

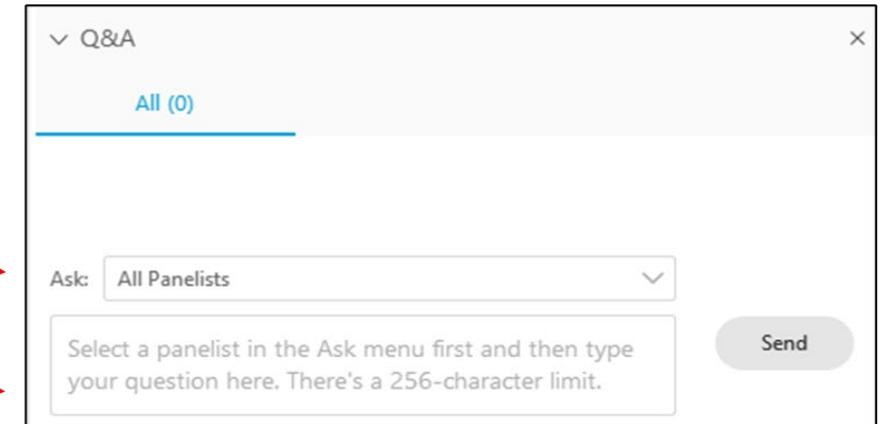
Using Data to Plan and Assess Quality Improvement Strategies to Reduce Low-Risk Cesarean Delivery in Medicaid and CHIP

June 24, 2022

Lekisha Daniel-Robinson, Chrissy Fiorentini, and Kate Nilles, Mathematica
Kristen Zycherman, CMS
William Sappenfield, Florida Perinatal Quality Collaborative
Judy Zerzan-Thul, Washington State Health Care Authority

How to Submit a Question

- **Use the Q&A function to submit questions or comments.**
 - To submit a question or comment, click the Q&A window and select “All Panelists” in the “Ask” menu
 - Type your question in the text box and click “Send”
 - Only the presentation team will be able to see your questions and comments
- **For technical questions, select “Host” in the “Ask” menu**



Q&A

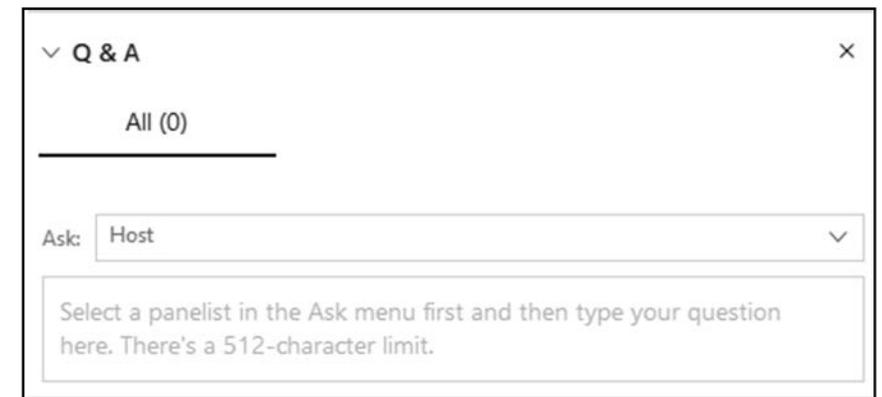
All (0)

Ask: All Panelists

Select a panelist in the Ask menu first and then type your question here. There's a 256-character limit.

Send

This screenshot shows the Q&A interface with the 'Ask' menu set to 'All Panelists'. A red arrow points from the text 'select "All Panelists" in the "Ask" menu' to the dropdown menu. Another red arrow points from the text 'click "Send"' to the 'Send' button.



Q & A

All (0)

Ask: Host

Select a panelist in the Ask menu first and then type your question here. There's a 512-character limit.

This screenshot shows the Q&A interface with the 'Ask' menu set to 'Host'. A red arrow points from the text 'select "Host" in the "Ask" menu' to the dropdown menu.

Objectives

- **Provide an overview of CMS's Maternal and Infant Health Initiative**
- **Describe the Improving Maternal Health by Reducing Low-Risk Cesarean Delivery (LRCD) Learning Collaborative**
- **Learn how state Medicaid and CHIP agencies can use data to plan and support LRCD quality initiatives**
- **Learn about how states have used data to establish baselines and monitor progress in reducing LRCD**

Agenda

Topic	Speakers
Welcome	Lekisha Daniel-Robinson, Mathematica
Overview of the Maternal and Infant Health Initiative and Low-Risk Cesarean Delivery (LRCD) Learning Collaborative	Kristen Zycherman, CMS
Core Set Measure: Low-Risk Cesarean Delivery	Chrissy Fiorentini, Mathematica
Improving the Health & Health Care of Florida's Mothers & Babies	William Sappenfield, Florida Perinatal Quality Collaborative
Maternal and Child Care: Incentivizing Health	Judy Zerzan-Thul, Washington State Health Care Authority
Questions	Lekisha Daniel-Robinson, Mathematica
Announcements and Next Steps	Kate Nilles, Mathematica

Overview
Maternal and Infant Health Initiative
and
Improving Maternal Health by Reducing Low-Risk Cesarean Delivery
Learning Collaborative

Kristen Zycherman, CMS

Maternal and Infant Health Initiative

- **Maternal and Infant Health Initiative (MIHI) launched to improve access to and quality of care for pregnant and postpartum persons and their infants.**
- **The Centers for Medicaid and Medicare (CMS) convened an MIH expert workgroup in 2019-2020 to provide updated recommendations about where Medicaid and CHIP can influence change in maternal and infant health.**
- **Three MIHI focus areas**
 - **Increase the use and quality of postpartum care visits**
 - **Increase the use and quality of infant well-child visits**
 - **Reduce the rate of low-risk cesarean delivery (LRCD)**

