



## **Low-risk, Primary Cesarean Births in Medicaid: NAMD/AMCHP Issue Brief**

**July 2015**

### **EXECUTIVE SUMMARY**

Across the country, Medicaid programs are implementing system wide payment and delivery reforms that reward quality care and move away from volume-based payment. Within these efforts, states are identifying a range of opportunities to drive innovation and deliver value for pregnant women and infants covered by the program. In some cases, states are targeting their innovation to address the excess use of cesarean births (C-sections) for low-risk, first time mothers (low-risk, primary C-sections). Low-risk births are understood to be births for which the conditions are optimal for vaginal delivery.<sup>1</sup> In many hospitals and geographic regions, the rate of these C-sections greatly exceeds what experts consider acceptable.<sup>2</sup> As such, states are focusing on this issue in order to address the adverse outcomes that result from low-risk, primary C-sections, as well as the significant cost implications of its overuse. These states see an opportunity to have a positive ripple effect on quality and costs by targeting this subset of births.

This issue brief, developed by the National Association of Medicaid Directors (NAMD) in partnership with the Association of Maternal & Child Health Programs (AMCHP), lays out key background information and the elements of state strategies to address the excessive use of C-sections for low-risk, first time mothers. It is important to note that this resource seeks to provide a high-level review of state options and does not offer a comprehensive analysis of this topic.

### **BACKGROUND**

As a major payer and market force in maternal and child health, Medicaid agencies are essential to innovations that improve the health of pregnant women and their children. Recent efforts to curb early elective deliveries demonstrate the potential impact of these reforms. As Medicaid programs transition to paying for value rather than volume, quality improvement for mothers and their infants continues to occur within the framework of these broader reforms, such as bundled payments, accountable care organizations, and health home programs.

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<sup>1</sup> Elliott Main, Christine Morton, David Hopkins, Giovanna Guiliani, Kathryn Melsop, and Jeffrey Gould, "Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Quality," California Maternal Quality Care Collaborative, December 2011. <https://www.cmqcc.org/resources/2079>, 6.

<sup>2</sup> Ibid., 53.

State Title V Maternal and Child Health Services (Title V) programs also are a vital partner in the work to improve maternal health and birth outcomes in Medicaid. Title V programs administer numerous public efforts that are natural access points for building and strengthening integrated service delivery systems. These include prenatal care programs, home visitation, early intervention for children with developmental delays (Part C of the *Individuals with Disabilities Education Act*), Special Supplemental Food and Nutrition Program for Women, Infants, and Children (WIC) programs, specialty clinics for children with special health care needs, and statewide toll-free hotlines to facilitate access to care.

C-sections, though often medically necessary and lifesaving, can place mothers and their babies at greater risk of certain adverse outcomes compared to vaginal birth. For example, mothers face a greater risk of infection and blood clots, and newborns face greater chances of respiratory distress and admission to a neonatal intensive care unit (NICU).<sup>3</sup> As a result, the excessive use of C-sections and variation between hospitals in the use of this procedure when not medically necessary opens up an opportunity for quality improvement efforts.<sup>4</sup> In addition, the overuse of low-risk C-sections also increases costs to the program. According to 2011 data, average hospital charges for a C-section without complications was \$7,202 more than the average hospital charges for a vaginal birth without complications (this excludes any additional charges for care provided to the newborn, such as NICU costs).<sup>5</sup>

To address the excessive use of non-medically indicated C-sections, some states are focusing on the subset of C-sections for low-risk births to first-time mothers. Delivering a baby via C-section for a first-time mother can have a ripple effect on quality and costs. Ninety percent of women who have a C-section for a first birth end up needing to have a C-section for a subsequent birth.<sup>6</sup> Reducing the excess use of low-risk, primary C-sections is seen as a way to decrease the chance of future C-sections, which can lead to compounding quality improvement and cost savings.

