Smart Care California
Meeting #6

Monday, June 5, 2017
10:30am-3:30pm

Department of Health Care Services (DHCS)
1700 K St, Sacramento, CA, 95811
<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Facilitator</th>
<th>Meeting Materials</th>
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<tbody>
<tr>
<td>10:00 AM</td>
<td>Light Breakfast and Networking</td>
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<tr>
<td>10:30 AM</td>
<td>Welcome and Introductions, Role of Smart Care CA</td>
<td>Lance Lang, MD, Covered CA</td>
<td>• Participant List</td>
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<tr>
<td>10:40 AM</td>
<td>Straw Proposal to Align Payment and Contracting with Medically Necessary use of C-sections</td>
<td>Lance Lang, MD, Covered CA</td>
<td>• C-section Levers for Change</td>
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<td>• Straw Proposal of Payment and Contracting Strategies</td>
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<tr>
<td>10:50 AM</td>
<td>C-Section Payment as a Priority: Overview of value-based payment for birth in California and nationally</td>
<td>Elliott Main, MD, California Maternal Quality Care Collaborative</td>
<td>• National Association of Medicaid Directors Low-risk, Primary Cesarean Births in Medicaid Issue Brief</td>
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<td>• Maternity Improvement Projects in California: Supporting Initiatives</td>
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<td>• C-Section Payment as a Priority (slide deck)</td>
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<tr>
<td>11:35 AM</td>
<td>Aligning Birth Payment with Desired Outcomes: How has it worked so far and what are the challenges and lessons learned?</td>
<td>Lance Lang, MD, Covered CA</td>
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<td></td>
<td>• Purchaser perspective</td>
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<td>○ Lance Lang, MD, Covered CA</td>
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<td>• Health plan perspective</td>
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<td>○ Barb Wentworth, PhD, and Pooja Mittal, DO, Health Net</td>
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<td>• Provider perspective</td>
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<td>○ Allyson Brooks, MD and Maureen Sparks, Hoag</td>
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<td>○ Jim Leo, MD, and Jennifer McNulty, MD, MemorialCare</td>
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<td>12:35 PM</td>
<td>Lunch -30 minutes</td>
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<td>1:05 PM</td>
<td>Discussion: Can Smart Care endorse or amend the proposal and what can we do to remove challenges to adoption?</td>
<td>Lance Lang, MD, Covered CA</td>
<td>• Straw Proposal of Payment and Contracting Strategies</td>
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<tr>
<td>1:35 PM</td>
<td>Updates on Additional Activities to Reduce Unnecessary C-section: Consumer Reports, CMQCC, CHCF education materials, Yelp Hospital Data Project, and Hospital Honor Roll</td>
<td>Stephanie Teleki, PhD, CHCF</td>
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<td>1:40 PM</td>
<td>Next Steps for Low Back Pain</td>
<td>Richard Sun, MD, MPH, CalPERS</td>
<td>• Low Back Pain Levers: Potential Ways to Address Levers and Resources</td>
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<td>• Frame work for low back pain from CalPERS perspective</td>
<td>Kathy Donneson, PhD, CalPERS</td>
<td>• Smart Care CA Low Back Pain Next Steps and Potential Measures</td>
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<td>• Existing programs on low back pain to serve as models</td>
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<td>• Measures for consideration</td>
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<td>2:25 PM</td>
<td>Break- 10 minutes</td>
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<td>2:35 PM</td>
<td>Updates on Reducing Opioid Overuse</td>
<td>Neal Kohatsu, MD, MPH, DHCS</td>
<td>• Opioid Levers: Potential Ways to Address Levers</td>
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<td>• Updates from Opioid Policy Taskforce</td>
<td>Kelly Pfeifer, MD, CHCF</td>
<td>• CDC MMWR Report on long term opioid use</td>
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<td>• Results and next steps for opioid health plan survey</td>
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<td>• CDPH Opioid Resource Letter for Providers/Prescribers</td>
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<td>• Health plan roundtable on increasing access to MAT and May 15 CMO and CMIO convening</td>
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<td>• Opioid health plan survey results</td>
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<td>• Smart Care CA Opioid Dashboard</td>
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<td>• Smart Care CA Opioid Dashboard</td>
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<tr>
<td>3:20 PM</td>
<td>Wrap up and Next Steps</td>
<td>Jennifer Wong, MPH, IHA</td>
<td>• Next meeting is Thursday, October 5, in Sacramento (location TBD)</td>
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<td>3:30 PM</td>
<td>Adjourn</td>
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Parag Agnihotri, MD  
Medical Director, Continuum Care  
Sharp Rees-Stealy Medical Group

Ruth Haskins, MD  
President  
California Medical Association

Lisa Aliferis  
Senior Communications Officer  
California HealthCare Foundation

Sharon Isonaka, MD  
Vice President, Clinical Transformation  
Cedars-Sinai Health System

Jacob Asher, MD  
Vice President and Chief Medical Officer  
Commercial Business  
Anthem

Howard Kahn, MD  
Emeritus  
LA Care Health Plan

Liana Bailey-Crimmins  
Interim Deputy Executive Officer  
CalPERS

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CA Department of Managed Health Care

Margareta Brandt, MPH  
Plan Manager  
Covered California

Angela Kline, MPH  
Project Manager  
Integrated Healthcare Association

John Brookey, MD  
Assistant Medical Director Kaiser SCPMG  
and Health Plan Physician Advisor KFHP

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Medical Director  
CA Department of Health Care Services

Allyson Brooks, MD (GUEST)  
Chief Quality Officer and Executive Medical Director of the Women's Health Institute  
Hoag Memorial Hospital Presbyterian

Lance Lang, MD (CO-CHAIR)  
Chief Medical Officer  
Covered California

Kathy Donneson, PhD (CO-CHAIR)  
Chief, Health Plan Administration Division  
CalPERS

James Leo, MD  
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MemorialCare Health System

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Julia Logan, MD, MPH (CO-CHAIR)  
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CA Department of Health Care Services

Robert Ducay  
Assistant Secretary  
CA Health and Human Services

David Lown, MD  
Chief Medical Officer  
Safety Net Institute

Matthew Emons, MD, MBA  
Medical Director, Quality Improvement and Health Assessment  
LA Care Health Plan

Elliott Main, MD (GUEST)  
Medical Director  
California Maternal Quality Care Collaborative

Ann Marie Giusto, RN  
Director of Variation Reduction  
Sutter Health
<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Role</th>
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<tbody>
<tr>
<td>Cathie Markow, BSN, MBA</td>
<td>Administrative Director</td>
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<tr>
<td>Jennifer McNulty, MD</td>
<td>Chair, Women’s Health Best Practice Team</td>
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<tr>
<td>Gregg Miller, MD</td>
<td>Chief Medical Officer</td>
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<td>Pooja Mittal, DO</td>
<td>Central Medical Director, CA State Health</td>
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<tr>
<td>Robert Moore, MD, MPH, MBA</td>
<td>Chief Medical Officer</td>
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<td>Amy Nguyen Howell, MD</td>
<td>Chief Medical Officer</td>
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<tr>
<td>Susan Perez, PhD, MPH</td>
<td>Research Associate</td>
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<tr>
<td>David Perrott, MD, DDS</td>
<td>Senior Vice President &amp; Chief Medical Officer</td>
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<tr>
<td>Joanne Peschko</td>
<td>Health Program Specialist</td>
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<tr>
<td>Lindsay Petersen, MS</td>
<td>Senior Quality Analyst</td>
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<tr>
<td>Kelly Pfeifer, MD</td>
<td>Director, High-Value Care</td>
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<tr>
<td>Catrina Reyes, Esq.</td>
<td>Associate Director</td>
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<tr>
<td>Jeff Rideout, MD</td>
<td>President and CEO</td>
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<tr>
<td>Tory Robinson</td>
<td>Director, Quality Improvement</td>
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<tr>
<td>Katie Rodriguez, MPP</td>
<td>Senior Program Officer, State Health Policy</td>
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<tr>
<td>Shirley Sanematsu, JD</td>
<td>Senior Attorney</td>
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<tr>
<td>Jennifer Sayles, MD, MPH</td>
<td>Chief Medical Officer</td>
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<tr>
<td>Karen Shore, PhD</td>
<td>Consultant</td>
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<tr>
<td>Julia Slininger, RN, BS, CPHQ</td>
<td>VP, Regional Quality Network</td>
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<tr>
<td>Maureen Sparks (GUEST)</td>
<td>Director, Managed Care Contracting</td>
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<td>Diane Stewart, MBA</td>
<td>Senior Director</td>
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<td>Richard Sun, MD, MPH</td>
<td>Chief Medical Officer</td>
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<td>Stephanie Teleki, PhD</td>
<td>Senior Program Officer, High-Value Care</td>
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Barbara Wentworth, PhD  
Senior Quality Improvement Specialist  
Health Net

Mike Witte, MD  
Chief Medical Officer  
California Primary Care Association

Salina Wong, PharmD  
Director, Clinical Pharmacy Programs  
Blue Shield of California

Jennifer Wong, MPH  
Project Manager  
Integrated Healthcare Association
Topic 1: C-Section for Low-Risk First-Time Births
Meeting Materials
Multi-Lever Model for Change

- Data/Transparency
- Purchaser Requirements
- Workforce
- Quality Improvement (QI)/Clinician Interventions
- Consumer Engagement
- Public Policy
- Payment

Reduce NTSV C-section
Straw Proposal for Smart Care California:  
Aligning Birth Payment to Reduce Unnecessary C-section

**TODAY'S OBJECTIVE**
To gain consensus from Smart Care California participants that health plans and purchasers in California should align payment and contract language with the goal of providing only medically warranted C-sections for women who are low-risk, first time mothers.

