Medi-Cal Explained FACT SHEET

Medi-Cal Explained: Paying for Maternity Services

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Introduction

In California, Medi-Cal pays for nearly half of the state's roughly 500,000 annual births. But it pays for births differently depending on whether the pregnant person[1] is enrolled in Medi-Cal through a managed care plan or covered by the fee-for-service system.

Fee-for-Service

Under the fee-for-service (FFS) system, providers are paid directly by the California Department of Health Care Services (DHCS) using the methodologies described below.

For nearly all maternity care services, Medi-Cal reimbursement rates are significantly lower than commercial reimbursement rates. Figure 1 (on page 2) shows the differences for Sacramento, where commercial rates can be five times as high for hospitals, and nearly 24 times as high for anesthesiologists when compared to Medi-Cal FFS rates. These reimbursement disparities also exist in other types of care, both primary care and specialties such as oncology and orthopedics, but maternity providers see a much larger portion of Medi-Cal patients than do providers in most other specialties.[2]

Professional Reimbursement Under FFS

Routine, uncomplicated obstetric care is reimbursed in three ways, with details provided in Table 1 (on page 2):

1. **Globally, for providers who render total obstetric care, which includes prenatal care, delivery, and postpartum care.** Payment is triggered by the baby's delivery and is all-inclusive for the obstetrician (e.g., routine urinalysis and ultrasounds are included and cannot be billed separately). However, it does not include anesthesiology, nor does it include medical complications of pregnancy (e.g., gestational diabetes or hypertension). This approach simplifies billing and can enable a team-based collaborative practice between physician and nonphysician providers. However, because the claim is submitted at the point of delivery, it can complicate the timely engagement of a managed care plan's quality improvement and care coordination resources and makes the identification of postpartum visits challenging. Global billing is more often used by private practice providers and is not typically used by Federally Qualified Health Centers (FQHCs).
2. **Per visit, for providers who do not render total obstetric care or who provide fewer than 13 prenatal visits.** Providers receive a higher payment for the initial prenatal visit and a lower payment rate for follow-up visits (up to 13) and one postpartum visit. Routine urinalysis

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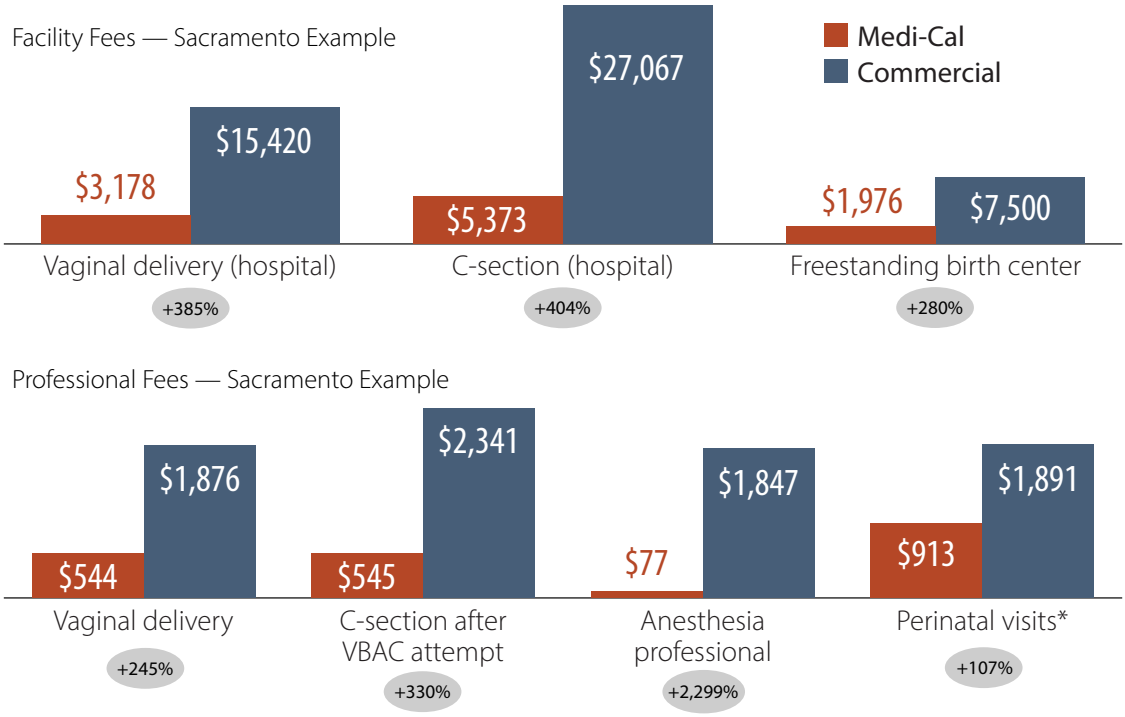
Figure 1. Medi-Cal FFS Reimbursement Compared to Commercial Reimbursement, for Facilities and Clinicians