On the surface, the excessive and non-medically indicated use of a service seems like a simple problem to resolve. However, states recognize that high rates of low-risk, primary C-sections are driven by many complex factors and there is no one-size-fits-all solution to reducing these rates. Some factors may include medical liability concerns for physicians, the use of electronic fetal monitoring, the culture of scheduling births, and changes in obstetric practices.<sup>7</sup> States tackling this issue must weigh the influence of these factors, and leverage a range of policy and

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<sup>3</sup>Main, et al, "Cesarean Deliveries," 27; Katy Backes Kozhimannil, Michael Law, and Beth Virnig, "Cesarean Delivery Rates Vary Tenfold Among US Hospitals; Reducing Variation May Address Quality and Cost Issues," *Health Affairs*, Vol. 32, No. 3, March 2013, <http://cfpcwp.com/MCDG/wp-content/uploads/2013/02/Health-Aff-2013-Kozhimannil-527-35.pdf>, 527.

<sup>4</sup>"Obstetric Care Consensus," American Congress of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine, No. 1, March 2014, [https://www.acog.org/Resources\\_And\\_Publications/Obstetric\\_Care\\_Consensus\\_Series/Safe\\_Prevention\\_of\\_the\\_Primary\\_Cesarean\\_Delivery](https://www.acog.org/Resources_And_Publications/Obstetric_Care_Consensus_Series/Safe_Prevention_of_the_Primary_Cesarean_Delivery).

<sup>5</sup>"Average U.S. Facility Charges for Giving Birth," National Partnership for Women and Families, <http://transform.childbirthconnection.org/resources/datacenter/chargeschart/>.

<sup>6</sup>Elliott Main, Christine Morton, David Hopkins, Giovanna Guiliani, Kathryn Melsop, and Jeffrey Gould, "Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Quality," California Maternal Quality Care Collaborative, December 2011. <https://www.cmqcc.org/resources/2079>, 55.

<sup>7</sup> *Ibid.*, 7.

payment reforms to address them. They also must identify ways to bring in the consumer voice regarding the health choices available to her in this process. Further, the complexity of the factors also requires states to develop strategies to ensure they do not inadvertently discourage necessary C-sections. Many states demonstrated the ability to hone similar strategies to reduce the non-medically indicated use of a service, such as efforts to address early (before 39 weeks) elective deliveries.

The excess use of low-risk, primary C-sections in Medicaid represents one of many opportunities for quality improvement and delivering value as part of ongoing state delivery system reforms. It also is a key opportunity for partnership with Title V agencies, which oversee, fund and interact with programs that can improve the rates of low-risk, primary C-sections. Title V also is required by statute to coordinate with their state Medicaid program, offering an opportunity to provide expertise on ways to target the excessive use of low-risk, primary C-sections.

## **ELEMENTS OF STATE STRATEGIES**

Because the excessive use of C-sections among low-risk, first-time mothers is a complex issue, multiple pathways to reform are necessary to drive change. Some of the main pathways to reform include transparency and reporting on low-risk C-section rates; education efforts for providers and consumers on the risks of non-medically indicated C-sections; and payment mechanisms that target the overuse of C-sections for low-risk, first-time mothers. Because Medicaid is the single largest payer of births in the United States, payment is the most salient strategy for Medicaid to address this issue.

Efforts to address excessive rates of low-risk, primary C-sections generally do not occur in isolation, but they often take place in partnership with sister state agencies and within larger state strategies to improve maternal health and birth outcomes, reducing disparities. Sister state agencies, such as the state Title V programs and public health departments, are likely to share a common interest in addressing this issue. They also are well-positioned to partner with Medicaid and often house additional subject matter expertise, key data, and unique tools that Medicaid may not have at its disposal. The elements of state strategies to address the excessive use of low-risk, primary C-sections in Medicaid are explored in the sections that follow, as well as opportunities for interagency partnership within each element.

**Payment.** As discussed above, Medicaid's most effective tool to promote transformation around the excessive use of low-risk, primary C-sections is the use of payment levers. Although payment approaches will vary across states, the goal of these mechanisms is the same: incentivize the use of vaginal deliveries for low-risk, primary births and discourage the excessive use of non-medically indicated C-sections. Medicaid has the market power to drive systemwide change by rewarding quality-based care and value. Likewise, public health programs, such as Title V, bring the population health and community-based perspectives to multiply the impact of these payment levers and help realize a state goal of reducing the excessive use of low-risk, primary C-sections.