**BACKGROUND**
Cesarean deliveries can be life-saving procedures. However, increasing numbers of healthy women, specifically first-time mothers at low risk for complications, are undergoing these surgical procedures when they may not be medically indicated. These practices result in a higher rate of complications for mothers and babies. Furthermore, approximately 90% of women with a prior cesarean have subsequent deliveries by cesarean, leading to higher risks of major complications. With more than 500,000 births every year in California, there is a compelling need to reduce unnecessary cesarean deliveries among low-risk, first time births (also known as NTSV C-section) and to provide appropriate, evidence-based care.

Smart Care California is leveraging the work of California Maternal Quality Care Collaborative (CMQCC), the California Health Care Foundation (CHCF) the Pacific Business Group on Health (PBGH), and Covered California to create greater alignment across the state regarding the importance of reducing NTSV C-section rates and the need to implement value-based payment approaches that eliminate perverse financial incentives for C-section deliveries. At the January 31 Smart Care meeting, participants heard from PBGH and Blue Shield on various value-based payment options for birth. In order to move the workgroup from concept to action, Smart Care California leadership has drafted the following proposal which highlights a short menu of value-based payment and contracting strategies to reduce unnecessary low-risk, first birth C-sections.

This menu is not an exhaustive list of approaches and there is not a one size fits all solution. However, this menu provides health plans and purchasers some specificity in regards to existing payment mechanisms and contract language that align with the desired outcome of reduced cesareans among low-risk, first time births. It is the hope of Smart Care leadership that as many payers/purchasers as possible will elect to implement strategies aligned with this menu, thereby leveraging their collective power to reduce harm and waste in the health care system related to births. Aligning payment with desired birth outcomes is critical not only to improve care initially but also to maintain improvements over time.

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1 The CDC defines a low-risk birth as nulliparous (first birth), term (37 or more completed weeks of gestation), singleton (one fetus), and vertex (head first), also known as NTSV (Nulliparous, Term, Singleton, Vertex) C-Section.
### Health Plan and Purchaser Payment Strategies to Align Payment with Medically Necessary Use of C-sections

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<thead>
<tr>
<th>Option</th>
<th>How would this work?</th>
<th>Rationale for Implementing</th>
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<tr>
<td>1) <strong>Adopt a blended case rate payment for both physicians AND hospitals</strong></td>
<td>• A blended case rate reimburses physicians and hospitals, separately, the same flat rate regardless of cesarean or vaginal delivery&lt;br&gt;• The blended rate would fall in between the current vaginal and C-section payment rates&lt;br&gt;• A blended case rate covers costs associated with labor and delivery, it does not apply to prenatal or postpartum care (Bundled, or episode payment, covers the entire episode from pregnancy to post-delivery)</td>
<td>• Paying the same rate for delivery removes financial incentives to perform a C-section for physicians and hospitals&lt;br&gt;• Incentives for birth must be aligned for both physicians and hospital concurrently</td>
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<td>2) <strong>Pay less for C-sections without active trial of labor and without medical indication</strong></td>
<td>• For mothers who have a C-section without an active trial of labor, and without clear medical indication, reimburse for birth according to the following:&lt;br&gt;  o If plan pays different rates for C-section and vaginal birth, reimburse at vaginal rate&lt;br&gt;  o If plans pay a blended rate, reimburse at lower than the equalized rate</td>
<td>• Dis-incentivizes scheduling of C-sections that are not medically necessary</td>
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<td>3) <strong>Include NTSV-section in existing hospital and physician quality incentive programs</strong></td>
<td>• Provide quality bonuses for physicians and hospitals that attain a NTSV C-section rate goal or make improvements in reducing NTSV&lt;br&gt;• Plans would determine the attainment and improvement thresholds within the context of the national target of 23.9 per cent</td>
<td>• Inclusion of NTSV as a quality metric signals the importance of reducing the measure&lt;br&gt;• Incentives can pay for the structural changes needed at the physician organization or hospital level to drive and sustain improvement</td>
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### Health Plan and Purchaser Contracting Strategies to Align Payment with Medically Necessary Use of C-sections

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<th>Option</th>
<th>How would this work?</th>
<th>Rationale for Implementing</th>
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<tr>
<td>1) <strong>Require or incent hospital participation in CMQCC’s Maternal Data Center (MDC)</strong></td>
<td>• In hospital contracts, explicitly require or incent hospitals to submit data to CMQCC’s MDC</td>
<td>• MDC can generate rapid-cycle OB quality metrics for QI at the hospital and physician level in a way that substantially minimizes data collection burden on hospitals&lt;br&gt;• Hospitals can benchmark against others&lt;br&gt;• Free in calendar year 2017 for newly-joining hospitals</td>
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<td>2) <strong>Implement health plan network quality improvement requirements with a deadline</strong></td>
<td>• Establish that hospitals achieve a specified NTSV C-section goal by a certain date and require annual reports of their rate&lt;br&gt;• For hospitals who do not meet the goal by the deadline, require plans to exclude low performers from the network or require documentation for an improvement plan to meet NTSV goals</td>
<td>• Signals the importance of reducing NTSV C-section</td>
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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.1 In many hospitals and geographic regions, the rate of these C-sections greatly exceeds what experts consider acceptable.2 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.

2 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). 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. 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).

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. 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. States tackling this issue must weigh the influence of these factors, and leverage a range of policy and

7 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. Many states have already built this partnership, offering the opportunity for others to

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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.9 This quality measure is currently included in the Centers for Medicare and Medicaid Services child core set of quality measures.10 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 birth11

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.12

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.13 If concerns exist in

12Ibid.
13Ibid.
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. 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

---

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.


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


Maternity Improvement Projects in California: Supporting Initiatives

California Maternal Quality Care Collaborative (2006)
Multiple-stakeholders: Professional organizations (OB, FP, RN, Midwifery), Hospital Assoc, Health Plans (Commercial and Medicaid), State departments of Public Health and Health Care Services, Public members

Criteria:
- NTSV Cesarean Delivery
- Episiotomy
- VBAC
- Breast Feeding

Annual Public Release
1. CHART Website (2015)
2. Smart Care/CA Secretary of HHS-Awards (2016)

CAL-SIM Application (2013)
1. All-payer approach
2. Major focus on maternity care with combined VBP and quality improvement efforts
3. Added “Balancing Metrics”
   - Baby outcomes (UNC)
   - Perineal Trauma

CMQCC Maternal Data Center (2012)
Rapid-cycle (45d), Low burden (admin+), QI Support

VBP Maternity Pilot (2014)
1. Pacific Business Group on Health
2. Blended Payments: both hospitals and medical groups
3. Pilot QI efforts

Smart Care California (2016)
State Orgs: Covered California (ACA), Medi-Cal (Medicaid), CalPERS (state employee)
Health Plans: Blue Shield, Anthem Blue Cross, Managed Medicaid Plans, others
Goal: All-payer efforts to coordinate VBP activities, including measures, for 3 areas—Cesarean birth (NTSV), Back pain, Opioid use.

Covered California (2016)
Contract that 1) holds plans accountable for reducing variation & 2) requires payment reform that removes incentive for operative delivery

CMQCC QI Toolkit for Supporting Vaginal Birth (2016)
Multi-disciplinary effort, nationally regarded

State-wide CMQCC QI Collaborative (2016–)
“Supporting Vaginal Birth/Reducing Primary Cesareans”
>90 hospitals engaged, metrics include NTSV Cesarean and balancing metrics as described above

Other Key State Partners
California Hospital Association (HQI), Professional Associations: ACOG, AWHONN, ACNM, CAFP

Projects supported by California Health Care Foundation
Projects supported by Robert Wood Johnson Foundation
C-Section Payment as a Priority: Overview of Value-based Payment for Birth in California and Nationally

Elliott K. Main, MD
Medical Director, CMQCC
Stanford University

Cathie Markow, MBA
Administrative Director, CMQCC
Stanford University

The Problem: Rising Rate of Cesareans

California rates are the same as national averages, but did not show any decline between 2010-2013.
Cesarean Delivery Rates Vary Tenfold Among US Hospitals; Reducing Variation May Address Quality And Cost Issues

**ABSTRACT** Cesarean delivery is the most commonly performed surgical procedure in the United States, and cesarean rates are increasing. Working with 2009 data from 593 US hospitals nationwide, we found that cesarean rates varied tenfold across hospitals, from 7.1 percent to 69.9 percent. Even for women with lower-risk pregnancies, in which more limited variation might be expected, cesarean rates varied fifteenfold, from 2.4 percent to 36.3 percent. Thus, vast differences in practice patterns are likely to be driving the costly overuse of cesarean delivery in many US hospitals. Because Medicaid pays for nearly half of US births, government efforts to decrease variation are warranted. We focus on four promising directions for reducing these variations, including better coordinating maternity care, collecting and measuring more data, tying Medicaid payment to quality improvement, and enhancing patient-centered decision making through public reporting.