*Commercial perinatal visits used CPT codes 59426 and 59430, while Medi-Cal used Z1032, Z1034, and Z1038 and assumed 14 perinatal visits.

Note: *VBAC* is vaginal birth after cesarean.

Source: Commercial reimbursement for freestanding birth center came from author's estimate using 50% of vaginal delivery payment sourced from Blair Dudley, *Promoting Midwifery and High Value Care in Medi-Cal,* Pacific Business Group on Health, April 2020.

and ultrasounds are included as part of the visit and cannot be billed separately. Per-visit billing can result in a higher reimbursement per episode than global billing.

3. **Based on face-to-face time spent for Comprehensive Perinatal Services Program (CPSP) services,** which are additional to obstetric care services described above, with bonuses for early initiation of care. To be eligible, providers must enroll as a CPSP provider. FQHCs are reimbursed at their Prospective Payment System (PPS) rate for CPSP services rather than according to the CPSP fee schedule.

Table 1. California Department of Health Care Services Fee Schedule*

	Professionals Working Outside an FQHC	Professionals Working in an FQHC
Global	Delivery: $1,390 for vaginal, $1,391 for c-section	Delivery: $1,390 for vaginal, $1,391 for c-section
Per Visit	Maximum: $1,571.31 Initial: $126 Follow-up and postpartum: $60 Delivery: $544 for vaginal, $545 for c-section	All prenatal and postpartum encounters paid at PPS rate: CA average: $202 (range: $61 to $993) Delivery: $544 for vaginal, $545 for c-section
CPSP services	Up to $1,192.57	All encounters paid at PPS rate: CA average: $202 (range: $61 to $993)

* Other care, including mental health services and specialty care, is provided on a fee-for-service basis and includes the benefits described in the previous section

Notes: *CPSP* is Comprehensive Perinatal Services Program; *FQHC* is Federally Qualified Health Center; *PPS* is Prospective Payment System.

Supplemental Payments

Historically, Medi-Cal FFS rates are among the lowest among state Medicaid programs nationally.[3] However, DHCS provides supplemental payments to certain providers. For maternity services, two sets of supplemental payments are particularly relevant:

1. **Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs):** Overall, FQHCs are paid based on a system that was historically tied to their costs of providing services. As a result, each FQHC has its own per-visit PPS rate paid by DHCS under Medi-Cal FFS. The average per-visit rate is $202.04 (range: $61.46 to $993.30), which is significantly higher than the FFS fee-schedule reimbursement for many services.[4] This is the rate for any service provided in an FQHC, not just maternity services.
   Medi-Cal managed care plans can set their own rates for FQHCs (and are required to pay them similarly to non-FQHC providers), and DHCS directly reimburses FQHCs for any difference based on a "wraparound" payment. In an important exception to the rule that Medi-Cal pays less than commercial insurance, the average PPS rate provides a higher level of reimbursement for prenatal and postpartum care than many commercial insurers. Deliveries are reimbursed separately and are not subject to PPS. Because reimbursement for seeing multiple patients in a day is higher than that for delivering one to two babies in a day, many FQHC providers do not perform deliveries. This results in a lack of continuity of care. In 2019, FQHC providers delivered 45% of the babies birthed by their patients, down from 57% in 2016.[5] The remainder of deliveries are typically handled by an on-call physician, contracted by the hospital and often unknown to the pregnant person.
2. **Hospital Quality Assurance Fee:** DHCS introduced the Hospital Quality Assurance Fee (HQAF) program in 2010 to provide funding for supplemental payments to California hospitals that serve Medi-Cal and uninsured patients. It levies a tax on certain hospitals, raising revenue to support the state's portion of Medicaid spending. Then the program redistributes the revenue to hospitals that provide care to more Medi-Cal patients. Based on the published HQAF VI model, in fiscal year 2019–20, the average net payment per Medi-Cal day to participating hospitals from the program was $1,168, providing an important offset to the discrepancy between commercial and Medi-Cal reimbursement to hospitals serving many patients with low incomes.[6]