Improving Maternal Health by Reducing Low-Risk Cesarean Delivery

Learning Collaborative Webinar Series

- **Webinar 1:** The Role of Medicaid in Reducing Low-Risk Cesarean Delivery: Improving Outcomes and Reducing Disparities
- **Webinar 2:** State Medicaid and CHIP Agencies and Obstetrical Partners: Working Together to Reduce Low-Risk Cesarean Deliveries
- **Webinar 3:** Using Data to Plan and Assess Quality Improvement Strategies to Reduce Low-Risk Cesarean Delivery in Medicaid and CHIP
- **Informational Webinar:** Improving Maternal Health by Reducing Low-Risk Cesarean Delivery Affinity Group Overview and Expression of Interest Process

Improving Maternal Health by Reducing Low-Risk Cesarean Delivery Affinity Group

- Action-oriented affinity group that will support state Medicaid and CHIP programs and their partners in identifying, testing, and implementing evidence-based change ideas for reducing the number of LRCDs and improving maternal health care.
- Opportunity for states to expand their knowledge of policies, programs, and practices to reduce LRCD rates and advance their knowledge of and skills in quality improvement and address inequities.
- Expressions of Interest are due **July 15, 2022, at 8:00 pm ET**
- More information is available at <https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-infant-health-care-quality/index.html>

Overview of the Core Set Measure: Low-Risk Cesarean Delivery

Chrissy Fiorentini, Mathematica

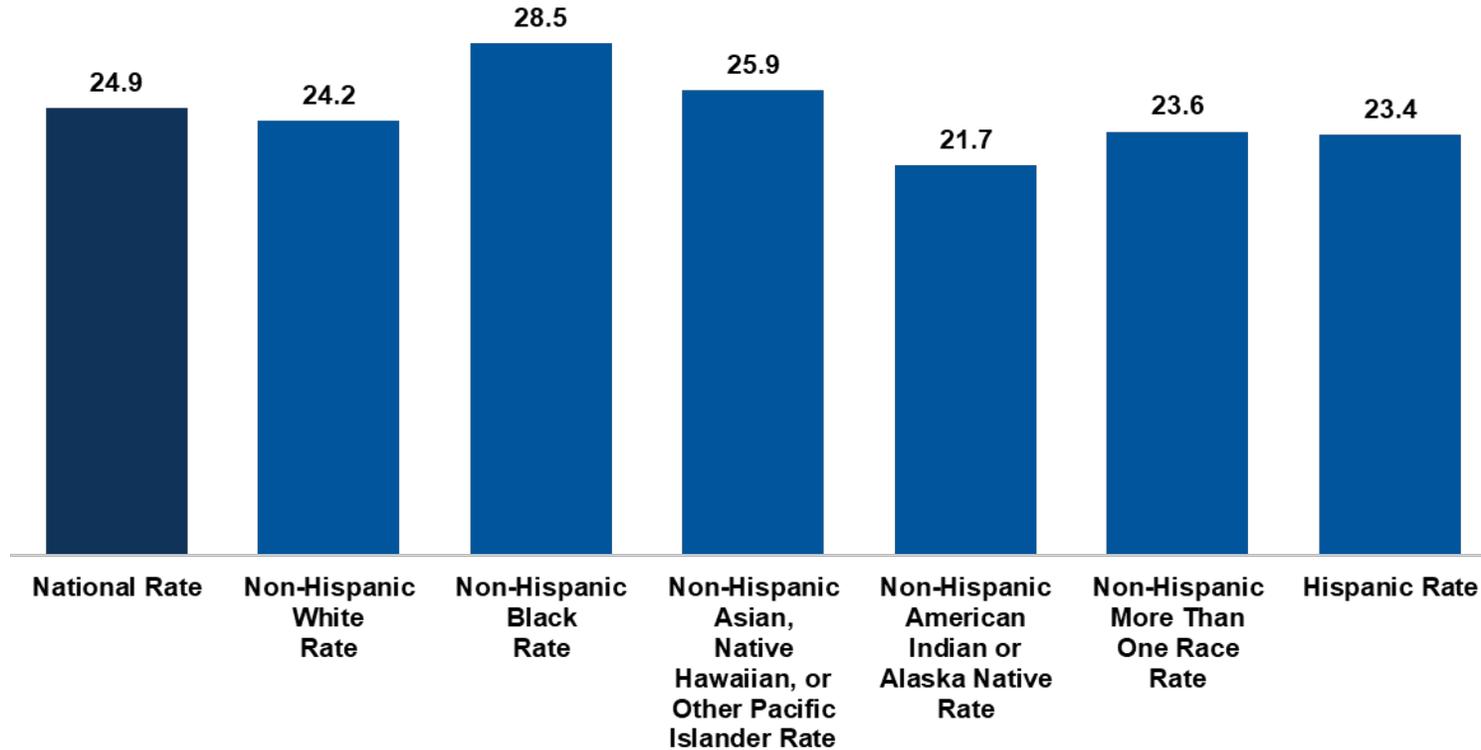
Core Set Measure: Low-Risk Cesarean Delivery (LRCD)

Description	Percentage of nulliparous (first birth), term (37 or more completed weeks based on the obstetric estimate), singleton (one fetus), in a cephalic presentation (head-first) births delivered by cesarean during the measurement year.
Measure steward	National Center for Health Statistics (NCHS)
NQF number	Not endorsed
Data collection method	State Vital Records submitted to the NCHS National Vital Statistics System, Natality
Denominator	The number of resident live births in the state in the reporting period with Medicaid as the principal source of payment for the delivery. All of the following additional criteria must be met: <ul style="list-style-type: none"> • The birth is a first live birth (Live Birth Order is “1”) • Fetal Presentation is “Cephalic” • The obstetric estimate of gestational age (OE Gestational Age Recode) is greater than or equal to 37 weeks • Plurality is “Single”
Numerator	The number of resident live births in the state with Medicaid as the principal source of payment for the delivery and that have a Delivery Method of “Cesarean” on the birth certificate.
Core Set reporting	<ul style="list-style-type: none"> • To reduce state burden and streamline reporting, CMS calculates this measure for states using state natality data obtained through the Centers for Disease Control and Prevention Wide-ranging Online Data for Epidemiologic Research (CDC WONDER). • The most recent NCHS natality data for each state are available at: http://wonder.cdc.gov/natality-expanded-current.html.