**Large Variation of Total Cesarean Rate Among 251 California Hospitals: 2013**

- **Range:** 15.0—71.4%
- **Median:** 32.5%
- **Mean:** 32.8%
Why should we care about CS rates?

- Relentless Rise without Baby or Mother benefit
  - 6% in early 70's, 20% in mid 80's, 33% in 2010
  - CP rates, neonatal seizures unchanged since 1980
  - Overall, no benefit for long-term urinary continence

- Increased maternal and neonatal morbidity
  - Impaired neonatal respiratory function, NICU admits
  - Affects maternal-infant interaction/Breast Feeding
  - Increased maternal PP infections, VTE, transfusions
  - Longer recovery, 2X PP re-admissions

- Prior CS can have major complications
  - Placenta previa and accreta (invasion deep into or thru the uterine wall) ➞ hysterectomy or worse
  - Uterine rupture; abdominal adhesions

Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Section Rate

- Risk Stratified (“standard population”)
  - No further risk-adjustment needed (more discussion later)

- Widely adopted nationally
  - DHHS: Healthy Person 2010 and 2020
  - NQF endorsed, Joint Commission Perinatal Core Measure (PC-02), LeapFrog, CMS e-measure

- >15 years experience
- National data and trends available
NTSV CS Rate Among CA Hospitals: 2014
(Nulliparous Term Singleton Vertex)
(Source: Linked OSHPD-Birth Certificate Data)
Range: 12%—70%
Median: 25.3%
Mean: 26.2%
Large Variation = Improvement Opportunity
National Target = 23.9%
40% of CA hospitals meet national target

Importance of the First Birth
If a woman has a Cesarean birth in the first labor, over 90% of ALL subsequent births will be Cesarean births
A classic example of path dependency
If a woman has a vaginal birth in the first labor, over 90% of ALL subsequent births will be vaginal births
Major Maternal Complications: Vaginal Births versus Primary Cesareans, Repeat Cesareans, and Vaginal Births After Cesarean

Figure 1. Maternal morbidity, by method of delivery and previous cesarean history: 41-state and District of Columbia reporting area, 2013

https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_04.pdf

Multiple Pressure Points Approach

Payment
Data/Transparency
Purchaser Requirements
Public Policy
Reduce NTSV C-section
Workforce
Consumer Engagement
Quality Improvement (QI)/Clinician Interventions
Pressure Points Activity-I

Data/Transparency
- The Joint Commission mandate for reporting NTSV CS rate
- Public Reporting on Cal Hospital Compare of national maternity metrics (NTSV, Episiotomy, VBAC, Breast Feeding)
- Smart Care CA Hospital Honor Roll for NTSV rates meeting HP 2020
- Strong Data Infrastructure: Hospitals can submit data to CMQCC’s Maternal Data Center’s online tool that generates rapid-cycle low-burden hospital maternity performance metrics

QI/Clinician Intervention
- Implement CMQCC Provider Toolkit to Support Vaginal Birth and Reduce Primary Cesareans
- Hospital participation in CMQCC QI Collaborative to Support Vaginal Birth and Reduce Primary Cesareans

Workforce
- Engage and partner with Professional Organizations
- Train more certified nurse midwives
- Establish on-going labor-support training for L&D nurses
- Encourage use of doulas
- Educate/ Change attitudes of current and new obstetric providers that birth is a natural process

Pressure Points Activity-II

Payment
- Adopt blended case rate payment for both professional fees and facility fees to remove financial incentive for C-section (see PBGH Maternity Pilot Project)
- Pay less for scheduled C-sections without trial of labor and without clear medical indication
- Pay-for-performance incentives for meeting NTSV C-section goals

Purchaser Requirements
- Contract language that holds health plans accountable for variation and requires removal of incentive for operative delivery
- Exclusion of hospitals who do not meet Healthy People 2020 goal of 23.9% for NTSV C-section from network, or require low performers to document a performance improvement plan
- Contract requirements for hospitals to submit data to Maternal Data Center and participate in QI activities
- Engage large employers who have local impact

Consumer Engagement
- Distribute CHCF, CMQCC, Consumer Reports jointly created materials on engaging consumers to encourage vaginal birth and avoid Cesarean Sections unless absolutely needed
- Encourage consumers to look at public reporting of maternity metrics on Yelp Hospital Pages (forthcoming)
Lessons Learned

- This is not an easy project…
- No one strategy will be effective alone
- By working together our efforts can have collective impact

Quality Improvement Toolkit

- Comprehensive, evidence-based “How-to Guide” to reduce primary cesarean delivery among NTSV women
- Developed by a multidisciplinary team of obstetricians, nurses, midwives, anesthesiologists, doulas, childbirth educators and hospitals administrators
- Best practices, sample policies, teaching aids, evidence reviews
- The principles are generalizable to all women giving birth
- Has a companion Implementation Guide

Download at CMQCC.org
Key Foundation Materials Based on National Guidelines

New National Guidelines for Defining Labor Abnormalities and Management Options

May 30, 2017

John Smith, MD
Chair, District X
American Congress of Obstetricians and Gynecologists

To Dr. Warheit:

I would like to congratulate you and all the contributors involved in the development of the CMQCC’s "Toolkit to Support Vaginal Birth and Reduce Primary Cesareans". We have had the honor to review this comprehensive toolkit and ACOG strongly supports its dissemination and use to address the efforts at reducing the primary Cesarean delivery rate. The toolkit includes a number of resources that could be implemented, and the plans to disseminate the information via speaker training sessions and site visits to encourage implementation are laudable.

Clearly, the rising Cesarean delivery rate, and particularly the primary Cesarean rate, is concerning to all of us involved in the provision of women’s healthcare, and although there have been a number of efforts nationwide to address this problem, they have been met with mixed success. This excellent resource, and the plan for encouraging awareness and implementation is an extremely commendable program to address this issue and should set a benchmark for achieving success in reducing the primary Cesarean delivery rate. We look forward to the program’s implementation, and to hearing of future successes.

Again, I express our sincere gratitude and strong support for everyone who had a part in developing this toolkit. Congratulations, and best wishes moving forward.

Sincerely,

John C. Lawrence, MD
Executive Vice President and CEO

Christopher M. Zahn, MD
Vice President, Practice Affairs

[Signature]

16
We have had the honor to review this comprehensive toolkit and ACOG strongly supports its dissemination and use to address the efforts at reducing the primary Cesarean delivery rate.

This excellent resource, and the plan for encouraging awareness and implementation is unquestionably a commendable program to address this issue and should set a benchmark for achieving success in reducing the primary Cesarean delivery rate.

CMQCC Supporting Vaginal Birth Toolkit Wins Lamaze President’s Award in 2016
CMQCC Supporting Vaginal Birth Collaborative

- 69 hospitals participating (rates >24%)
- 11 mentor groups

- Round 1 May 2016 start, extended for 6 months
- Round 2 Jan 2017 start
- Kaisers (N+S) internal process (w/CMQCC)
- Recruiting for Round 3 with Sept 2017 start

What Can Hospitals Accomplish?

Control Chart

- Measure Data
- Center Line
- Control Limit 2 SD
- Control Limit 3 SD
What Can Hospitals Accomplish?

Control Chart

HCP LAN

ACCELERATING AND ALIGNING
CLINICAL EPISODE PAYMENT MODELS
LAN Maternity Care Episode Payment Recommendations

1. Episode Definition
   - Episode includes maternity and newborn care for the majority of pregnancies that are lower risk, as well as for women with elevated risk conditions for which there are defined and predictable care trajectories.

2. Episode Timing
   - Episode begins 40 weeks before the birth and ends after the postpartum period for women, and 30 days post-birth for the baby.

3. Patient Population
   - The patient population is women and newborns who are lower risk, as well as women who may be at elevated risk due to conditions with defined and predictable care trajectories.

4. Services
   - All services provided during pregnancy (labor and birth, and the postpartum period for women), and newborn care for the baby. Pediatric services are not included. Other service exclusions should be limited.

5. Patient Engagement
   - Engage women and their families in all three phases of the episode (antenatal, labor and birth, and postpartum/newborn).

6. Accountable Entity
   - Accountable entity chosen based on readiness to both re-engineer care and the way care is delivered to the patient, and to accept risk.

7. Payment Flow
   - Payment flow – whether retrospective re-engineering or prospective payment – depends on the unique characteristics of the model's phases.

8. Episode Price
   - The episode price should balance single and multiple providers and regional utilization history. It should reflect the cost of services needed to achieve the goals of the episode payment model.

9. Type and Level of Risk
   - Ultimate goal is both upside network and downside risk, with strategies in place to mitigate risk, encourage provider participation, and support inclusion of a broad patient population.

10. Quality Metrics
    - Prioritize use of metrics that support the episode goals, including measures of clinical outcomes and patient reported outcomes, for use in payment, accountability, quality, and other tools to communicate with and engage patients and other stakeholders.