Facility Reimbursement Under FFS

Hospitals are paid through All Patient Refined Diagnosis Related Groups (APR-DRGs).[7] This system, also used by many managed care plans, pays hospitals a facility-specific case rate that is adjusted based on the reason for admission, severity of illness, and risk of mortality. It builds on a similar system used in Medicare that was introduced in 1983, but was developed with Medicaid populations in mind.[8] In California, DHCS implemented APR-DRGs in 2013. Under the system, hospitals receive higher reimbursement for c-section deliveries than vaginal deliveries for all but the lowest acuity level, covering the costs of the operating room and longer length of stay, and potentially creating an incentive for a c-section, even if it is unwarranted.[9] The APR-DRG system does, however, provide an incentive for the hospital to reduce variable costs within a specific type of delivery (e.g., by reducing length of stay).

Freestanding birth centers are paid a flat rate for deliveries that is about 35% of the average APR-DRG low-risk vaginal delivery rate. If the patient needs to be transferred to a hospital, the birth center gets between 25% and 75% of the rate, depending on when the transfer occurs.

How DHCS Pays Managed Care Plans

Plans typically receive a monthly capitation amount for every individual enrolled based on their aid code. Importantly, specialty mental health and substance use disorder services are delivered by an enrollee's county, distributing accountability and adding complexity to care coordination for a higher-risk group of pregnancies.

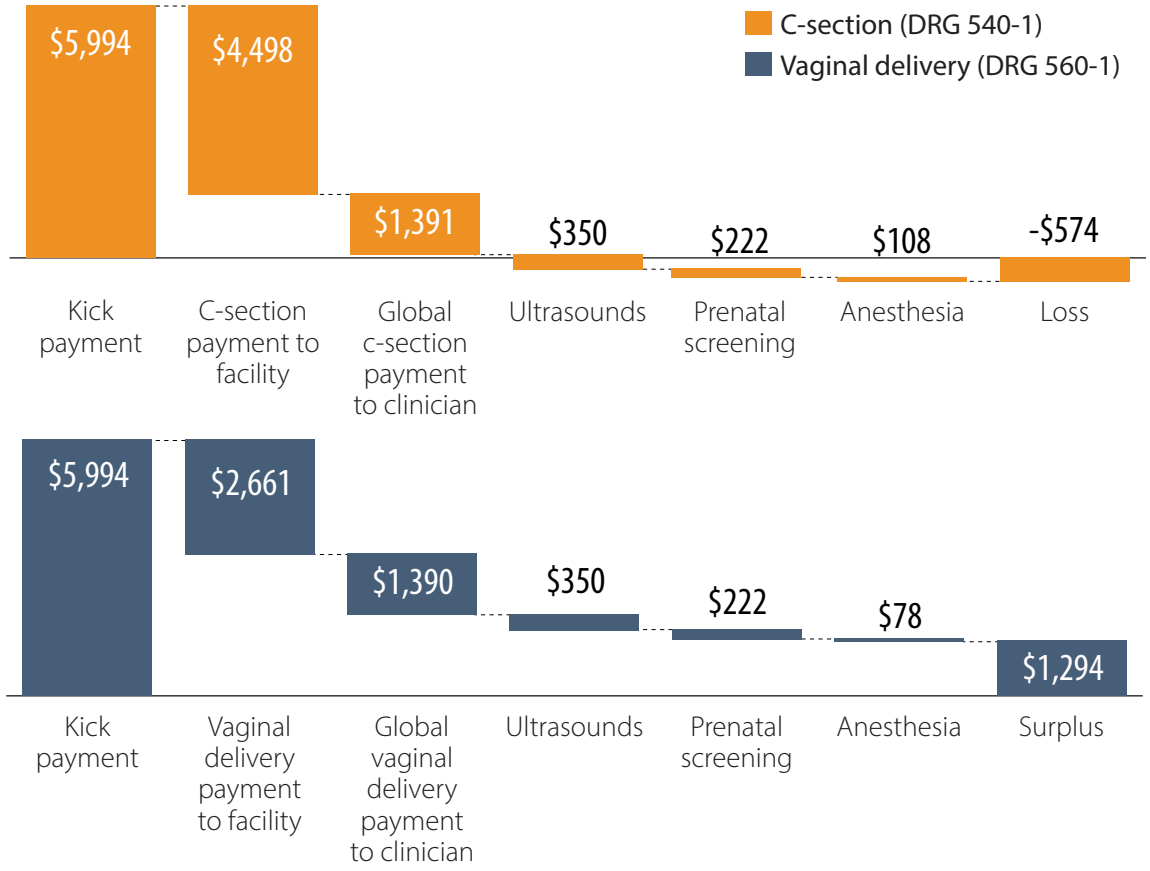
For counties with a single managed care plan, maternity spending is factored into monthly capitation rates paid by DHCS. For counties with more than one plan, maternity services are treated differently because births are high-cost events and may not be evenly distributed between plans in a given year. As a result, plans receive a supplemental payment for every live birth, designed to cover the physician and facility spending for the birth episode.[10] These supplemental payments are commonly referred to as "kick" payments.

