SMART CARE CALIFORNIA
Less Waste. Less Harm. Better Care.

October 2017

Aligning Birth Payment to Reduce Unnecessary C-Section:
A Menu of Options

PURPOSE OF THE MENU. The menu on page 2 presents a set of strategies that payers in California should consider for adoption to align payment strategies and contract language with the goal of providing only medically warranted C-sections for women who are low-risk, first-time mothers. This menu is intended for payers including purchasers and health plans, as well as provider groups taking on increasing financial risk, such as medical groups, independent practice associations, and accountable care organizations (ACOs). Although payers will choose the strategies that work best for their respective organizations, there is substantial value in having every payer in California address the same quality issue through the implementation of an aligned payment strategy that reinforces a consistent business model that ensures provider revenue supports achieving the same quality target.

BACKGROUND ON CESAREAN DELIVERIES (C-SECTIONS). Cesarean deliveries can be life-saving procedures in certain circumstances. However, significant 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.[1] C-sections are performed with the goal of improving maternity outcomes. But the evidence documents that the rise in C-sections for low-risk pregnancies has actually resulted in a higher rate of complications for mothers and babies.[2] Complications for mothers include hemorrhage, transfusions, infection, and blood clots, while babies have higher rates of infection, respiratory complications, and neonatal intensive care unit admission.[3] Furthermore, approximately 90% of women with a prior cesarean have subsequent deliveries by cesarean, leading to higher risks of additional complications, including placenta previa or accreta and uterine rupture (all of which can lead to massive hemorrhage, hysterectomy, and even death).[4] 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.

ABOUT SMART CARE CALIFORNIA

Smart Care California is a public-private partnership working to promote safe, affordable health care in California. The group currently focuses on reducing the overuse of inappropriate care in three areas: C-sections, opioid prescriptions, and low back pain. Smart Care California is co-chaired by the state's leading health care purchasers: the Department of Health Care Services, Covered California, and the California Public Employees' Retirement System (CalPERS). Collectively, Smart Care California participants purchase or manage care for more than 16 million Californians — or 40% of the state.

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Payer Payment Strategies to Align Payment with Medically Necessary Use of C-Sections

	OPTION	HOW WOULD THIS WORK?	RATIONALE FOR IMPLEMENTING
1.	Adopt a blended case rate payment for both physicians and hospitals	▸ A blended case rate reimburses physicians and hospitals, separately, the same flat rate regardless of cesarean or vaginal delivery ▸ The blended rate would fall in between the current vaginal and C-section payment rates. ▸ A blended case rate covers costs associated with labor and delivery, which can be greater when supporting a prolonged labor than it is for a scheduled C-section. ▸ It does not apply to prenatal or postpartum care (bundled, or episode payment, covers the entire episode from pregnancy to post-delivery).	▸ Paying the same rate for delivery shifts some revenue to support vaginal delivery and removes financial incentives to perform a C-section for physicians and hospitals. ▸ Incentives for birth must be aligned for both physicians and hospital concurrently
2.	Include a NTSV C-section metric in existing hospital and physician quality incentive programs	▸ Provide quality bonuses for physicians and hospitals that attain a NTSV C-section rate goal or that make improvements in reducing NTSV C-sections. ▸ Plans would determine the attainment and improvement thresholds within the context of the national target of 23.9%.	▸ Inclusion of NTSV as a quality metric signals the importance of both attaining and sustaining an NTSV C-section rate at or below the national target of 23.9%. ▸ Incentives can pay for the structural changes needed at the physician organization or hospital level to drive and sustain improvement.
3.	Adopt population-based payment models, such as ACO-like arrangements	▸ In the simplest form of population-based payment, payers would contract with a network of doctors and hospitals (the ACO), who are held accountable for the quality and cost of the entire continuum of care for an attributed population of patients. ▸ The contract would establish specific quality and cost thresholds. If the quality threshold is met and the cost of care delivered is less than the targeted amount, both the payer and the ACO share in the savings. ▸ A more mature model of population-based payment would involve payers paying the provider network a fixed per-member per-month payment that adequately covers the cost of care for the group of patients.	▸ Population-based payment models, like ACO arrangements, help optimize care by providing financial incentives for the health care delivery system to more effectively coordinate care to improve quality while reducing costs. ▸ Provider quality benchmarks for NTSV C-section in the ACO contract are vital to properly incentivize evidence-based care.

Potential Payer Payment Strategies to Align Payment with Medically Necessary Use of C-Sections (requires testing)

	OPTION	HOW WOULD THIS WORK?	RATIONALE FOR IMPLEMENTING

1.	Pay less for C-sections without medical indication and for scheduled repeat C-sections	▸ For mothers who have a C-section without clear medical indication, or who are scheduled for a repeat C-section, reimburse for birth if the plan pays a:
		  ▸ Different rate for C-section and vaginal birth, *reimburse at vaginal rate*
		  ▸ Blended rate, *reimburse at a rate lower than the blended rate*
			▸ Removes incentives for scheduling of C-sections that are not medically necessary.