THE COST OF HAVING A BABY IN THE UNITED STATES

TRUVENT HEALTH ANALYTICS MARKETSCAN® STUDY

Prepared for:
- Childbirth Connection
- Catalyst for Payment Reform
- Center for Healthcare Quality and Payment Reform

January 2013
Figure 2: Average Total Maternal Health Care Payments by Type of Service among Commercial Beneficiaries with Vaginal and Cesarean Births, 2010

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Vaginal Childbirth (Average Allowed Payment: $12,950)</th>
<th>Cesarean Childbirth (Average Allowed Payment: $16,073)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Fees</td>
<td>$688</td>
<td>$540</td>
</tr>
<tr>
<td>Radiology/Imaging Fees</td>
<td>$932</td>
<td>$1,107</td>
</tr>
<tr>
<td>Laboratory Fees</td>
<td>$567</td>
<td>$547</td>
</tr>
<tr>
<td>Prof. Service Fees</td>
<td>$2,887</td>
<td>$3,309</td>
</tr>
<tr>
<td>Prof. Anesthesiology Fees</td>
<td>$990</td>
<td>$1,192</td>
</tr>
<tr>
<td>Facility Fees</td>
<td>$6,718</td>
<td>$9,932</td>
</tr>
</tbody>
</table>

Figure 4: Average Total Maternal Health Care Payments by Type of Service among Medicaid Beneficiaries with Vaginal and Cesarean Births, 2010

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Vaginal Childbirth (Average Allowed Payment: $6,117)</th>
<th>Cesarean Childbirth (Average Allowed Payment: $7,983)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Fees</td>
<td>$500</td>
<td>$601</td>
</tr>
<tr>
<td>Radiology/Imaging Fees</td>
<td>$454</td>
<td>$504</td>
</tr>
<tr>
<td>Laboratory Fees</td>
<td>$362</td>
<td>$408</td>
</tr>
<tr>
<td>Prof. Service Fees</td>
<td>$1,445</td>
<td>$1,654</td>
</tr>
<tr>
<td>Prof. Anesthesiology Fees</td>
<td>$165</td>
<td>$166</td>
</tr>
<tr>
<td>Facility Fees</td>
<td>$3,102</td>
<td>$4,355</td>
</tr>
</tbody>
</table>

In 2013, Ohio won a federal innovation grant to adopt two payment models that reward higher-quality, value-based care

- **Goal**: 80-90 percent of Ohio’s population in some value-based payment model (combination of episode- and population-based payment) within five years

- **State’s Role**
  - Shift rapidly to PCMH and episode model in Medicaid fee-for-service
  - Require Medicaid MCO partners to participate and implement
  - Incorporate into contracts of MCOs for state employee benefit program

<table>
<thead>
<tr>
<th>Year</th>
<th>Patient-centered medical homes</th>
<th>Episode-based payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td><strong>In 2014 focus on Comprehensive Primary Care Initiative (CPCI)</strong></td>
<td><strong>State leads design of six episodes: asthma acute exacerbation, COPD exacerbation, perinatal, acute and non-acute PCI, and joint replacement</strong></td>
</tr>
<tr>
<td>2015</td>
<td><strong>Collaborate with payers on design decisions and prepare a roll-out strategy</strong></td>
<td><strong>State leads design of seven new episodes: URI, UTI, cholecystectomy, appendectomy, GI hemorrhage, EGD, and colonoscopy</strong></td>
</tr>
<tr>
<td>2016</td>
<td><strong>Model rolled out to at least two major markets</strong></td>
<td><strong>20 episodes defined and launched across payers, including behavioral health</strong></td>
</tr>
<tr>
<td>2017-2018</td>
<td><strong>Model rolled out to all markets</strong></td>
<td><strong>50+ episodes defined and launched across payers, including behavioral health</strong></td>
</tr>
</tbody>
</table>

*Note: *September 2015 to October 2015*

*Note: *August 27, 2015
Retrospective thresholds reward cost-efficient, high-quality care

Provider cost distribution (average risk-adjusted reimbursement per provider)

- **Negative incentive**: No incentive payment
- **No change**: Eligible for positive incentive payment based on cost, but did not pass quality metrics
- **Positive incentive**: Eligible for positive incentive payment based on quality metrics

Avg. risk-adjusted reimbursement per episode

Acceptable

Commendable

Positive incentive limit

Principal Accountable Provider

NOTE: Each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost.

---

All Medicaid PAP curve (used to set thresholds) - Perinatal

Provider risk-adjusted cost distribution

| Provider risk-adjusted cost distribution | PAP average episode cost | Low volume | High volume
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Medicaid summary statistics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative incentive payments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Providers above acceptable threshold</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Episodes attributed to those providers</td>
<td>3,310</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Total negative incentive amount</td>
<td>$42,686</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive incentive payments¹</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Providers below commendable threshold</td>
<td>45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Episodes attributed to those providers</td>
<td>3,220</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Total positive incentive amount</td>
<td>$424,619</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Accepted threshold

Commendable threshold

Positive incentive limit

1. Top 10 percent of providers by volume
2. Assumes all providers pass quality metrics tied to incentive payments
3. SOURCE: Ohio Medicaid FFS and Encounter Data, CY 2014
NAMD/AMCHP Issue Brief (2015):
Low-risk Primary Cesarean Births in Medicaid

- Potential payment approaches to promote change
  - Blending payments (similar rates for vaginal and cesarean births)
  - Defining and paying for an episode (prenatal thru delivery for both physicians and hospitals)
  - Withholding a portion of state payments to managed care companies with payment based on quality metrics
  - Withholding a portion of hospital payments to managed care companies with payment based on quality metrics
  - Paying non-medically indicated CS at the vaginal birth rate
State Efforts

- Maternity Episode Payments
  - Arkansas, Tennessee, Ohio (very similar-McKesson) Focus on costs, not quality metrics

- Washington
  - Combined Vaginal birth and Uncomplicated CS Delivery DRGs (Health Authority: Medicaid and State Employees): 15% reduction in NTSV CS rates

- Minnesota
  - Blended payments for vaginal birth and cesarean BUT only for FFS (<10% of Medicaid births): overall ~10% decline but hard to discern effect
Topics Needing “Special Attention”

- Sustainability
- Engaging “Laggards”

Alignment of Quality Measures to Support QI Actions at Multiple Levels of Care

Current Practice: No Alignment!!

- Hospital
  - TJC
  - LeapFrog
  - CHART
  - NTSV CS

- Med Group
  - NCQA (HEDIS)

- Health Plan
  - NCQA (HEDIS)

- Provider
  - none
Alignment of Quality Measures to Support QI Actions at Multiple Levels of Care

Goal: align as many as possible

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Provider</th>
<th>Med Group</th>
<th>Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>TJC LeapFrog</td>
<td>Internal Hospital</td>
<td>NCQA (HEDIS)</td>
<td>NCQA (HEDIS)</td>
</tr>
<tr>
<td>CHART</td>
<td>(CMQCC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NTSV CS</td>
<td>NTSV CS</td>
<td>NTSV CS</td>
<td>NTSV CS</td>
</tr>
</tbody>
</table>

Combination of CMQCC and IHA

Rodger’s Adoption/Innovation Curve

Geoffrey Moore (1991) argued that a gap exists between early adopters of a change/technology/innovation and the “masses” —the key is the strategy to bridge that chasm.
Moore: Crossing the Chasm

- 4 books
- Chasm Institute
- MBA courses
- Business plans

The CHASM

Summary
- Great product
- Marketing
- Evangelists
- Many partners

Topics Needing “Special Attention”

- Sustainability
- Engaging “Laggards”

Payment Strategies will be Critical
Collaborative Action=Collective Impact

- Data/Transparency
- Purchaser Requirements
- Workforce
- Quality Improvement (QI)/Clinician Interventions
- Consumer Engagement
- Public Policy

Reduce NTSV C-section

Thank You!

Visit: CMQCC.org
Topic 2: Low Back Pain
Meeting Materials
Multi-Lever Model for Change

- Reduce inappropriate care for low back pain
- Data/Transparency
- Purchaser Requirements
- Workforce
- Quality Improvement (QI)/Clinician Interventions
- Consumer Engagement
- Public Policy
- Payment
### Potential Ways to Address Low Back Pain Levers

| **Data/Transparency** | • Existing measures: HEDIS imaging from IHA, back surgery rates from OSPHD, work-related lower back hospitalizations from CDPH  
• Potential new measures: Use of Oswetry Disability Index (ODI) to monitor patient function; use of validated screening (stratification) tool |
| **QI/Clinician Interventions** | • Use validated screening tool to stratify patients at risk of chronic pain and disability and match to appropriate treatment plan (e.g. Stanford CERC Identification, Coordination, and Enhanced-Decision Making [ICE] model)  
• Adopt CDS to reduce inappropriate imaging  
• Guidelines for acute low back pain: ACP 2017 guidelines, ICSI currently revising guidelines, Kaiser WA  
• CTAF and ICER review of cognitive and mind-body interventions to treat chronic low back and neck pain |
| **Payment** | • Value-based insurance design (e.g. bundle multiple PT visits for one copay)  
• Increase access for alternative therapies and multidisciplinary care |
| **Purchaser Requirements** | • Promote adoption of stratification tools and tools to measure patient function  
• Tiered/preferred networks of providers who use evidence-based practices |
| **Workforce** | • Use of multidisciplinary teams  
• Train individuals to serves as back coaches to provide self-management (from Stanford CERC ICE model) |
| **Consumer Engagement** | • Distribute Consumer Reports materials on low back pain to patients |
| **Public Policy** | • Develop public policies regarding prescribing of opioid drugs for low back pain |
# Existing Resources to Address Low Back Pain Levers

**Data/Transparency**
- Existing measures: HEDIS imaging, back surgery rates, work-related lower back hospitalizations
- Potential new measures: ODI, STarT Back Screening (Stratification) Tool

**QI/Clinician Interventions**
- **Bree Collaborative** in WA State, a public-private partnership created by the WA State legislature released a report of spine/low back pain best practice recommendations for clinicians, health plans, and purchasers.
- IHA has catalogued 9 CDS companies that target clinicians and have EMR integration including Stanson Health, Grand Round Table, and MedCurrent.
- Guidelines for acute low back pain: ACP 2017, ICSI, Kaiser WA.