Payments are based on the historical spending for deliveries in each county and are the same for each plan. This structure provides an in-year incentive[11] for plans to reduce unnecessary c-sections and other costly interventions, as the kick payment may not fully cover the spending for a c-section, resulting in a loss. By comparison, the kick payment more than covers the spending for a vaginal birth, resulting in a small surplus. Figure 2 illustrates an example of this using kick payment rates for Kern County and common perinatal utilization using the FFS fee schedule and the facility-specific DRG rate for a high-volume maternity hospital in the county.

How Managed Care Plans Pay Providers

While the example above is illustrative, in interviews with seven Medi-Cal managed care organizations conducted in the autumn of 2019,[12] many noted that they often use the FFS fee schedule, though some noted that they may pay 10% to 30% more than FFS rates. Contracts vary by provider and are often proprietary and confidential. Some plans have adopted the state's APR-DRGs for their hospital contracting, but others rely on per diem rates. Under per diems, plans play hospitals a negotiated rate per day. This provides an incentive for the hospital to reduce variable costs within a day but provides no incentive to reduce length of stay.

Figure 2. Supplemental "Kick" Payments Are the Same Regardless of Mode of Delivery, Creating an Incentive for Plans to Reduce Unnecessary C-sections



Source: Kern County Maternity Kick Payments from DHCS FY 2017/18. Medi-Cal reimbursement sourced using DHCS fee schedule and DRG calculator accessed March 10, 2020. Bakersfield Memorial used for DRG example.

DHCS and Managed Care Plan Perinatal Quality Programs: Incentives and Accountability

PRIME: One of four elements of the Medi-Cal 2020 1115 waiver, the PRIME (Public Hospital Redesign and Incentives in Medi-Cal) program created pay-for-performance incentives of up to $3.26 billion over five years for public and district and municipal hospitals. Twenty hospitals worked on improving perinatal care, focusing on five goals:[14]

1. Decrease maternal morbidity and mortality related to obstetrical hemorrhage.
2. Promote vaginal birth.
3. Foster breastfeeding.
4. Support smooth transitions from hospital to home.
5. Ensure access to timely comprehensive, evidence-based prenatal and postpartum care.

A June 2018 interim evaluation of the first three years of self-reported data showed that PRIME hospitals improved performance on the following metrics:

- Prenatal and postpartum care
- C-section rates
- Exclusive in-hospital breastfeeding rates and Breast Friendly Certification

Performance on outcome measures, including obstetrical hemorrhage and unexpected newborn complications, was more mixed. When restricting to Medi-Cal data, and comparing to peer hospitals not participating in PRIME (which was not possible for all measures), performance improved relative to peers for prenatal care, among participating public hospitals. Performance on c-section rates also improved, but at the same rate of improvement as in comparison hospitals.[15]

California Maternal Quality Care Collaborative (CMQCC): The PRIME program, along with two large Medicaid managed care plans, Inland Empire Health Plan and Partnership HealthPlan of California, required network hospitals to participate in CMQCC, a statewide, multi-stakeholder quality improvement organization, and provided incentives for network hospitals to reduce low-risk c-section rates. CMQCC's work is associated with a significant decline in the rate of low-risk c-sections without a negative impact to maternal and neonatal safety.[16] In addition, Partnership HealthPlan of California provided incentives for strong performance related to early elective deliveries and exclusive breastfeeding. The California Children's Services program requires participating hospitals to participate in CMQCC's sister organization, the California Perinatal Quality Care Collaborative, which focuses on quality improvement in neonatal intensive care units, and has a similar track record of success.[17]