For more information on the LRCD measure in the Medicaid & CHIP Core Set, see:
<https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>



Low-Risk Cesarean Delivery Rate per 100 Deliveries, by Maternal Race/Ethnicity: Births Paid by Medicaid, 2020



Notes:

The national rate and all stratified rates include births to residents of the 50 U.S. states and the District of Columbia.

Source:

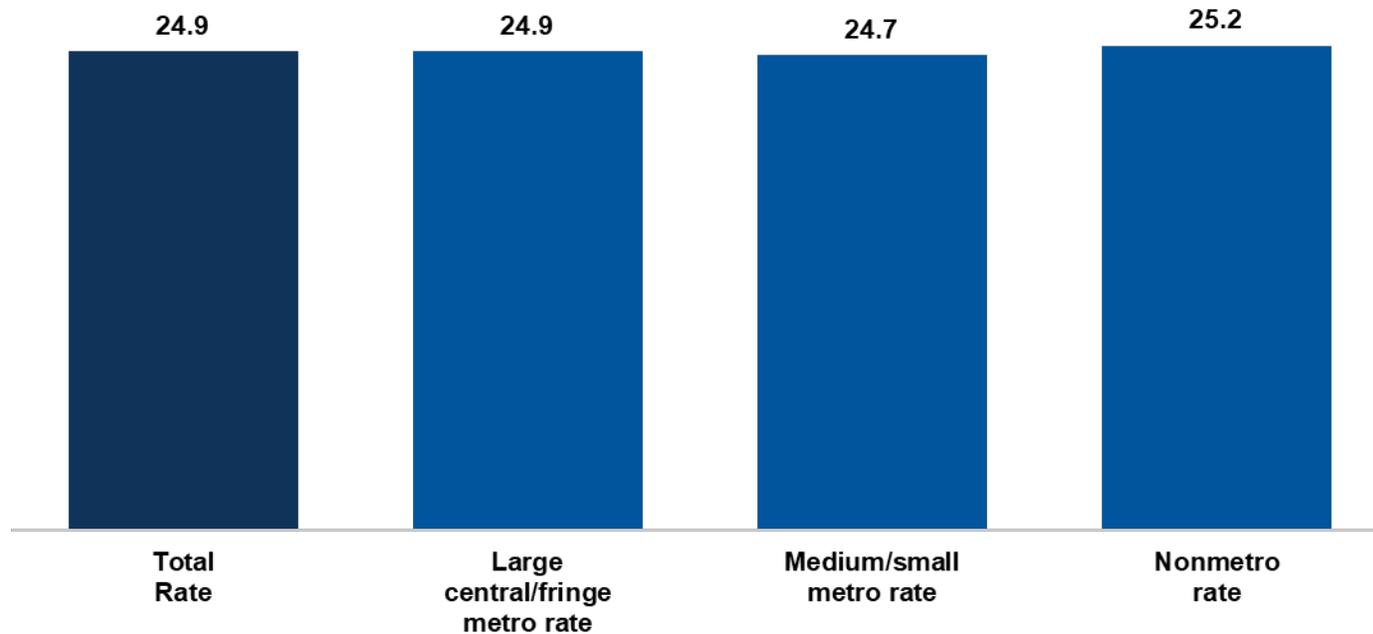
National Center for Health Statistics (NCHS). 2020 Natality Public Use Data on CDC WONDER online database.

Available at:

<https://wonder.cdc.gov/>



Low-Risk Cesarean Delivery Rate per 100 Deliveries, by Geography: Births Paid by Medicaid, 2020



Notes:

The national rate and all stratified rates include births to residents of the 50 U.S. states and the District of Columbia.

Source:

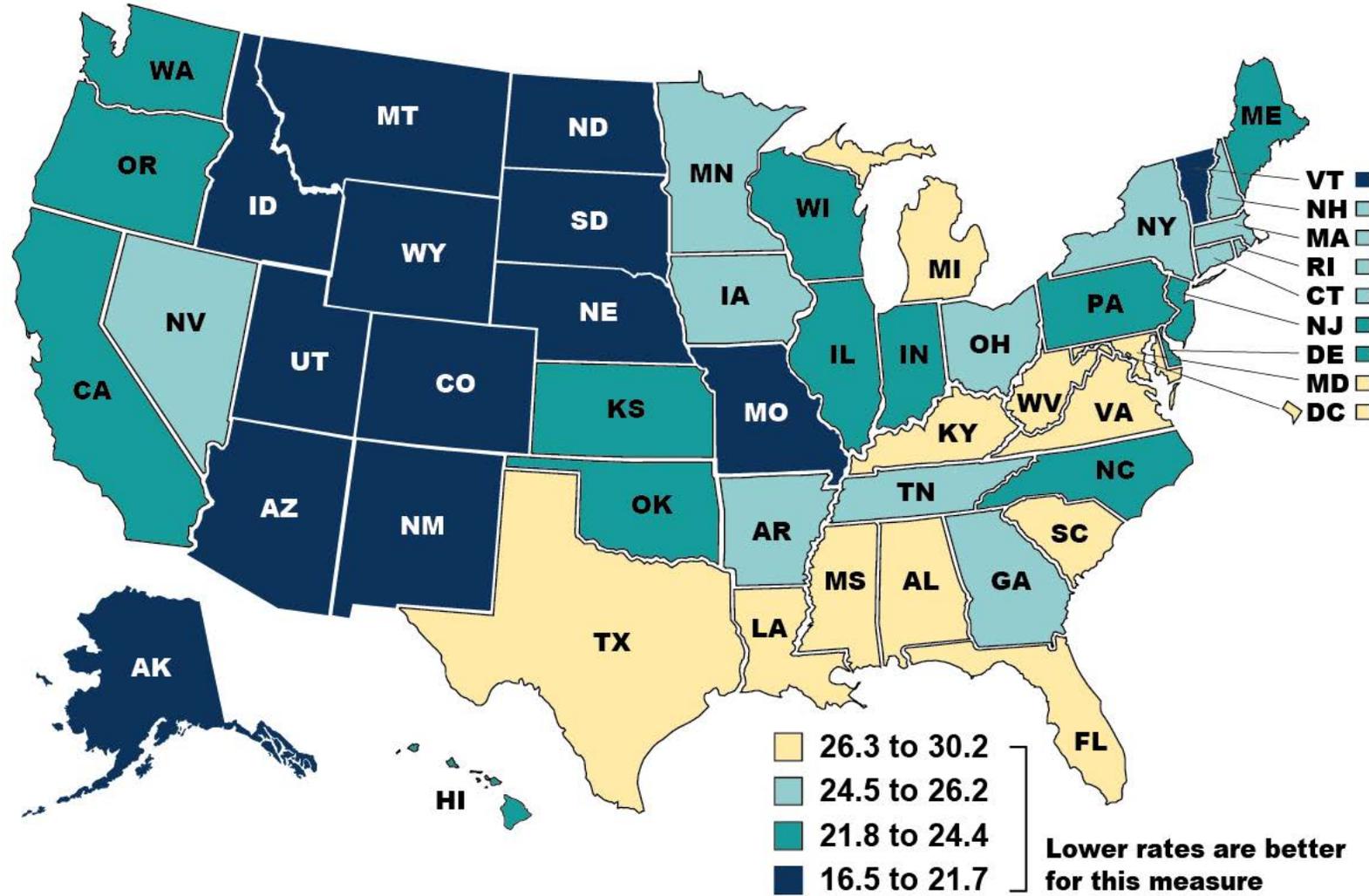
National Center for Health Statistics (NCHS). 2020 Natality Public Use Data on CDC WONDER online database.