**Payment**
- **Geisinger Health Plan** bundled 5 physical therapy visits for one co-pay
- **Oregon Health Authority (OHA)** has established a Health Evidence Review Commission (HERC) which provides coverage guidance for low back pain treatments

**Purchaser Requirements**
- **WA State Healthcare Authority**, which manages WA’s Medicaid and public employee benefits, has adopted Bree Collaborative recommendations into health plan contracts
- **Virginia Mason Spine Clinic** was redesigned due to pressure from employers like Starbucks, Intel, and Boeing

**Workforce**
- **Cochrane review** found patients experienced less pain and disability with multidisciplinary biopsychosocial rehabilitation

**Consumer Engagement**
- **Consumer Reports consumer facing materials**

**Public Policy**
- Develop public policies regarding prescribing of opioid drugs for low back pain
**Smart Care CA Next Steps for Low Back Pain**

SCC will focus on patients with acute back pain, consistent with the Choosing Wisely advice on use of imaging, aiming to prevent progression to chronic pain and disability. In previous meetings, the group decided to focus on 3 general approaches for low back pain: 1) patient education; 2) provider resources, and 3) clinical decision support.

<table>
<thead>
<tr>
<th>Focus</th>
<th>What Activities Can SCC Promote (related to the focus)</th>
<th>Next Steps</th>
<th>Thoughts?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase speed to the correct modality (such as PT)</td>
<td>Encourage rapid access to PT within 24 hours of referral</td>
<td>• Explore value-based payment for PT and alternative therapies (e.g. Geisinger Health Plan used VBID approach and bundled 5 PT treatments for one co-pay)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Encourage use of alternative therapies such as exercise, yoga, massage, acupuncture</td>
<td>• Work with health plans to expand benefit design or remove PA for use of alternative modalities</td>
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<tr>
<td>Agree upon outcome measure(s)</td>
<td>Encourage use of functional status assessment tool as an outcomes measure of low back pain</td>
<td>• Agree on which functional status assessment tool to use (Oswestry Disability Index seems most widely used)</td>
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<td>• Encourage health plans and purchasers to promote use of functional status assessment tool</td>
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<td></td>
<td>Identify other outcome indicators of low back pain</td>
<td>• See &quot;Potential Measures&quot; on next page</td>
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<tr>
<td>Measure</td>
<td>Developer (Measure ID)</td>
<td>Comments</td>
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<td>*Use of imaging studies for low back pain: % of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis</td>
<td>NCQA (NCQA: 0052)</td>
<td>Currently used for PRIME, Medicare Physician QRS, Medicaid Adult Core, and IHA VBP4P. Currently reported as an inverse rate (appropriate imaging) statewide by IHA</td>
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<td>*Imaging efficiency: % of MRI of the lumbar spine studies with a diagnosis of low back pain on the imaging claim and for which the patient did not have prior claims-based evidence of antecedent conservative therapy.</td>
<td>CMS (NQMC: 010435)</td>
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<td>Laminectomy or spinal fusion: laminectomy or spinal fusion area rate</td>
<td>AHRQ (NQMC 005550)</td>
<td>CA has this data by county but there is no ideal rate yet. Data from OSHPD.</td>
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<tr>
<td>Adult acute and subacute low back pain: % of patients with low back pain diagnosis who are prescribed opioids.</td>
<td>ICSI (NQMC: 007518)</td>
<td>Oregon Health Care Quality Corporation has used this measure in an analysis of LBP utilization.</td>
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<tr>
<td>Adult acute and subacute low back pain: % of patients with low back pain diagnosis who have their functional status assessed using the Oswestry Disability Questionnaire or other assessment tool.</td>
<td>ICSI (NQMC: 007519)</td>
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<tr>
<td>*Spinal surgery: average change between lumbar spinal fusion pre-operative and one year (9 to 15 months) post-operative functional status as measured with the Oswestry Disability Index, version 2.1a</td>
<td>MN Comm Measuremen t (NQMC: 010404)</td>
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<tr>
<td>*Lumbar functional status: mean change score in lumbar functional status for patients with lumbar impairments receiving physical rehabilitation.</td>
<td>FOTO Inc (NQMC: 002632)</td>
<td>Lumbar Functional Status measure uses items from various back pain scales.</td>
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<tr>
<td>Adult acute and subacute low back pain: % of patients with non-specific low back pain diagnosis who have had collaborative decision-making with regards to referral to a specialist.</td>
<td>ICSI (NQMC: 007521)</td>
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<tr>
<td>Adult acute and subacute low back pain: % of patients who were advised on maintenance or resumption of activities, against bed rest, use of heat, education on importance of active lifestyle and exercise, and recommendation to take anti-inflammatory or analgesic medication in the first six weeks of pain onset in the absence of &quot;red flags.&quot;</td>
<td>ICSI (NQMC: 008333)</td>
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</table>

*Indicates NQF Endorsed Measure
Topic 3: Opioid Overuse
Meeting Materials
Multi-Lever Model for Change

Reduce Opioid Overuse

- Payment
- Public Policy
- Consumer Engagement
- Quality Improvement (QI)/Clinician Interventions
- Purchaser Requirements
- Workforce
## Potential Ways to Address Opioid Overuse Levers

### Data/Transparency
- CDPH Dashboard with CURES data
- Smart Care California Opioid Dashboard

### QI/Clinician Interventions
- Implement clinical decision support tools to promote [CDC Guidelines](https://www.cdc.gov) for safer opioid use for acute and chronic pain
- Offer or support specific programs that help providers develop taper plans for patients on high opioid doses or combinations (opioids and benzos)
- Expand access points for medication-assisted treatment (in primary care, specialty addiction treatment, ED, inpatient, jail and prison)

### Payment
- Implement formulary controls to limit new starts, implement quantity limits for new starts
- Implement formulary dose limits
- Increase access to non-pharmacological therapies such as physical therapy, acupuncture, yoga, mindfulness
- Remove prior authorization requirements and lower copays for buprenorphine for addiction management, and naloxone for overdose reversal

### Purchaser Requirements
- Require health plans to adopt payment and benefit design strategies that decrease new starts, identify and manage patients on risky opioid regimens, streamline access to buprenorphine and methadone to treat opioid addiction and streamline access to naloxone for overdose reversal

### Workforce
- Offer or support provider education on co-prescribing naloxone and prescribing buprenorphine
- Behavioral health integration in primary care
- Use [Project ECHO](https://projectecho.org) to provide free training on opioid addiction treatment

### Consumer Engagement
- Distribute consumer facing materials on risks of taking opioids to patients, members, and employees
- Provide member education on naloxone

### Public Policy
- Opioid prescribers required to participate in CURES
- CA 2017-2018 Assembly Bill 40: CURES health IT integration
Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015

Anuj Shah1; Corey J. Hayes, PharmD1,2; Bradley C. Martin, PharmD, PhD1

Because long-term opioid use often begins with treatment of acute pain (1), in March 2016, the CDC Guideline for Prescribing Opioids for Chronic Pain included recommendations for the duration of opioid therapy for acute pain and the type of opioid to select when therapy is initiated (2). However, data quantifying the transition from acute to chronic opioid use are lacking. Patient records from the IMS Lifelink+ database were analyzed to characterize the first episode of opioid use among commercially insured, opioid-naïve, cancer-free adults and quantify the increase in probability of long-term use of opioids with each additional day supplied, day of therapy, or incremental increase in cumulative dose. The largest increments in probability of continued use were observed after the fifth and thirty-first days on therapy; the second prescription; 700 morphine milligram equivalents cumulative dose; and first prescriptions with 10- and 30-day supplies. By providing quantitative evidence on risk for long-term use based on initial prescribing characteristics, these findings might inform opioid prescribing practices.

A random 10% sample of patient records during 2006–2015 was drawn from the IMS Lifelink+ database, which includes commercial health plan information from a large number of managed care plans and is representative of the U.S. commercially insured population (3). The data are provided in a deidentified format and the institutional review board at the authors’ institution deemed the study was not human subject research. Records were selected of patients aged ≥18 years who had at least one opioid prescription during June 1, 2006–September 1, 2015, and ≥6 months of continuous enrollment without an opioid prescription before their first opioid prescription. Patients excluded were those who had any cancer (other than nonmelanoma skin cancer) or a substance abuse disorder diagnosis in the 6 months preceding their first opioid prescription, or whose first prescription was for any buprenorphine formulation indicated for treatment of substance abuse.