Medi-Cal Accountability Set: Two perinatal measures — timely prenatal and postpartum care — are included in the set of measures that DHCS uses to evaluate Medi-Cal managed care plans. Plans must perform above a minimum level on these measures or face sanctions and corrective action plans. In 2020, performance on the timely prenatal care measure was one of a subset of quality measures that DHCS used to assign new members who did not select a plan, in order to encourage competition between plans and strengthen the business case for improving quality.[18]

In addition, some plans rely heavily on value-based payment mechanisms such as global or professional services capitation to delegated medical groups.[13] These risk-bearing groups use a combination of capitation and fee-for-service to pay their contracted providers and, like managed care plans, vary in their rates and approaches, which are proprietary and confidential. Some stakeholders raised concerns about access to CPSP services in managed care and the delegated environment, and there is very little publicly available data about utilization of the program.

In summary, Medi-Cal payment complexity is challenging for providers and plans to understand and navigate. California could benefit from examining and adopting policies that other states have implemented and proven effective, particularly around payment policies that do not reward unnecessary intervention and ensure continuity of care across the perinatal episode (see Table 2 on page 6). Specific areas that warrant consideration include the following:

- **Rewarding outcomes:** Clinicians and hospitals continue to be paid based on the type of delivery rather than the outcome, with no reward for the sometimes time- and resource-intensive practice of supporting physiologic birth[19] (e.g., waiting out a labor that has slowed or staying on-site to ensure the safety of a vaginal birth after a prior c-section). In addition, California could follow the lead of other states and stop paying for procedures that are not concordant with guidelines.
- **Ensuring continuity of care across the perinatal episode:** FQHCs face a disincentive to provide continuity of care through the delivery. Similarly, doulas and other perinatal allied health professionals and community health care workers are reimbursed in the ambulatory setting through CPSP, but not in the hospital setting.

Table 2. Medicaid Policies from Other States That California Might Consider

Category	Specific Policy	States
Covered benefits	Covers doulas or other continuous labor support provider.	IN, MN, NJ, NY, OR, WA
Payment policies	Uses blended rates (a single payment amount for delivery, regardless of whether it was cesarean or vaginal) and/or bundled payments (a single fixed payment for a group of maternity services (e.g., prenatal care, delivery, and postpartum visit).	AL, AZ, AR, MI, MN, NC, OH, TN, WA, WI, WY
	Reduces payments or does not cover procedures that do not follow clinical guidelines (e.g., early elective deliveries, elective inductions, and c-sections that are not medically indicated).	AK, FL, GA, IN, IA, LA, MN, MS, MO, MT, NV, NM, NY, NC, OK, OR, SC, TX, WA, WY

Source: Mathematica, *Inventory of State-Level Medicaid Policies, Programs, and Initiatives to Improve Maternity Care and Outcomes,* Medicaid and CHIP Payment and Access Commission, March 2020.

- **Improving access to midwife-led care and labor support:** While DHCS has ensured that midwives receive the same payment as physician providers in FFS, this is not always true in managed care plans.[20] In addition, DHCS has not created a means to reimburse for physician supervision of certified nurse-midwives and nurse practitioners, which often runs about $500 per month.[21] Finally, oversight and surveillance of access to midwife-led care in both hospitals and freestanding birth centers could be strengthened, particularly in the delegated model, given how important these options are to pregnant people covered by Medi-Cal, and the evidence of their positive impact on birth outcomes.[22]
- **Ensuring sufficient resources for quality improvement:** Evidence shows that hospital-level quality improvement matters, and given the reimbursement discrepancy between Medi-Cal and commercial, it is possible that hospitals that serve a disproportionate share of pregnant people with Medi-Cal coverage may not have the resources for robust quality improvement. The PRIME program demonstrated what is possible in public and district hospitals, but almost three-quarters of the hospitals that have concentrated numbers of Medi-Cal deliveries are investor owned or nonprofit.
- **Reducing payment complexity:** Providers face a convoluted array of payment mechanisms from DHCS, plans, and delegated medical groups, making it difficult to draw a line between payment and action or create transparency. In addition, with few exceptions, no plan has enough share of any provider's volume to foment practice change. This creates opportunities for statewide action and/or multipayer alignment.

For an overview of maternity services in the Medi-Cal program, please see companion paper *Medi-Cal Explained: Maternity Care* available for download on CHCF's website.

Medi-Cal Explained is an ongoing series on Medi-Cal for those who are new to the program, as well as those who need a refresher. To see other publications in this series, visit www.chcf.org/MC-explained.