Available at:

<https://wonder.cdc.gov/>



Low-Risk Cesarean Delivery Rate per 100 Deliveries, by State: Births Paid by Medicaid, 2020



Source:
National Center for Health Statistics (NCHS). 2020
Natality Public Use Data on CDC WONDER online
database.

Available at:
<https://wonder.cdc.gov/>



Existing Quality Measures of Low-Risk Cesarean Delivery

	LRCO	PC-02 Cesarean Birth
Specified for	Population-level reporting (national, by state, by demographic group)	Hospital-level reporting
Denominator definition	Nulliparous, term, singleton births, in a cephalic presentation	Nulliparous, term, singleton births, in a vertex presentation
Data source(s)	State vital records	Medicaid administrative data and medical record review
Excluded populations	<ul style="list-style-type: none"> • Births to women with previous live births or unknown parity • Gestational age < 37 weeks or “Unknown or Not Stated” • Multiple gestations • Other or unknown presentations (fetal presentation is “Breech,” “Other,” “Unknown or Not Stated,” or “Not Reported”) • Delivery method is “Unknown or Not Stated” 	<ul style="list-style-type: none"> • Births to women with previous live births • Gestational age < 37 weeks or unable to determine • ICD-10 diagnosis codes for multiple gestations • ICD-10 diagnosis codes for other presentations • Less than 8 years of age • Greater than or equal to 65 years of age • Length of Stay >120 days
National performance rate*	25.9% (2018 data)	25.5% (2018 data)

* Sources: National Center for Health Statistics (NCHS), Natality Public Use Data on CDC WONDER online database and the Joint Commission. Data are for all payers.

Potential Data Sources for Identifying Low-Risk Cesarean Deliveries

- **Medicaid claims and enrollment data:** Do not contain all the data elements needed but could use to identify births to Medicaid beneficiaries if linked with one of the sources below.
- **Vital records:** Could use to identify low-risk cesarean deliveries to Medicaid beneficiaries, using the LRCD specifications. Access to data and length of data lag may vary.
- **Medical records:** Could use to identify low-risk cesarean deliveries, using the PC-02 specifications. May need to link to Medicaid data to identify births to Medicaid beneficiaries.
- **Hospital discharge data:** Availability and content of a state-level database with hospital discharge data will vary by state. If available, it may contain some or all the data elements needed.

Florida Perinatal Quality Collaborative (FPQC)

*Improving the Health & Health Care of
Florida's Mothers & Babies*



FPQC's Vision & Values

“All of Florida’s mothers, infants & families will have the best health outcomes possible through receiving respectful, equitable, high quality, evidence-based perinatal care.”



- Voluntary
- Data-Driven
- Population-Based
- Evidence-Based
- Equity-Centered
- Value-Added

FPQC Partners & Funders





PROVIDE 2.0

Promoting Primary Vaginal Deliveries



Florida Medicaid / AHCA and FPQC Relationship

- Reducing primary cesarean rates is 1 of 3 Medicaid Birth Outcomes' (MBO) goals for Medicaid Health Plan contracts
- FPQC consults with Florida Medicaid and FDOH on hospital NTSV cesarean rate awards for reaching the HP 2030 objective
- FPQC confidentially shares hospital cesarean rates with Florida Medicaid using birth certificate and hospital discharge data
- FPQC advises Florida Medicaid and Health Plans on potential strategies to reduce primary cesarean rates
- Florida Medicaid and Health Plans participated on the PROVIDE Advisory Group and in statewide FPQC PROVIDE hospital meetings
- FPQC and Florida Medicaid have together advised hospitals on cesarean rates.

NTSV Cesarean Rates

N	ulliparous — <i>First time pregnancy</i>
T	erm — <i>37 weeks gestation or more</i>
S	ingleton — <i>Not twins, triplets or more</i>
V	ertex — <i>Head down in the uterus</i>