Patients were followed from the date of their first prescription until loss of enrollment, study end date, or discontinuation of opioids, which was defined as ≥180 days without opioid use. The duration of use and number of prescriptions and cumulative dose (expressed in morphine milligram equivalents*) for the first episode of opioid use (defined as continuous use of opioids with a gap of no greater than 30 days) were calculated. The number of days’ supply and average daily dose in morphine milligram equivalents for the first prescription were also calculated. The first opioid prescription was categorized

into six mutually exclusive categories: long-acting; oxycodone short-acting; hydrocodone short-acting; other Schedule II short-acting; Schedule III–IV and nalbuphine; and tramadol.†

The Kaplan-Meier statistic was used to estimate median time to discontinuation of opioid use; probability of continued opioid use at 1 year and 3 years for different treatment duration thresholds (daily for 1–40 days and weekly for 1–26 weeks); number of prescriptions (1–15); and cumulative dose of the first episode of opioid use (50–2000 morphine milligram equivalents). Similarly, the relationship between the number of days’ supply, choice of first opioid prescription, and probability of continued opioid use at 1 and 3 years was also examined. Sensitivity analyses were conducted by modifying the discontinuation definition from ≥180 opioid-free days to ≥90 opioid-free days, changing the allowable gap in the first episode of opioid use from 30 days to 7 days, and excluding patients whose average daily dose of the first prescription exceeded 90 morphine milligram equivalents.

A total of 1,294,247 patients met the inclusion criteria, including 33,548 (2.6%) who continued opioid therapy for ≥1 year. Patients who continued opioid therapy for ≥1 year were more likely to be older, female, have a pain diagnosis before opioid initiation, initiated on higher doses of opioids, and publicly or self-insured, compared with patients who discontinued opioid use in <365 days (Table). Among persons prescribed at least 1 day of opioids, the probability of continued opioid use at 1 year was 6.0% and at 3 years was 2.9% (supplemental figure 1; https://stacks.cdc.gov/view/cdc/44182) (supplemental figure 2; https://stacks.cdc.gov/view/cdc/44550) with a median time to discontinuation of 7 days (supplemental figure 3; https://stacks.cdc.gov/view/cdc/44551). Approximately 70% of patients have an initial duration of opioids of ≤7 days and 7.3% were initially prescribed opioids for ≥31 days. The largest incremental increases in the probability of continued opioid pain reliever use were observed when the first prescription supply exceeded 10 or 30 days (Figure 1), when a patient received a third prescription (Figure 2), or when the cumulative dose was ≥700 morphine milligram equivalents (supplemental figure 4; https://stacks.cdc.gov/view/cdc/44552). Substantial increases in probabilities of continued opioid use occurred when the initial duration reached 6 and 31 days (supplemental figure 2; https://stacks.cdc.gov/view/cdc/44550); the findings of the sensitivity analyses were similar (supplemental figures 5–10; https://stacks.cdc.gov/view/cdc/44183).

The highest probabilities of continued opioid use at 1 and 3 years were observed among patients who initiated treatment with a long-acting opioid (27.3% at 1 year; 20.5% at 3 years), followed by those whose initial treatment was with tramadol...
TABLE. Characteristics of incident opioid users and patients who continued opioid use for ≥365 days (1 year) and ≥1,095 days (3 years) — United States, 2006–2015

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No. (%)</th>
<th>95% CI</th>
<th>No. (%)</th>
<th>95% CI</th>
<th>No. (%)</th>
<th>95% CI</th>
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<tr>
<td><strong>All incident opioid users (N = 1,294,247)</strong></td>
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<tr>
<td>Duration of first episode of opioid use</td>
<td>14.81 (65.00) 14.70–14.92</td>
<td>183.28 (343.27) 179.61–186.96</td>
<td>362.40 (593.26) 347.91–376.90</td>
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<td>Enrollment duration (yrs)</td>
<td>2.48 (2.04) 2.47–2.48</td>
<td>3.30 (1.83) 2.47–2.48</td>
<td>4.98 (1.48) 4.94–5.02</td>
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<tr>
<td>Age (yrs)</td>
<td>44.52 (15.64) 44.50–44.54</td>
<td>49.58 (13.45) 49.44–49.72</td>
<td>50.52 (12.68) 50.21–50.83</td>
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<td><strong>Patients who continued opioid therapy for ≥365 days (n = 33,548)</strong></td>
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<tr>
<td>No. (%)</td>
<td>18,768 (55.94) 18,768–55.94</td>
<td>55.41–56.47</td>
<td>3,500 (54.34) 3,500–54.34</td>
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<tr>
<td>Treatment indication</td>
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<tr>
<td>Back pain</td>
<td>226,681 (17.51) 17.45–17.58</td>
<td>10,396 (30.99) 10,300–31.49</td>
<td>2,137 (33.18) 23.14–33.24</td>
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<tr>
<td>Neck pain</td>
<td>90,352 (6.98) 6.94–7.03</td>
<td>3,824 (11.40) 11.06–11.74</td>
<td>775 (12.03) 7.12–12.85</td>
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<tr>
<td>Head pain</td>
<td>30,123 (2.33) 2.30–2.35</td>
<td>1,495 (4.46) 4.24–4.68</td>
<td>306 (4.75) 4.26–5.30</td>
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<tr>
<td>Joint pain</td>
<td>389,700 (30.11) 30.03–30.19</td>
<td>14,862 (44.30) 43.77–44.83</td>
<td>2,968 (46.08) 44.87–47.30</td>
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<tr>
<td><strong>Patients who continued opioid therapy for ≥1,095 days (n = 6,441)</strong></td>
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<tr>
<td>No. (%)</td>
<td>18,768 (55.94) 18,768–55.94</td>
<td>55.41–56.47</td>
<td>3,500 (54.34) 3,500–54.34</td>
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<tr>
<td>Patient region</td>
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<tr>
<td>South</td>
<td>476,565 (36.74) 36.64–36.83</td>
<td>13,437 (40.05) 39.53–40.53</td>
<td>2,449 (38.02) 36.84–39.21</td>
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<tr>
<td>Midwest</td>
<td>376,520 (29.09) 29.01–29.17</td>
<td>9,566 (28.51) 28.03–29.00</td>
<td>1,973 (30.63) 29.52–31.77</td>
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<tr>
<td>East</td>
<td>279,595 (21.60) 21.53–21.67</td>
<td>6,153 (18.34) 17.93–18.76</td>
<td>1,234 (19.16) 18.22–20.14</td>
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<tr>
<td>West</td>
<td>142,698 (11.03) 10.97–11.08</td>
<td>3,640 (10.85) 10.52–11.19</td>
<td>574 (8.91) 8.24–9.63</td>
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<tr>
<td>Missing/Other</td>
<td>19,869 (1.54) 1.51–1.56</td>
<td>752 (2.24) 2.09–2.41</td>
<td>211 (3.28) 2.87–3.74</td>
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<tr>
<td><strong>Payer type</strong></td>
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<tr>
<td>Commercial</td>
<td>866,815 (66.97) 66.89–67.06</td>
<td>20,920 (62.36) 61.84–62.88</td>
<td>3,910 (60.70) 38.11–40.49</td>
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<tr>
<td>Medicaid/State CHIP</td>
<td>14,855 (1.15) 1.13–1.17</td>
<td>864 (2.58) 2.42–2.76</td>
<td>154 (2.39) 2.05–2.79</td>
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<tr>
<td>Medicare</td>
<td>16,951 (1.31) 1.29–1.33</td>
<td>9,566 (28.51) 28.03–29.00</td>
<td>1,973 (30.63) 29.52–31.77</td>
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<tr>
<td>RX only/Unknown</td>
<td>19,869 (1.54) 1.51–1.56</td>
<td>752 (2.24) 2.09–2.41</td>
<td>211 (3.28) 2.87–3.74</td>
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<td><strong>Prescription characteristic</strong></td>
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<tr>
<td>First prescription ≥90 MME*</td>
<td>89,438 (6.91) 6.87–6.95</td>
<td>2,613 (7.79) 7.51–8.08</td>
<td>545 (8.46) 7.81–9.17</td>
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<tr>
<td>First prescription ≥120 MME*</td>
<td>22,895 (1.77) 1.75–1.79</td>
<td>1,075 (3.20) 3.02–3.40</td>
<td>244 (3.79) 3.35–4.28</td>
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<td>First long-acting opioid prescrip†</td>
<td>6,588 (0.51) 0.50–0.52</td>
<td>905 (2.70) 2.53–2.88</td>
<td>226 (3.51) 3.09–3.99</td>
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**Abbreviations:** CHIP = Children’s Health Insurance Plan; CI = confidence interval; MME = morphine milligram equivalents; RX = prescription; SD = standard deviation.

* Average daily dose was calculated as total strength of the prescription expressed in MME divided by the days’ supply of the first prescription. If a patient had multiple prescriptions on the first day, the daily dose in MME for all the prescriptions on the index date were summed and divided by the days’ supply of the longest-lasting prescription.

† The first prescription was categorized into six mutually exclusive categories and, in case of multiple prescriptions, on the index date using the following hierarchy to assign category: 1) long-acting; 2) other Schedule II short-acting; 3) Oxycodone short-acting; 4) Hydrocodone short-acting; 5) Schedule III-IV and Nalbuphine; or 6) tramadol.