Endnotes

1. We use the term "pregnant person" to recognize that not all people who become pregnant and give birth identify as a woman or a mother.
2. Steve Zuckerman, Aimee Williams, and Karen Stockley, *Medi-Cal Physician and Dentist Fees: A Comparison to Other Medicaid Programs and Medicare,* California HealthCare Foundation, April 2009.
3. Zuckerman, Williams, and Stockley, *Medi-Cal Physician and Dentist Fees.*
4. Author analysis of Department of Health Care Services, *FQHC and RHC Current Rates Report,* accessed April 30, 2020.
5. Author analysis of California FQHCs from "2019 Uniform Data System (UDS) Resources," Healthcare Resources and Services Administration, Bureau of Primary Health Care, accessed September 2, 2020.
6. Author analysis of Department of Health Care Services, *Hospital Quality Assurance Fee Program Model (HQAF VI),* accessed August 1, 2020.
7. Department of Health Care Services, "Diagnosis Related Group Hospital Inpatient Payment Methodology," last modified April 8, 2020.
8. Richard F. Averill et al., *All Patient Refined Diagnosis Related Groups (APR-DRGs), Version 20.0: Methodology Overview* (PDF), 3M Health Information Systems, 2003.
9. Ilir Hoxha et al., "Caesarean Sections and For-Profit Status of Hospitals: Systematic Review and Meta-Analysis," *BMJ Open* 7, no. 2 (February 17, 2017): e013670, doi:10.1136/bmjopen-2016-013670.
10. Michael Engelhard, Steve Soto, and Athena Chapman, *Medi-Cal Payment to Managed Care Plans — Current Process and Challenges,* California Health Care Foundation, February 2019.
11. The incentive is limited to in-year because DHCS bases what it pays plans on the spending they have incurred in the past. As a result, when a managed care plan improves quality and efficiency of the care, resulting in less spending, DHCS reduces what it pays the plan in the next rate-setting cycle. This so-called "premium slide" may discourage plans from making investments that result in lower total cost of care. More details are available at *Intended Consequences: Modernizing Medi-Cal Rate Setting to Improve Health and Manage Costs*.
12. Plans interviewed included CalOptima, Community Health Group of San Diego, Health Net, Inland Empire Health Plan, L.A. Care Health Plan, Partnership HealthPlan of California, and Santa Clara Family Health Plan.
13. Blair Dudley, *Promoting Midwifery and High Value Care in Medi-Cal,* Pacific Business Group on Health, April 2020.
14. Liane Winter, *PRIME: Improving Maternity Care and Outcomes via Collaboration,* California Department of Health Care Services, December 7, 2017.
15. Nadereh Pourat et al., *Interim Evaluation of California's Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program,* UCLA Center for Health Policy Research, March 2020.
16. Elliott K. Main et al., "Safety Assessment of a Large-Scale Improvement Collaborative to Reduce Nulliparous Cesarean Delivery Rates," *Obstetrics & Gynecology* 133, no. 4 (April 2019): 613–623, doi:10.1097/AOG.0000000000003109.
17. Henry C. Lee et al., "Comparison of Collaborative Versus Single-Site Quality Improvement to Reduce NICU Length of Stay," *Pediatrics* 142, no. 1 (July 2018): e20171395, doi:10.1542/peds.2017-1395.
18. Department of Health Care Services, *Medi-Cal Managed Care: Auto-Assignment Incentive Program Overview,* updated October 2019.
19. A normal physiologic labor and birth is one that is powered by the innate human capacity of the pregnant person and fetus. This birth is more likely to be safe and healthy because there is no unnecessary intervention that disrupts normal physiologic processes.
20. Dudley, *Promoting Midwifery and High Value Care in Medi-Cal.*
21. Brendan Martin and Maryann Alexander, "The Economic Burden and Practice Restrictions Associated with Collaborative Practice Agreements: A National Survey of Advanced Practice Registered Nurses," *Journal of Nursing Regulation* 9, no. 4 (January 2019): 22–30, doi:10.1016/S2155-8256(19)30012-2.
22. Lisa Dubay et al., "Improving Birth Outcomes and Lowering Costs for Women on Medicaid: Impacts of 'Strong Start for Mothers and Newborns,'" *Health Affairs (Millwood)* 39, no. 6 (June 2020): 1042–1050, doi:10.1377/hlthaff.2019.01042.

Acknowledgments

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