NTSV Cesarean QI Measures

National Quality Forum measure

- NTSV as defined on the Birth Certificate

Joint Commission measure

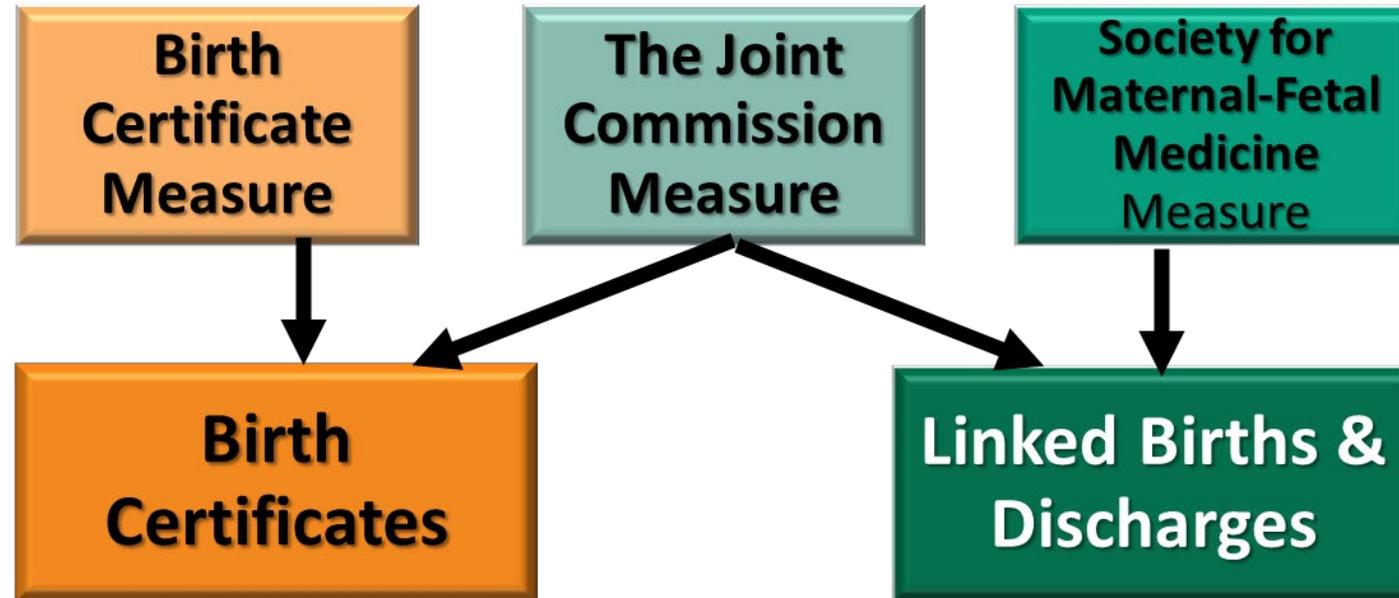
- Age: $8 < ?? \leq 65$
- LOS > 120 days
- Multiple gestations and other presentations

Society of Maternal Fetal Medicine (SMFM) measure

- Multiple gestations and other presentations
- Maternal factors; preterm birth; fetal factors; stillborn; uterine /placental factors; conduct of labor