A key consideration for states in designing a payment approach is the level within the delivery system to target. States may focus the payment initiative at hospitals, providers, or managed care plans. Each level raises unique considerations and has a fundamental impact on the design of the approach. In addition, states may find it appropriate to roll the approach into a larger payment reform that is promoting value in the program.

While the payment approaches to address excessive use of low-risk, primary C-sections vary to a great degree, some examples of potential payment approaches include:

- Blending payment for births to provide a similar payment rate for C-sections as for vaginal births
- Creating and defining an “episode” of perinatal care as an alternative to paying for one visit at a time. This approach places the focus on paying for outcomes rather than each service delivered, including reducing low-risk, primary C-sections
- Retaining a portion of the state payment to managed care companies and allowing plans to receive the withheld funds on the achievement of quality performance benchmarks, including benchmarks around low-risk, primary C-section rates
- Withholding a portion of supplemental funds for hospitals and making the funds available based on performance on quality metrics, such low-risk, primary C-sections
- Paying non-medically indicated C-sections at the vaginal birth rate to discourage low-risk, primary C-sections

**Data.** Vital records serve as the basis for states to determine the degree that C-sections are being used for low-risk women, including first-time mothers, and the level of practice variation between providers and hospitals. While the data provide baseline information for states, it also underpins many policy interventions to address this issue. For example, states need this data in order to establish a benchmark for low-risk, primary C-section rates that Managed Care Organizations (MCOs) would be expected to achieve. It does this by allowing states to calculate the average low-risk, primary C-section rate among all hospitals and the variation between hospital performance. This statistic then helps states determine what low-risk, primary C-section rate might be a reasonable benchmark for hospitals to achieve.

Since vital records are housed within the public health department, Medicaid must partner with this sister state agency around the use of this data. The agencies will determine how to link vital records and Medicaid administrative data if this linkage does not exist already. This may involve the development of data use agreements or going through the process of institutional review board clearance.<sup>8</sup> Many states have already built this partnership, offering the opportunity for others to

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<sup>8</sup>“Strategies for Using Vital Records to Measure Quality of Care In Medicaid and CHIP Programs,” Medicaid.gov, Medicaid/CHIP Health Care Quality Measures, Technical Assistance Brief, No. 4, January 2014, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Using-Vital-Records.pdf>, 3.

learn about promising practices for collaboration in this area. Medicaid and the public health department also may want to partner in their analysis of the data. In particular, public health departments often house analytic expertise, including epidemiologists, that Medicaid may lack and can support a more robust review of the vital record data.

**Quality/Value Measurement.** Policy approaches that address the excessive use of low-risk, primary C-sections typically rely on a quality measure that allows states to assess hospital, provider and/or MCO performance. Vital records and other Medicaid data serve as the basis for calculating this quality measure. For example, states need a standardized measure in order to conduct hospital reporting on low-risk, primary C-section rates. Likewise, states need a quality measure to establish a benchmark for performance that triggers a payment adjustment. These comparisons, which are made possible through the underlying data and quality metric, allow states to determine what providers are meeting desired goals, while identifying providers that may be underperforming.

Some states are currently utilizing a National Quality Forum-endorsed measure on low-risk, primary C-sections (NQF #0471) to support their policies in this area.<sup>9</sup> This quality measure is currently included in the Centers for Medicare and Medicaid Services child core set of quality measures.<sup>10</sup> The calculation of this measure relies on vital records data (discussed above), and four of the key data elements derived from the vital records include:

- *Parity.* This shows whether it is a women's first time giving birth and specifies the number of pregnancies a woman has delivered at 20 weeks or beyond
- *Gestational age.* This describes how far along the woman is in the pregnancy and is measured in weeks
- *Plurality.* This reveals whether a woman is delivering one or more fetuses in a given pregnancy
- *Presentation.* This reveals the position of the fetus in the birth canal when giving birth<sup>11</sup>

For the NQF-endorsed measure, states are focusing on women with a parity of zero, gestational age of 37 weeks or greater, a plurality of one and presentation as vertex. Vertex presentation is when the baby is head first in the birth canal.<sup>12</sup>

As with all quality measurement, the accuracy of this measure relies on the consistency with which data are coded. The consistency with which "presentation" of the baby is coded is particularly important as this data element is key to ensuring that only low risk births, which are those babies that present as vertex (the baby is head-first in the birth canal), are included.<sup>13</sup> If concerns exist in

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<sup>9</sup>"NQF #0471 PC-02 Cesarean Section," National Quality Forum, <https://www.cmqcc.org/resources/2073/download>.