Discussion

The probability of long-term opioid use increases most sharply in the first days of therapy, particularly after 5 days or 1 month of opioids have been prescribed, and levels off after approximately 12 weeks of therapy. The rate of long-term use was relatively low (6.0% on opioids 1 year later) for persons whose first episode of use was for ≥31 days. Although ≥31 days of initial opioid prescriptions are not common, approximately 7% do exceed a 1-month supply. Discussions with patients about the long-term use of opioids to manage pain should occur early in the opioid prescribing process, perhaps as early as the first refill, because approximately 1 in 7 persons who received a refill or had a second opioid prescription authorized were on opioids 1 year later. As expected, patients initiated on long-acting opioids had the highest probabilities of long-term use. However, the finding that patients initiated with tramadol had the next highest probability of long-term use was unexpected; because of tramadol’s minimal affinity for the μ-opioid receptor, it is deemed a relatively safe opioid agonist with lower abuse potential than other opioids (4). However, a report by the Substance Abuse and Mental Health Services Administration determined that emergency department visits associated with tramadol-related adverse events increased by 145% during 2005–2011 (5). Long-term (13.7% at 1 year; 6.8% at 3 years) or a Schedule II short-acting opioid other than hydrocodone or oxycodone (8.9% at 1 year; 5.3% at 3 years) (supplemental table; https://stacks.cdc.gov/view/cdc/44181). The probabilities of continued opioid use at 1 and 3 years for persons starting on hydrocodone short-acting (5.1% at 1 year; 2.4% at 3 years), oxycodone short-acting (4.7% at 1 year; 2.3% at 3 years), or Schedule III–IV (5.0% at 1 year; 2.2% at 3 years) opioids were similar (supplemental table; https://stacks.cdc.gov/view/cdc/44181).
data on tramadol for pain management are sparse, with only one trial exceeding 12 weeks in duration (6). Despite this, among patients initiated with tramadol, >64% of patients who continued opioid use beyond 1 year were still on tramadol, suggesting that tramadol might be prescribed intentionally for chronic pain management. A 2016 study in Oregon (7), which did not include tramadol (a predictor of long-term use according to current data), reported similar findings: opioid naïve patients aged <45 years who received two prescription fills (versus one) or a cumulative dose of 400–799 (versus <120) morphine milligram equivalents in their first month of therapy were 2.3 and 3.0 times as likely to be chronic opioid users, respectively. However, that analysis only examined opioid use in the first month after initiation of opioid therapy to characterize risks for long-term use and did not account for the actual duration of therapy.

The findings in this report are subject to at least five limitations. First, although the cumulative dose of the first episode of opioid use is described, the likelihood of long-term use when the prescriber was titrating the dose was not determined. Rather, the total cumulative dose was calculated, which might have been increasing or decreasing over time. Second, the extent to which chronic opioid use was intentional versus the outgrowth of acute use is not known. Less than 1% of patients in this analysis were prescribed Schedule II long-acting opioids at the outset, so intentional chronic opioid prescribing might be uncommon; however, approximately 10% of patients were prescribed tramadol, which might indicate intentional chronic opioid prescribing. Third, information on pain intensity or duration were not available, and the etiology of pain, which might influence the duration of opioid use, was not considered in the analysis. Fourth, the frequency of prescriptions having certain days’ supplied (e.g., prescriptions with a 7-day supply would be more frequently observed than those with an 11- or 13-day supply) was not considered. The variability in the relationships between days’ supply, the cumulative dose, and duration of first episode and the probability of long-term use could be affected. Finally, prescriptions that were either paid for out-of-pocket or obtained illicitly were not included in the analysis.

Transitions from acute to long-term therapy can begin to occur quickly: the chances of chronic use begin to increase after the third day supplied and rise rapidly thereafter. Consistent with CDC guidelines, treatment of acute pain with opioids should be for the shortest durations possible. Prescribing <7 days (ideally ≤3 days) of medication when initiating opioids could mitigate the chances of unintentional chronic use. When initiating opioids, caution should be exercised when prescribing >1 week of opioids or when authorizing a refill or a second opioid prescription because these actions approximately double the chances of use 1 year later. In addition, prescribers should discuss the long-term plan for pain management with patients for whom they are prescribing either Schedule II long-acting opioids or tramadol.

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1 Division of Pharmaceutical Evaluation and Policy, College of Pharmacy, University of Arkansas for Medical Sciences; 2Division of Health Services Research, College of Medicine, University of Arkansas for Medical Services. Corresponding author: Bradley C. Martin, bmartin@uams.edu, 501-603-1992.
Summary

What is already known about this topic?

Based on the CDC Guideline for Prescribing Opioids for Chronic Pain, literature supporting long-term opioid therapy for pain is limited; research suggests an increased risk for harms with long-term opioid use. Early opioid prescribing patterns for opioid-naïve patients have been found to be associated with the likelihood of long-term use.

What is added by this report?

In a representative sample of opioid naïve, cancer-free adults who received a prescription for opioid pain relievers, the likelihood of chronic opioid use increased with each additional day of medication supplied starting with the third day, with the sharpest increases in chronic opioid use observed after the fifth and thirty-first day on therapy, a second prescription or refill, 700 morphine milligram equivalents cumulative dose, and an initial 10- or 30-day supply. The highest probability of continued opioid use at 1 and 3 years was observed among patients who started on a long-acting opioid followed by patients who started on tramadol.

What are the implications for public health practice?

Awareness among prescribers, pharmacists, and persons managing pharmacy benefits that authorization of a second opioid prescription doubles the risk for opioid use 1 year later might deter overprescribing of opioids. Knowledge that the risks for chronic opioid use increase with each additional day supplied might help clinicians evaluate their initial opioid prescribing decisions and potentially reduce the risk for long-term opioid use. Discussions with patients about the long-term use of opioids to manage pain should occur early in the opioid prescribing process.

References

March 21, 2017

Dear Health Care Provider/Prescriber,

As you are aware, the overuse of prescription opioids has become a national epidemic. In California, there were 1,966 opioid-related overdose deaths in 2015. On behalf of the Statewide Prescription Opioid Misuse and Overdose Prevention Workgroup and partners, I am contacting you to offer resources to assist you in addressing this critical issue with your patients including:

- strategies for assisting high-risk patients
- medication-assisted treatment certification programs
- local addiction recovery services locator
- information about CURES (California's prescription drug monitoring program)
- opioid prescribing guidelines
- opioid prescriber resource sheet

Please see the sections below for brief descriptions on each topic and a link to all resources at the bottom of this letter.

Don’t “Fire” Your Patients Who May Be Over-using Opioids

We recognize providing safe and effective pain management can be challenging. We understand there are multiple complexities to be considered in pain management when treating patients with acute and chronic pain. One of the most difficult situations for prescribers may be how to respond to patients with difficulty decreasing opioid intake or with other possible addiction symptoms. It is our hope that these resources can help you maintain your clinical relationship with your patients who are using opioid medications and improve their overall well-being. These patients may need your assistance more than ever.

Clinic Tools for Assisting Patients on Opioids

Patients on high doses of opioids are at increased risk of overdose and diminishing function. Tapering a patient, weaning them from higher opioid doses, can be an important first step to reducing overdose risk and improving function. It is also helpful to maintain ongoing communication with your patient about your concern for their wellbeing and your commitment to safe prescribing. A variety of tools are available on the prescriber resource sheet (link below) including a tapering pocket guide, telephone consultation services, an opioid overdose toolkit, and more.
Medication-Assisted Treatment
When addiction is confirmed, the use of medication-assisted treatment (MAT), such as buprenorphine has proven highly effective in lowering overdose risk, decreasing HIV and hepatitis C, and increasing patient retention in treatment. If you are not already certified to prescribe buprenorphine, consider obtaining a certification. There are several online MAT training programs available for prescribers.

Referral and Treatment Service Locators
If you are unable to provide medication assisted treatment yourself, refer patients to an opioid treatment program or other drug recovery program within your community. Access to more information about local addiction recovery services is readily available.

Prescription Drug Monitoring Program - CURES
An important tool for identifying patients at risk is the Controlled Substance Utilization Review and Evaluation System (CURES). CURES can be accessed relatively easily, and checking CURES with each new patient, and every four months thereafter, will soon be required by law. In the next few months, the Medical Board of California will send additional information specifically about CURES and how to best utilize it.

Prescribing Guidelines for Opioids and Controlled Substance for Pain
Both the Medical Board of California (MBC) and the Centers for Disease Control and Prevention (CDC) guidelines provide information about best practices for prescribing opioids, options for non-pharmacological treatment of pain symptoms, along with recommendations for those patients presenting with symptoms of addiction. Abbreviated versions of these guidelines are also available.

To access the above mentioned resources and tools – please scan this QRC code below with your mobile device. It will quickly take you to a resource sheet for opioid prescribers with helpful links.

Opioid Prescribers Resource Sheet

Also available at this URL: https://www.cdph.ca.gov/PrescriberResources

Healthcare prescribers are essential partners in ending this epidemic. Working together, we want to ensure that California prescribers have access to resources and support to help improve patient pain management, while avoiding opioid overdose and addiction. Thank you for providing quality medical care to your patients in need of effective pain management.