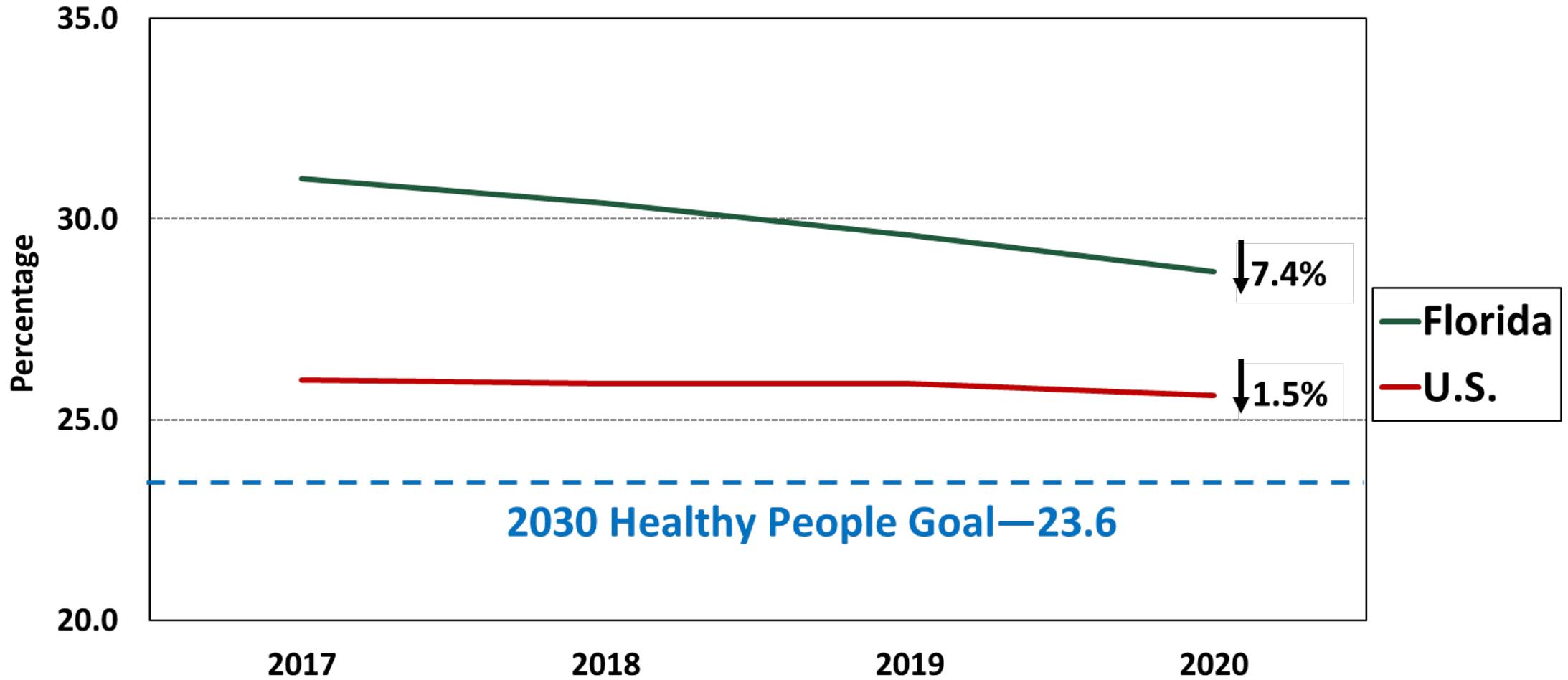
Florida NTSV Cesarean Data Sources



Two weeks after
month's end

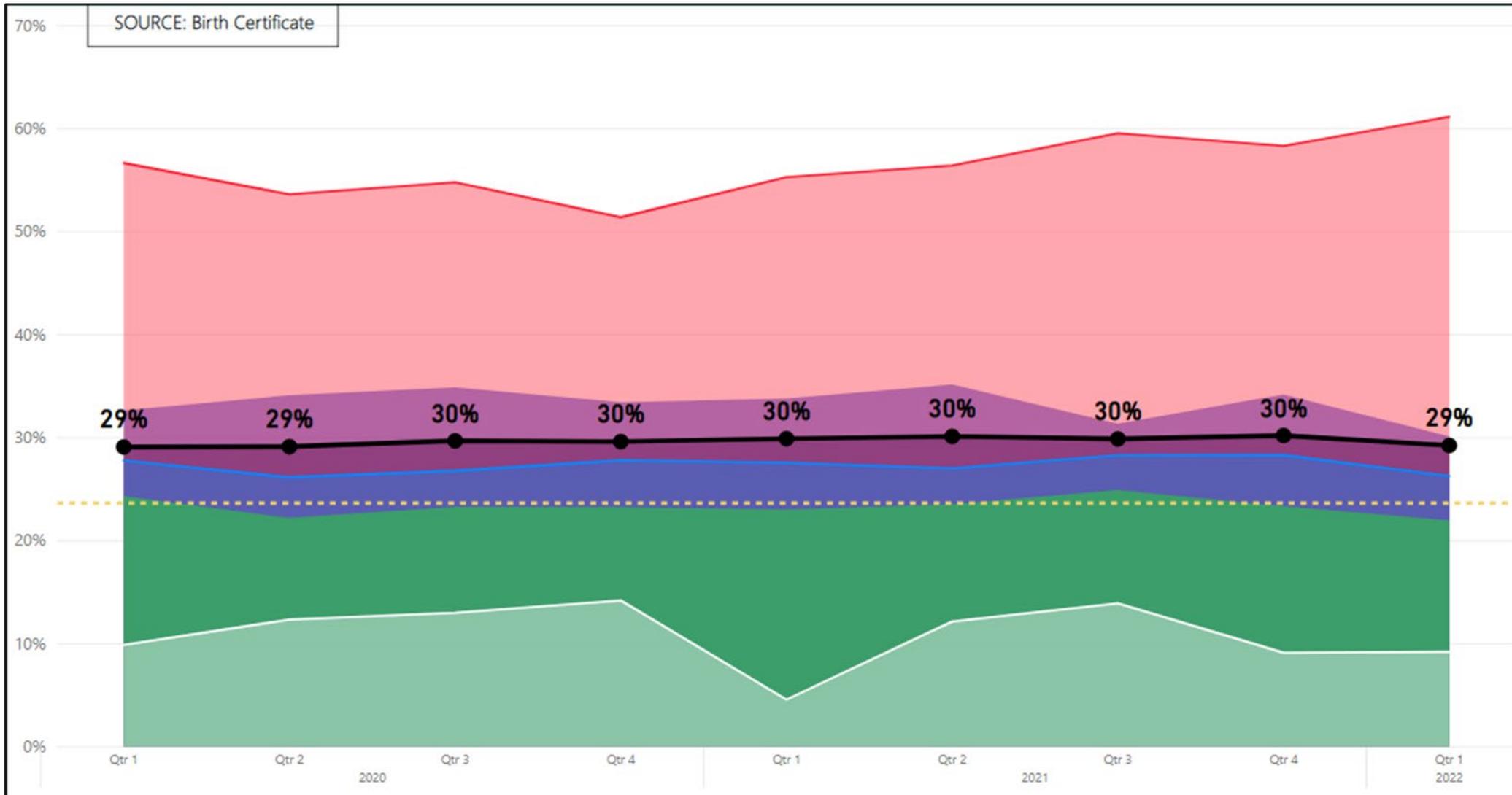
15-18 months after