<sup>10</sup> "2015 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)," Centers for Medicare and Medicaid Services, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-child-core-set.pdf>.

<sup>11</sup> "Obstetric Data Definitions (Version 1.0)." American College of Obstetricians and Gynecologists. 2014. <http://www.acog.org/-/media/Departments/Patient-Safety-and-Quality-Improvement/2014reVITALizeObstetricDataDefinitionsV10.pdf>.

<sup>12</sup> Ibid.

<sup>13</sup> Ibid.

the consistency of this data element, states may find it appropriate to use the ICD-9/ICD-10 diagnosis codes as an alternative to determine presentation of the baby.

**Stakeholder Engagement.** As with other Medicaid and public health efforts, stakeholders play an essential role in policies that address excessive rates of low-risk, primary C-sections. In addition to partnership with sister state agencies, such as Title V agencies and state public health departments, it may be beneficial to bring in a wide range of other groups to this work. Key stakeholders for these policy efforts will likely include:

- Hospitals
- OB/GYNs and nurse-midwives
- Labor and delivery teams
- Pregnant women
- Consumer and/or professional organizations that traditionally conduct outreach to pregnant women, like the March of Dimes, the Childbirth Connection, and Association of Women's Health, Obstetric and Neonatal Nurses
- MCOs

Partnership with each of these groups, as well as other relevant entities, may help states effectively tackle the varied drivers of this multifaceted issue. Specifically, states point to the importance of engaging consumers and consumer-focused groups in a thoughtful manner, and recognize that consumer demand may exist to avoid C-sections due to concerns with the after-effects of vaginal birth.<sup>14</sup> In addition, private payers also may be an effective partner to help Medicaid expand its market power and drive wider-reaching change around the overuse of low-risk, primary C-sections.

Some examples of stakeholder approaches may include:

- Forming workgroups or collaboratives (or leveraging an existing workgroup such as a perinatal quality collaborative) to identify and implement policy solutions
- Partnering with provider associations to offer education on birthing methods through written resources or the direct provision of evidence-based training
- Partnering with hospital associations and other professional societies such as the American College of Obstetricians and Gynecologists (ACOG) to further policies and help implement evidence based guidelines
- Collaborating with MCOs to promote consumer education on vaginal delivery and risks of non-medically indicated C-sections

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<sup>14</sup> See the Academy for Health Care Research and Quality's technical assessment, "Cesarean Delivery on Maternal Request." March 2006. <http://archive.ahrq.gov/downloads/pub/evidence/pdf/cesarean/cesarreq.pdf>.

Medicaid also has a range of opportunities to partner with Title V agencies and public health departments to enhance its stakeholder engagement efforts. For example, public health departments have unique relationships with hospitals, which these agencies often license and regulate. Because of this, joint outreach to hospitals may be appropriate and could enhance the effectiveness of this work. In addition, agencies that administer WIC also may be a prime partner for stakeholder engagement. These agencies work with many pregnant women served by Medicaid and could support consumer education around normal labor and delivery.

## CONCLUSION

As Medicaid programs implement system wide reforms that reward value, efforts to target the excessive use of low-risk, primary C-sections will likely continue to be a focus for some states. Although a variety of policy approaches may be used to drive this innovation for pregnant women and their infants, payment approaches will continue to be the most salient strategy for Medicaid. In addition, there will continue to be key opportunities for partnership with Title V agencies, and other state agencies that are focused on this issue. Likewise, many of the elements raised in this resource will underpin the plethora of approaches used to address the quality and cost implications of the excessive use of low-risk, primary C-sections in the program.

