California State Innovation Model (SIM) Maternity Care Initiative

Frequently Asked Questions (FAQ)

Q1: Why is maternity care a major focus of the California State Health Care Innovation Plan?

A1: The California State Health Care Innovation Plan was developed through extensive input from a wide range of stakeholders. The intent is to develop a few broad initiatives that could leverage existing efforts already in place and be quickly spread across public and private payers and providers to significantly impact costs and quality. Maternity care clearly met these criteria; there is significant need for improvement and multiple efforts have begun to take hold in California.

The need for improvement is highlighted by several factors including: (1) an estimated 7,000 early elective deliveries, defined as deliveries which had a scheduled cesarean or induction before 39 weeks without medical indication; (2) a rapid rise in cesarean section deliveries in California from 22 to 33 percent between 1998 and 2008 with some outlier hospitals with rates as high as 80 percent, and (3) more than 44 percent of California hospitals do not offer a meaningful Vaginal Birth After Cesarean (VBAC) opportunity for Medi-Cal patients despite NIH consensus recommendations that a vaginal labor trial for subsequent children is a reasonable option.

Equally compelling are the existence of a number of programs currently in place in California to address these challenges, which have gained traction. These include:

A. 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 quality improvement (QI) activities by generating perinatal performance metrics.
B. The Patient Safety First (PSF) initiative funded by Anthem Blue Cross has been working with over 100 California hospitals since 2009 in several patient safety areas, including obstetrics.
C. Six California Hospital Engagement Networks (CalHENs) have been providing assistance to hundreds of hospitals to identify and spread best practices in reducing early elective deliveries.
D. The recent formation of the Hospital Quality Institute (HQI) by the California Hospital Association (CHA) committed to improving maternity care.
E. The work by the Pacific Business Group on Health funded by the Robert Wood Johnson Foundation to develop and test bundled payment for maternity.
F. The Integrated Healthcare Association-sponsored Value Based Pay for Performance program which has incorporated maternity care into its measurement and rewards program.

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The combination of compelling need for improvement and continued momentum provide an outstanding opportunity to leverage the power of the state-led CalSIM initiative to improve both quality and costs for an important area of health care affecting millions of newborns and parents in California.

Q2: What components will be included in the CalSIM Maternity Initiative?

A2: The key elements of the CalSIM Maternity Care Initiative include data collection, performance measurement and benchmarking, quality improvement (QI) and payment incentives.

Q3: When would these components begin?

A3: The intent is to promote voluntary participation in the data collection, measurement and QI beginning 2015, with subsequent required participation through contracts; and to include widespread payment incentives for improved maternity care beginning 2016 and 2017.

Q4. Why is it necessary to submit data directly to the California Maternal Quality Care Collaborative (CMQCC)? Why not just use the current OSHPD data reporting and birth certificate data for C-section, VBAC, and unexpected newborn complications measurement and the Joint Commission data for the early elective deliveries measure?

A4: There are several reasons why direct data reporting by hospitals to CMQCC is considered an important component of the CalSIM Maternity Care Initiative. First is the timeliness of data. The data currently available using OSHPD is 18-24 months old. Data collected and reported by the California Maternal Data Center (CMDC), which is affiliated with CMQCC, is reported 45-60 days after submission and can occur as frequently as monthly or quarterly, depending upon interests. Second, the information provided by CMDC not only provides more extensive data— well beyond simple numerators and denominators— but also provides extensive automated analytic tools to facilitate quality improvement efforts at individual facilities. Third, this approach will provide complete cross-hospital data collection, allowing more accurate and timely medical group, hospital and purchaser performance rates, which in turn will facilitate provider incentive programs and statewide benchmarking.

Q5: Won't reporting data to CMQCC be an administrative burden to hospitals?

A5: Reporting to CMQCC does involve an extra administrative task for hospitals because reporting is more frequent. However, the burden is minimal since the data elements are consistent with those currently reported to OSHPD, the Joint Commission and CMS. In return, individual stakeholders will receive more timely feedback and analyses, along with technical assistance for quality improvement.

Q6: Will there be a fee to receive QI reports from CMQCC?

A6: Currently, there is not a fee to submit data and receive reports from CMQCC since this work is funded by the California Healthcare Foundation. This funding will be phased out in 2015, and while other grant funds will be pursued, they are not yet secured. At some point in the future, grant funds will not be available to support this work and some form of fee or charge will likely be required.

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Q7: Do the hospitals reporting directly to CMQCC perform better on the maternity quality measures than hospitals that are reporting only to OSPHD and Joint Commission?

A7: This question is under review and has not yet been answered. It is clear that hospitals reporting data to CQMCC are making significant strides. For example, hospitals that have participated in direct submission to CMQCC, have decreased the average baseline EED rate from 13.8% to 6%, representing a 55% decline in the percentage of non-medically indicated deliveries performed in the 37 and 38 week period. In general, participants in quality measurement and improvement tend to have better outcomes than non-participants.

Q8: Will hospitals be required to participate in a formal quality improvement learning collaborative?

A8: Hospitals and physicians will be strongly encouraged, but not required to participate in an existing learning collaborative. Several learning collaborative programs already exist in California today, including the Hospital Quality Institute (HQI) sponsored by the California Hospital Association, the Patient Safety First sponsored by Anthem Blue Cross, the California Hospital Engagement Network (CalHEN) and CMQCC.

Q9: Will a "no-pay" policy be put in place for early elective deliveries (EED)?

A9: A no-pay policy may be worth considering at some point, but it is not a priority at this time. The EED rate in California has declined significantly in recent years through voluntary efforts, with some hospitals achieving dramatic decreases.

Q10: Will the results be publicly reported for hospitals contributing data to CMQCC?

A10: Cesarean and VBAC rates for hospitals in California are already publicly reported on CalQualityCompare.org using OSHPD data. It is the intent of CalSIM to track and publicly report performance for each of its four (4) initiatives, including Maternity Care, and it is anticipated that this reporting will be timelier than what is currently in place.

Q11. Will hospitals that are providing data directly to CQMCC be listed in network directories or otherwise distinguished?

A11: Large purchasers have expressed interest in indicating which hospitals are reporting data to CMQCC as an incentive for voluntary participation in this process. This could occur in provider directories and/or be posted on websites available to employees evaluating health plan or provider options.

Q12: What timing should be considered to move participation from data collection and reporting to implementing payment incentive programs?

A12: There are already some payments incentives in place today such as private payer incentives to hospitals for maternal care. Also, the IHA-sponsored Value Based Pay for Performance program has incorporated maternity care in its measure set in 2014, with data collection and calculations handled by CMQCC. Nonetheless, these incentives programs are not widespread and the goals of this initiative include widespread payment incentives for improved maternity care beginning 2016 and 2017.

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