a quarter's end

NTSV Cesarean Rates



Source: NCHS, CDC Birth Certificate Data

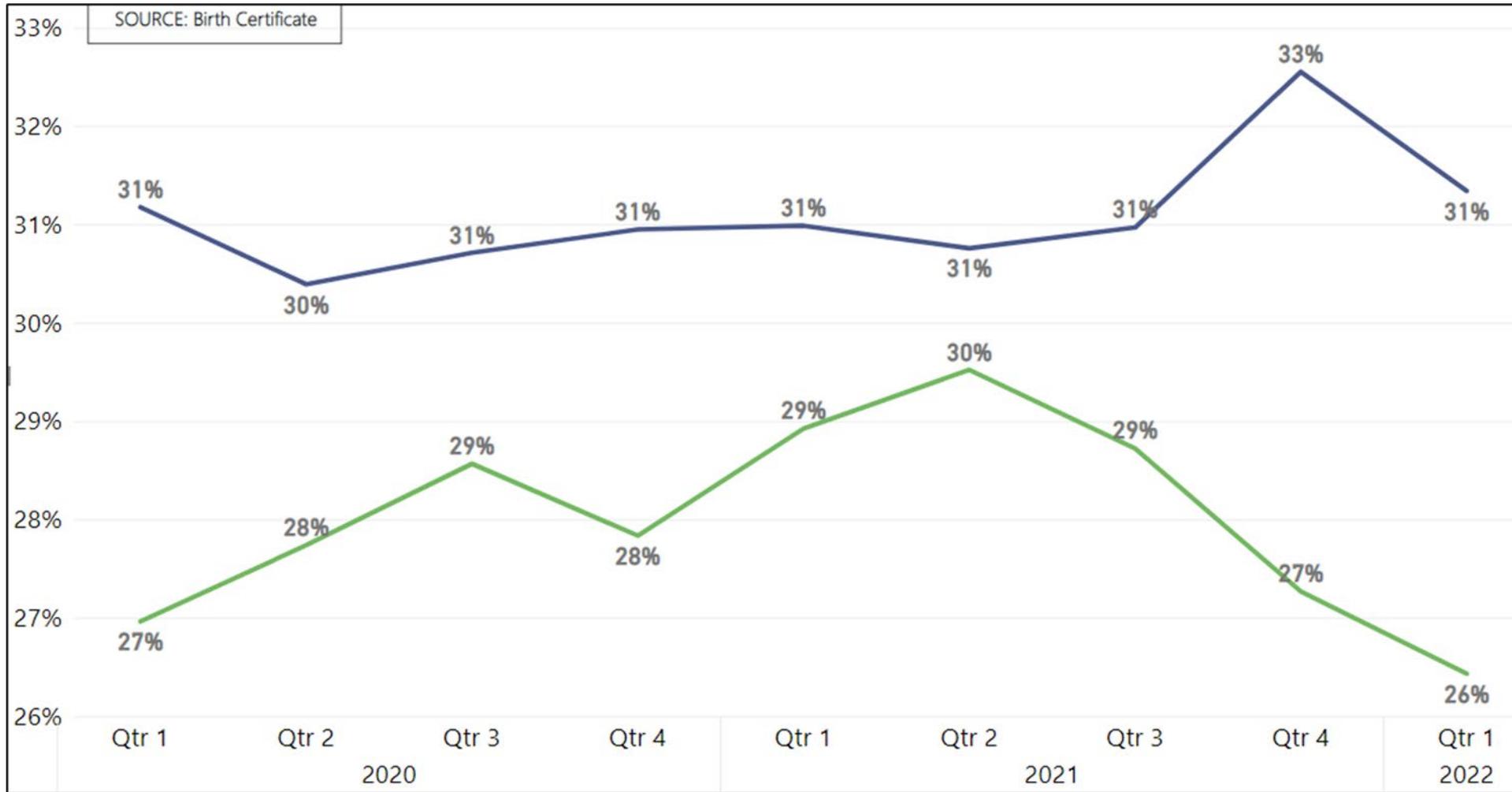
% NTSV Rate for ALL PROVIDE hospitals, 2020-Q1 2022



