Medi-Cal program only covers about 68 percent of

the cost of providing care to Medi-Cal patients, leaving an annual shortfall to hospitals in excess of $5.6 billion. Medi-Cal payment shortfalls result in significant financial losses for hospitals, and force hospitals to shift these unpaid costs to private payers.

Under the state's Hospital Quality Assurance Fee Program, California hospitals already provide the state with more than $4.3 billion annually. The state uses $3.5 billion as the non-federal share (in lieu of state General Funds) to draw down matching federal funds for the Medi-Cal program. Supplemental payments are issued to hospitals up to the federal limit; however, half of these payments are hospital funds – creating a shortfall that can never be filled unless the state meets its obligation to pay for health care services for the Medi-Cal population. The remaining $800 million is retained by the state and provides General Fund relief for Medi-Cal services already being provided to children. **CHA urges the state to fund such initiative either with state General Funds or with savings derived from its proposed Federal-State Savings initiative.**

Data Collection

The CalSIM Maternity Care initiative will require health plans and purchasers to require that hospitals for which they purchase maternity care report appropriately and timely data to the California Maternal Quality Care Collaborative (CMQCC) in order to publicly report maternity outcomes and drive quality improvement activities.

Should the state decide to proceed with this proposal, CHA would like to better understand the rationale for using data submitted to CMQCC directly, rather than relying on data that is currently available and publicly reported, or is soon planned for public reporting. The CalSIM Maternity Care initiative notes the data reported directly to CMQCC would be more timely than the current nine-month delay. Additional information regarding the timing of data collection and its planned release for public reporting would be helpful to better understand the opportunities and challenges of similar data with different time periods being publicly reported. Figures 1 and 2, provided to CHA on March 25, offer additional insight on this issue, but we welcome further discussion. Further, the proposal does not detail where the data would be publicly reported. We welcome additional discussion regarding this section of the proposal, as we are concerned about what seems to be plans to report data at a more granular level (e.g., patients in each health plan within the hospital patient population rather than an overall hospital performance).

As you know, the CalSIM Maternity Care initiative would require hospitals to report discharge data and to perform limited chart abstraction to link the birth record data. CHA supports the important role CMQCC plays in helping hospitals compile and understand their current performance on a number of maternity care measures. CMQCC has been a strategic partner in CalHEN's work with HQI, and we have promoted *voluntary* participation in these efforts since 2012. However, we have seen slow adoption by hospitals over the past several years due to the burden associated with duplicative reporting. While this has been characterized as a simple re-creation of a file, it requires time to ensure the data is accurate and congruent with other data being reported in different time periods.

As noted in the CalSIM Maternity Care proposal, only 50 out of more than 250 hospitals are currently reporting directly through CMQCC. Hospitals that chose to report voluntarily through CalHEN could do so at **no cost to the hospital through 2014**. Many of the measures collected by CMQCC are duplicative of current reporting requirements (voluntary and mandatory), and as such, create a financial and personnel burden on hospitals. Moving from what is now a voluntary effort to mandatory reporting of a set of quality measures into a system that is in many instances duplicative of current public reporting requirements for TJC and CMS is of great concern. CMQCC is not a national data repository at this time

and will soon require additional resources – likely through fees to hospitals – to ensure its long-term financial viability.

CHA urges DHCS to consider the following before proceeding:

- **If the state proposes to require mandated monthly reporting to CMQCC, it must also find a way to defer the costs that will likely be proposed by way of a hospital fee to participate. CMQCC must have a sustainable business model that should be supported by these efforts as whole, not supported by a hospital fee for participation.** Hospitals are already reporting many of these measures through other mechanisms. To ask hospitals to pay a fee to duplicate reporting is a waste of resources – a cost that, in our view, may not outweigh the benefit of such measures as the EED measure, which will be available by next year and can be used by CalSIM for this initiative. **At no time should hospitals be required to pay a fee to CMQCC for reporting under this initiative.**
- CHA would urge CMQCC to find an approach that would allow hospitals already reporting to TJC and others to confer rights to the data, rather than having hospitals manually report the same data multiple times to different repositories.
- Currently this proposal articulates four quality measures for reporting to CMQCC. However, hospitals have been encouraged by CMQCC to report all 10 measures. In light of our concerns regarding two of the four measures, we would like to ensure that reporting on more measures is voluntary and that mandatory reporting on all 10 measures does not become a requirement of this initiative.

Importantly, CHA believes that all data must be made available for a confidential preview by hospitals prior to public reporting. A 30-day period to make corrections to the data should also be required before posting. And finally, we strongly believe that, at a minimum, a 12-month baseline period of data is essential for health plans and providers to review prior to negotiating value-based payment designs. We anticipate this would delay some contracts until 2017. This provides for additional time to pilot many of the alternative payment reform methods discussed below.

It is imperative that hospitals and health plans have accurate and transparent data before proceeding in any negotiations, and this revised timeline is much more reasonable to ensure that this occurs.

"Hard Stop" Policy
DHCS' current proposal also outlines a "Hard Stop" policy that 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. CHA acknowledges that this method has been successfully used in other states. This method can be effective, but it is best accomplished when all payers agree to implement a hard stop policy and process. This makes uniform implementation throughout an organization much easier and assures better compliance. In addition to all all-payer approach, it is critical that the approval process is reliable and timely for a needed C-section prior to 39 weeks. Treatment authorization requests (TARs) are not compatible with "Hard Stop" policies.

Provider Education and Quality Improvement
CHA appreciates the acknowledgement in the CalSIM Maternity Care initiative of the need for a robust provider education and quality improvement network to support hospitals in making improvements. Many such programs exist, and hospitals participate in more than one. We are concerned, however, with the lack of specific education directed at independent physicians who may or may not be closely aligned with larger medical groups or health systems. We anticipate a concentrated focus may be needed in this

area. With that said, CHA does not support the development of *new* programs for hospitals that require additional time and resources and are duplicative. Provider education about this initiative is critical, and the proposal should explain in greater detail the planned rollout and education plan.

CHA appreciates the opportunity to provide our initial thoughts on this proposal. We share in the state's commitment to promote healthy, evidence-based obstetrical care and to improve the quality of care provided to mothers and babies. We are very encouraged by the work done to date and wish to engage further on these important discussions.

Sincerely,

Anne McLeod
Senior Vice President, Health Policy & Innovation

cc: Diana Dooley, Secretary, California Health and Human Services Agency
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