Sincerely,

Karen L. Smith, MD, MPH
Director and State Public Health Officer
California Department of Public Health
Curbing the Opioid Epidemic: Checklist for Covered CA, CalPERS, & Medi-Cal

In early 2017, Smart Care California conducted a survey among health plans that serve Covered California, CalPERS, and Medi-Cal members to learn more about which approaches aimed at lower opioid-related morbidity and mortality are currently in place, or under consideration. The survey was based on Smart Care California’s health plan and purchaser checklist for curbing the opioid epidemic. The survey results have been condensed to identify the top approaches for plans. Below are aggregated results across the three business lines. Note Medi-Cal plans were not asked about buprenorphine and naloxone, as they are carved out from Medi-Cal managed care.

Smart Care California is focused on four priority areas with the strongest evidence for impact:

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Approach</th>
<th>Responses</th>
<th>Covered CA Plans</th>
<th>CalPERS Plans</th>
<th>Medi-Cal Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease number of new starts</td>
<td>Implement formulary controls to limit new starts (e.g. authorization requirements for ongoing treatment after first fill)</td>
<td>In Place</td>
<td>50.0%</td>
<td>25.0%</td>
<td>45.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In Planning</td>
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<td></td>
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<td>37.5%</td>
<td>75.0%</td>
<td>15.0%</td>
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<tr>
<td></td>
<td>Implement quantity limits for new starts</td>
<td>In Place</td>
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<td>70.0%</td>
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<tr>
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<td>Remove prior authorization requirement for first course of physical therapy for back pain</td>
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<td>57.1%</td>
<td>50.0%</td>
<td>68.4%</td>
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<td>15.8%</td>
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<td>No Plans</td>
<td>42.9%</td>
<td>20.0%</td>
<td>15.8%</td>
</tr>
<tr>
<td>Identify patients on risky regimens (high dose, or opioids and sedatives) and work with them to taper to safer doses</td>
<td>Implement formulary dose limits (total morphine milligram equivalents, with prompt authorization review to manage exceptions)</td>
<td>In Place</td>
<td>87.9%</td>
<td>50.0%</td>
<td>75.0%</td>
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<td>12.5%</td>
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<td>10.0%</td>
</tr>
<tr>
<td></td>
<td>Limit concurrent prescriptions for opioid and benzodiazepines</td>
<td>In Place</td>
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<td>15.0%</td>
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</tr>
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<td>20.0%</td>
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<tr>
<td></td>
<td>Notify outpatient prescriber(s) about hospital admission for near-fatal overdose events</td>
<td>In Place</td>
<td>42.9%</td>
<td>50.0%</td>
<td>21.1%</td>
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<tr>
<td></td>
<td>Offer or support specific programs that help providers develop taper plans for patients on high opioid doses or combinations (opioids and benzodiazepines)</td>
<td>In Place</td>
<td>25.0%</td>
<td>66.7%</td>
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<td>16.7%</td>
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<td>No Plans</td>
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<td>16.7%</td>
<td>15.0%</td>
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<tr>
<td>Streamline access to buprenorphine and methadone to treat opioid addiction.</td>
<td>Evaluate network adequacy for opioid addiction treatment with buprenorphine and develop action plan to meet demand</td>
<td>In Place</td>
<td>42.9%</td>
<td>66.7%</td>
<td>26.3%</td>
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<td>28.6%</td>
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<td>36.8%</td>
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<tr>
<td></td>
<td>Offer or support provider education on buprenorphine prescribing (e.g. waiver training)</td>
<td>In Place</td>
<td>37.5%</td>
<td>50.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td></td>
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<td>In Planning</td>
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<td>No Plans</td>
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<tr>
<td></td>
<td>Remove authorization requirements for initiating and maintaining buprenorphine for addiction (including eliminating requirements for detox in lieu of maintenance)</td>
<td>In Place</td>
<td>28.6%</td>
<td>40.0%</td>
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<tr>
<td></td>
<td></td>
<td>In Planning</td>
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<td>No Plans</td>
<td>42.9%</td>
<td>20.0%</td>
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</tr>
<tr>
<td>Streamline access to naloxone for overdose reversal</td>
<td>Ensure coprescribing of naloxone for members at risk of opioid overdose (e.g. daily opioid use)</td>
<td>In Place</td>
<td>25.0%</td>
<td>25.0%</td>
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<tr>
<td></td>
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<td>In Planning</td>
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</tr>
<tr>
<td></td>
<td>Offer or support provider education on coprescribing naloxone</td>
<td>In Place</td>
<td>12.5%</td>
<td>20.0%</td>
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</tr>
<tr>
<td></td>
<td>Remove authorization requirement for naloxone</td>
<td>In Place</td>
<td>75.0%</td>
<td>50.0%</td>
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<tr>
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</table>
## Reducing Opioid Overuse Dashboard for Smart Care California

### Statewide measures

<table>
<thead>
<tr>
<th>Goal</th>
<th>Target</th>
<th>Measure</th>
<th>Data Source</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower inappropriate and unsafe opioid prescribing</td>
<td>Lower total volume of prescribed opioids by ≥ 50% by 2020</td>
<td>Total morphine milligram equivalents per resident. (Baseline 2014)</td>
<td>CURES (CDPH dashboard)</td>
<td>Opioid prescriptions increased four-fold in last 15 years, correlating with death rates</td>
</tr>
<tr>
<td></td>
<td>Lower number of people receiving both benzos and opioids by ≥ 50% by 2020</td>
<td>Residents on Opioids/Benzos (≥ 30 days)</td>
<td>CURES (CDPH dashboard)</td>
<td>40% of opioid-related deaths involve benzos</td>
</tr>
<tr>
<td></td>
<td>Lower number of people on high-dose opioids (≥90 MME) by 50% by 2020</td>
<td>Residents on ≥90 MME Daily (≥ 30 days)</td>
<td>CURES (CDPH dashboard)</td>
<td>High-dose opioids lead to 9 times greater death rate compared to low-dose</td>
</tr>
<tr>
<td>Increase access to medication-assisted treatment</td>
<td>Buprenorphine prescriptions quadruple by 2020</td>
<td># buprenorphine prescriptions per 1000 residents in 2020 compared to 2015</td>
<td>CURES (CDPH dashboard)</td>
<td>Only 1 in 10 Californians can access MAT</td>
</tr>
<tr>
<td>Increase use of naloxone</td>
<td>Triple the use of naloxone in the Medi-Cal population by 2020</td>
<td>Number of naloxone claims per 1000 Medi-Cal beneficiaries in 2020 compared to 2015</td>
<td>Medi-Cal Fee for Service pharmacy data</td>
<td>Naloxone prevents overdose deaths. Naloxone is a carve-out, so Medi-Cal data is available statewide.</td>
</tr>
</tbody>
</table>
# Reducing Opioid Overuse Dashboard for Smart Care California

<table>
<thead>
<tr>
<th>Goal</th>
<th>Target</th>
<th>Measure</th>
<th>Data Source</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lower # of new patients progressing to chronic opioid use</strong></td>
<td>Decrease number acute users progressing to chronic use by ≥50% by 2020</td>
<td>% of patients with opioid prescriptions in the measurement period (months) who did not have an opioid prescription in the 90 days before the first day of the measurement period (Partnership Health Plan of California)</td>
<td>Health plan or health system data</td>
<td>Rationale: 67% of people using opioids for 90 days become chronic users</td>
</tr>
<tr>
<td><strong>Lower use of opioids in acute pain</strong></td>
<td>Decrease number of patients with new pain diagnoses who are prescribed opioids by 50% by 2020.</td>
<td>Options: *Adult acute and subacute low back pain: % of patients with low back pain diagnosis who are prescribed opioids. <a href="http://example.com">NQMC:007518</a> *% of patients diagnosed with acute low back pain who have a new or existing narcotics prescription. <a href="http://example.com">Oregon Health Care Quality Corporation [Q Corp]</a></td>
<td>Health plan or health system data</td>
<td>CDC guidelines state that nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain.</td>
</tr>
<tr>
<td><strong>Increase access to medication-assisted treatment</strong></td>
<td>Triple number of people with opioid use disorder treated with MAT</td>
<td># people treated with MAT over # diagnosed with opioid use disorder</td>
<td>Commercial health plan data</td>
<td>Opioid agonist treatment is standard of care for opioid use disorder; health plans should ensure their members are treated effectively</td>
</tr>
<tr>
<td><strong>Increase access to nonpharmacologic modalities</strong></td>
<td>80% of patients access appropriate modality for low back pain within X days of request</td>
<td>TBD: will vary by health plan or delivery system</td>
<td>Health plan or health system data</td>
<td>Low back pain is a common diagnosis with chronic opioid use, but no data support its chronic use. PT is a marker of alternative therapies offered in a timely way. Stanford includes rapid access to PT as an evidence-based best practice. Timely access regulations require managed care plans to provide ancillary services within 15 days of call.</td>
</tr>
<tr>
<td><strong>Increase use of naloxone</strong></td>
<td>Triple the use of naloxone in high risk populations by 2020</td>
<td>Number of naloxone claims per 1000 members in 2020 compared to 2015</td>
<td>Health plan data</td>
<td>Naloxone prevents overdose deaths and should be co-prescribed to patients taking high dose opioids (some experts recommend co-prescribing for all opioid users)</td>
</tr>
</tbody>
</table>