

LOW RISK CESAREAN DELIVERIES

National Performance Measure 2: Percent of cesarean deliveries among low-risk first births.

Goal: To reduce the number of cesarean deliveries among low-risk first births.

Definition: Numerator: Cesarean delivery among term (37+ weeks), singleton, vertex births to nulliparous women/ Denominator: All term (37+ weeks), singleton, vertex births to nulliparous women.

Healthy People 2020 Objectives:

Maternal, Infant, and Child Health (MICH) Objective 7.1. Reduce cesarean births among low-risk women with no prior cesarean (Baseline: 26.5%, Target: 23.9%).

Data Source: Birth certificates.

Policy Context:

While cesarean delivery can be a life-saving procedure, it poses avoidable maternal risks of morbidity and mortality for most low-risk women. In addition to the avoidable risks for women, avoiding unnecessary health care costs are a reason to reduce non-medically indicated cesarean deliveries and labor inductions prior to 39 weeks gestation. Trends are changing as a result of the efforts of national organizations, federal initiatives, and state program and policy efforts.

This low-risk cesarean measure is endorsed by the American College of Obstetrics and Gynecologists (ACOG), The Joint Commission (PC-02), National Quality Forum (#0471), Center for Medicaid and Medicare Services (CMS) - CHIPRA Child Core Set of Maternity Measures, and the American Medical Association-Physician Consortium for Patient Improvement.

An important related policy trend is aimed at reducing the rate of early elective deliveries. ACOG clinical guidelines discourage elective deliveries prior to 39 weeks gestation without medical or obstetrical need. As part of the Strong Start for Mothers and Newborns initiative, the Centers for Medicare and Medicaid is supporting projects that encourage best practices for reducing the number of early elective deliveries, partnering with national organizations and more than 3,700 hospitals participating in Hospital Engagement Networks (HENs).

(<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/EED-Brief.pdf>). Measurement of early elective deliveries has become a standard expectation for state Medicaid agencies.

The Collaborative Improvement and Innovation Networks (CoIIN) sponsored by the Health Resources and Services Administration in partnership with the States and private sector organizations includes a focus on reducing early elective deliveries as one core strategy for

reducing infant mortality. In addition, several innovative states (e.g., Arkansas, Indiana, Minnesota, Louisiana, New York, New Mexico, North Carolina, South Carolina, Tennessee, Texas, and Washington State) have modified their Medicaid payment and provider policies in an effort to reduce non-medically indicated, early elective deliveries. Several states are changing practices through collaborative improvement projects (e.g., Alabama, California, Florida, Kentucky, Maryland, Michigan, Mississippi, Oklahoma, Ohio, North Carolina, Tennessee).

Action Agenda for State Title V MCH Block Grant Programs:

- Link vital statistics birth records with Medicaid claims data to get a more accurate estimate of the proportion of cesarean or early elective deliveries in your state. (<http://www.childhealthdata.org/browse/medicaid-perinatal-data-portal>).
- Collect and report cesarean and/or early elective deliveries based on one of the national performance measures.
- Encourage use of doula support through training, certification, and Medicaid payment policies.
- Use perinatal partnerships or quality collaboratives to change clinical practice in hospitals.
- Use the “Healthy Babies are Worth the Wait” multi-stakeholder collaborative model developed in Kentucky by public health, March of Dimes, and others.
- Require hospitals participating in Medicaid to establish prior authorization or peer review prior to scheduling early elective deliveries (through regulation or contracts).
- Require monthly reporting of hospital early elective deliveries rates by gestational age (through public health or Medicaid regulations).
- Use Medicaid payment policy to create disincentives for early elective cesarean deliveries (e.g., equalize payment for low-risk vaginal and cesarean births).
- Deny Medicaid payment for non-medically indicated early elective deliveries.
- Provide Medicaid financial bonus payments for hospitals that achieve a targeted performance goal or defined reduction in early elective deliveries.