Payer Contracting Strategies to Align Payment with Medically Necessary Use of C-Sections

	OPTION	HOW WOULD THIS WORK?	RATIONALE FOR IMPLEMENTING
1.	Require or incent hospital participation in CMQCC's Maternal Data Center (MDC)	▸ In hospital contracts, explicitly require or incent hospitals to submit data to CMQCC's MDC.	▸ MDC can generate rapid-cycle OB quality metrics for quality improvement at the hospital and physician level in a way that substantially minimizes the data collection burden on hospitals. ▸ Hospitals can benchmark against others. ▸ Annual member fee waived for 2017 for newly joining hospitals.
2.	Implement network quality improvement requirements with a deadline	▸ Establish that hospitals and providers achieve a specified NTSV C-section goal by a certain date and require annual reports of their rate. ▸ For hospitals and providers who do not meet the goal by the deadline, require excluding low performers from the network, or require documentation for an improvement plan to meet NTSV goals. ▸ One example of an improvement plan could be encouraging hospitals with high rates to join the CMQCC quality collaborative for supporting vaginal birth and reducing primary cesareans.	▸ Signals the importance of reducing NTSV C-section.

AN OPPORTUNITY FOR IMPROVEMENT. There have been multiple efforts in California to improve maternity care that are starting to yield positive results. Low-risk, first-birth C-section rates have declined from 27.3% in 2013 to 25.6% in 2015.[5] While the California state average is close to the federal Healthy People 2020 goal of 23.9% for low-risk, first-birth C-sections, there remains a wide degree of unwarranted variation, even within a single county. Only 40% of maternity hospitals met the 23.9% goal in 2015, and NTSV C-section rates for maternity hospitals in California ranged from 11% to 77% in 2015.[6] The evidence suggests that a woman's chance of having a C-section depends largely on the hospital where she delivers and the practices of her clinical team. There are also significant cost implications for high C-section rates because cesarean deliveries are more costly than vaginal deliveries ($12,739 vs. $9,048 for private health insurers in 2010).[7] Potential complications from a C-section are also costly. Reducing medically unnecessary C-sections for low-risk, first-time mothers, which support better health outcomes, could therefore save money for patients, consumers, purchasers, and taxpayers.

PAYMENT IS ONE LEVER TO PROMOTE CHANGE. Smart Care California is leveraging the work of the California Maternal Quality Care Collaborative (CMQCC), the California Health Care Foundation, the Pacific Business Group on Health, 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.

CALL TO ACTION. To move the Smart Care California workgroup participants from concept to action, Smart Care California leadership drafted a menu of value-based payment and contracting strategies to improve alignment of reimbursement strategies across California's purchasers and health plans to support evidence-based maternity care.

ENDORSED BY SMART CARE CALIFORNIA. This menu provides payers some specificity regarding existing payment mechanisms and contract language that align with the desired outcome while providing flexibility for individual organizations to adapt to its own context. The ultimate goal is to reinforce provision of evidence-based care for low-risk, first-time births. It is the intent of Smart Care California leadership that payers in California will implement strategies from 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 to maintain improvements over time.

Endnotes

1. The Centers for Disease Control and Prevention defines a low-risk cesarean delivery as a c-section for a mother giving birth for the first time (nulliparous) who is at term (37 or more completed weeks of gestation), singleton (one fetus), and vertex (head first). This is also known as an NTSV (nulliparous, term, singleton, vertex) c-section.
2. J. P. Souza et al., "Caesarean Section Without Medical Indications Is Associated with an Increased Risk of Adverse Short-Term Maternal Outcomes: The 2004-2008 WHO Global Survey on Maternal and Perinatal Health," *BMC Medicine* 8 (November 10, 2010): 71, doi:10.1186/1741-7015-8-71.
3. Sally C. Curtin et al., "Maternal Morbidity for Vaginal and Cesarean Deliveries, According to Previous Cesarean History: New Data from the Birth Certificate, 2013," *National Vital Statistics Reports* 64, no. 4 (May 20, 2015): 1-13, back cover, www.cdc.gov (PDF).
4. Placenta previa is a condition where the placenta incorrectly attaches to the lower part of the uterus, covering the cervix. Placenta accreta is a more severe form of placenta previa, where the placenta attaches to the uterine wall.
5. Cal Hospital Compare, calhospitalcompare.org.
6. Soumya Karlamangla and Ryan Menezes, "Find Your Hospital's C-Section Rate," *Los Angeles Times*, March 8, 2016, spreadsheets.latimes.com/c-section-rates.
7. Katy Backes Kozhimannil, Michael R. Law, and Beth A. Virnig, "Cesarean Delivery Rates Vary Tenfold Among US Hospitals; Reducing Variation May Address Quality And Cost Issues," *Health Affairs* 32, no. 3 (March 2013): 527-35, doi:10.1377/hlthaff.2012.1030.