## RESOURCES

The following resources provide additional information on the issue of low-risk, primary C-sections and aim to support Medicaid programs that are interested in taking a deeper look at this maternal health and birth outcomes issue.

“Cesarean Rate for Low Risk, First Birth Women (NTSV CS Rate).” California Maternal Quality Care Collaborative.

[https://www.cmqcc.org/maternity\\_quality\\_measures/cesarean\\_rate\\_for\\_low\\_risk\\_first\\_birth\\_women\\_ntsv\\_cs\\_rate](https://www.cmqcc.org/maternity_quality_measures/cesarean_rate_for_low_risk_first_birth_women_ntsv_cs_rate).

“Forging a Comprehensive Initiative to Improve Birth Outcomes and Reduce Infant Mortality: Policy and Program Options for State Planning.” Association of Maternal & Child Health Programs. July 2012.

<http://www.amchp.org/programsandtopics/womens-health/Focus%20Areas/improvingbirthoutcomes/infant-mortality/Documents/AMCHP%20Birth%20Outcomes%20Compendium%202012.pdf>

Health for Every Mother A Maternal Health Resource and Planning Guide for States. Association of Maternal & Child Health Programs. Spring 2015.

[http://www.amchp.org/programsandtopics/womens-health/Focus%20Areas/MaternalMortality/Documents/Health-for-Every-Mother\\_FINAL\\_WebOptimized.pdf](http://www.amchp.org/programsandtopics/womens-health/Focus%20Areas/MaternalMortality/Documents/Health-for-Every-Mother_FINAL_WebOptimized.pdf)

Kozhilmannil, Katy Backes, Michael Law, and Beth Virnig. “Cesarean Delivery Rates Vary Tenfold Among US Hospitals; Reducing Variation May Address Quality and Cost Issues.” *Health*

*Affairs*. Vol. 32, No. 3, March 2013, 527-535. <http://cfpcwp.com/MCDG/wp-content/uploads/2013/02/Health-Aff-2013-Kozhimannil-527-35.pdf>.

Main, Elliott, Christine Morton, David Hopkins, Giovanna Giuliani, Kathryn Melsop and Jeffrey Gould. "Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Quality." California Maternal Quality Care Collaborative. December 2011. <https://www.cmqcc.org/resources/2079>.

"NPP Maternity Action Pathway Final 2012 Progress Report: Improving Maternity Care for Mothers and Babies." National Priorities Partnership. National Quality Forum. Dec. 19, 2012. <http://www.astho.org/WorkArea/DownloadAsset.aspx?id=8024>.

"NQF #0471 PC-02 Cesarean Section." National Quality Forum. <https://www.cmqcc.org/resources/2073/download>.

"Obstetric Care Consensus Statement: Safe Prevention of the Primary Cesarean Delivery." American Congress of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine. No. 1, March 2014. <http://www.acog.org/Resources-And-Publications/Obstetric-Care-Consensus-Series/Safe-Prevention-of-the-Primary-Cesarean-Delivery>.

Osterman, Michelle, and Joyce Martin. "Trends in Low-risk Cesarean Delivery in the United States, 1990-2013," Centers for Disease Control, Division of Vital Statistics, National Vital Statistics Report, Vol. 63 No. 6, Nov. 5, 2014, [http://www.cdc.gov/nchs/data/nvsr/nvsr63/NVSR63\\_06.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr63/NVSR63_06.pdf).

"State Title V Program Approaches to Improving Birth Outcomes: Lowering Non-Medically Indicated Deliveries." Association of Maternal and Child Health Programs. January 2014. [http://www.amchp.org/Policy-Advocacy/health-reform/Documents/AMCHP\\_Kellogg\\_NMI%2039%20week%20Issue\\_Brief%20FINAL.pdf](http://www.amchp.org/Policy-Advocacy/health-reform/Documents/AMCHP_Kellogg_NMI%2039%20week%20Issue_Brief%20FINAL.pdf).

"Strategies for Using Vital Records to Measure Quality of Care In Medicaid and CHIP Programs." Medicaid.gov. Medicaid/CHIP Health Care Quality Measures, Technical Assistance Brief, No. 4, Jan. 2014. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Using-Vital-Records.pdf>.