- Highest hospital rate
- Median
- Lowest hospital rate

- Highest 25% of hospitals
- Highest 50% of hospitals
- Lowest 50% of hospitals
- Lowest 25% of hospitals

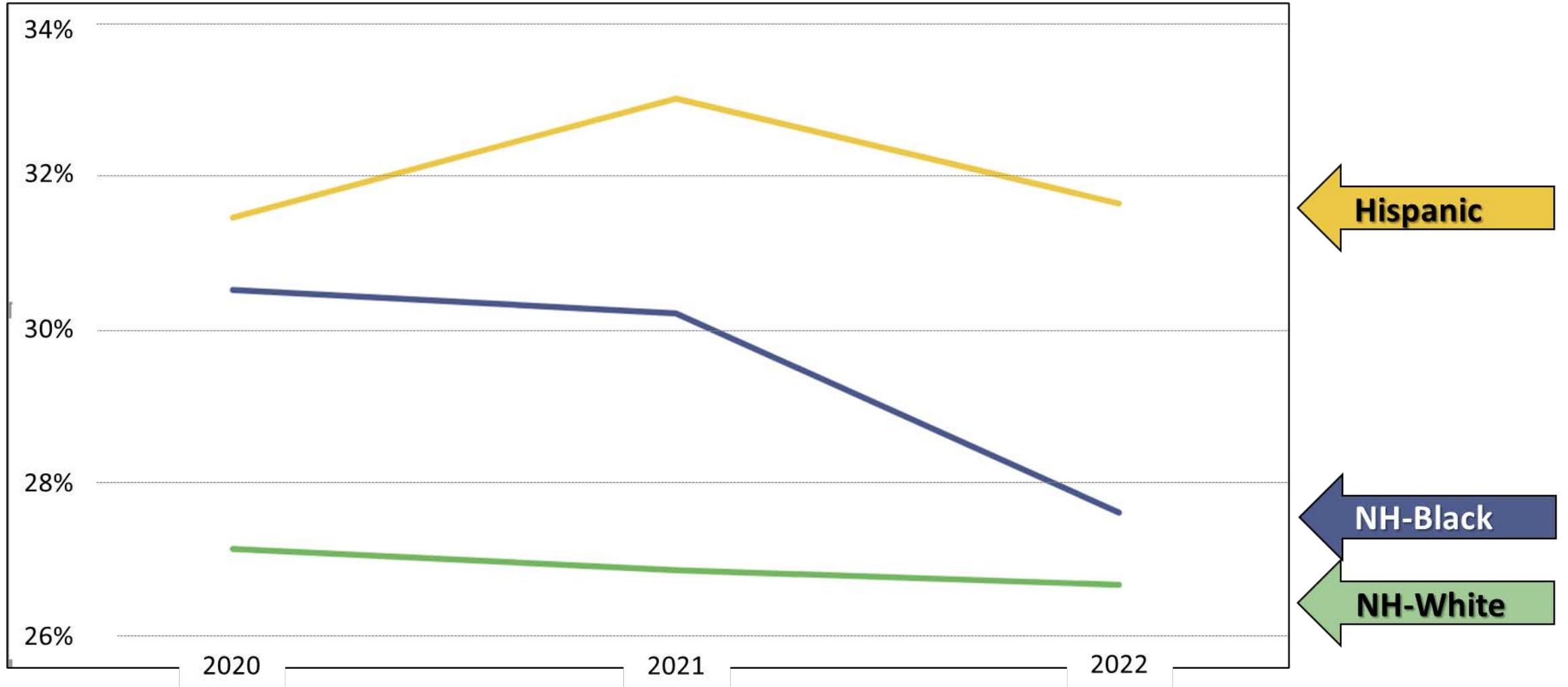
% NTSV Cesarean Rates by Payer Source



Private Insurance

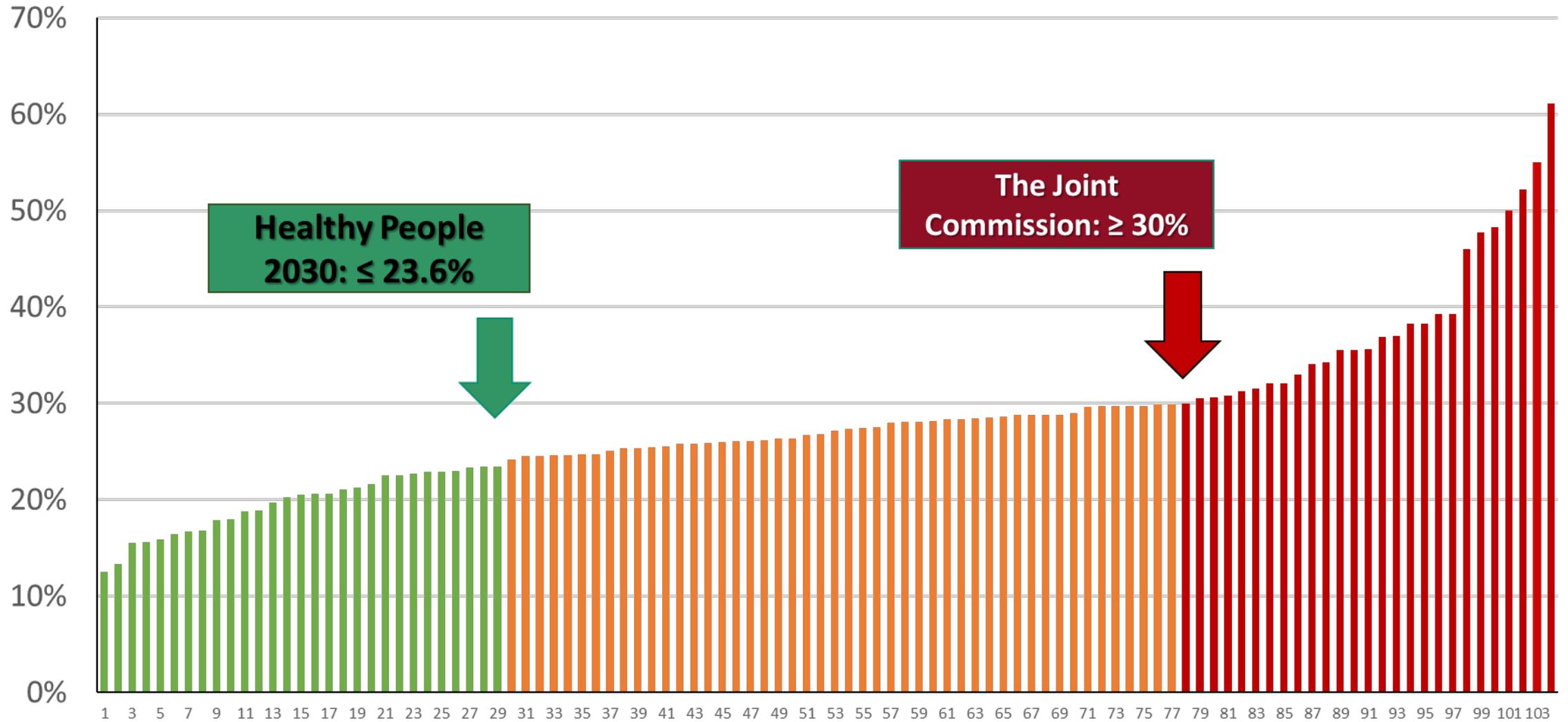
Medicaid

% NTSV Rates by Race/Ethnicity, PROVIDE Hospitals

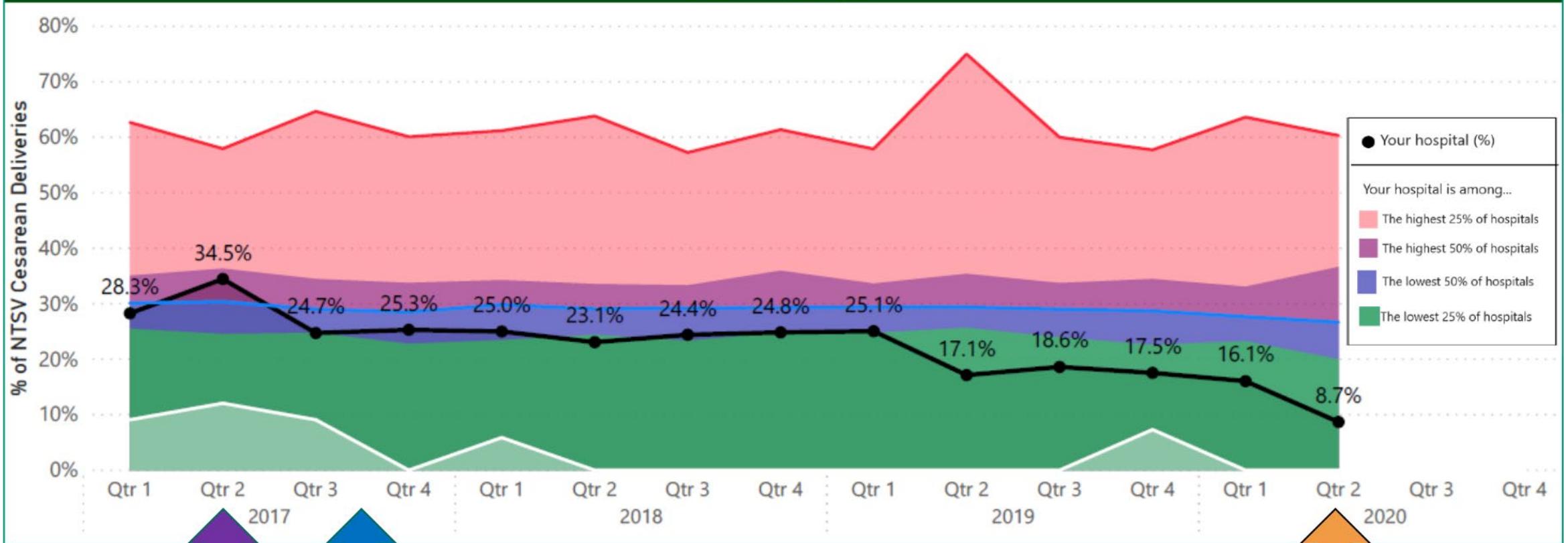


Source: FPQC PROVIDE (FDOH Birth Certificates)

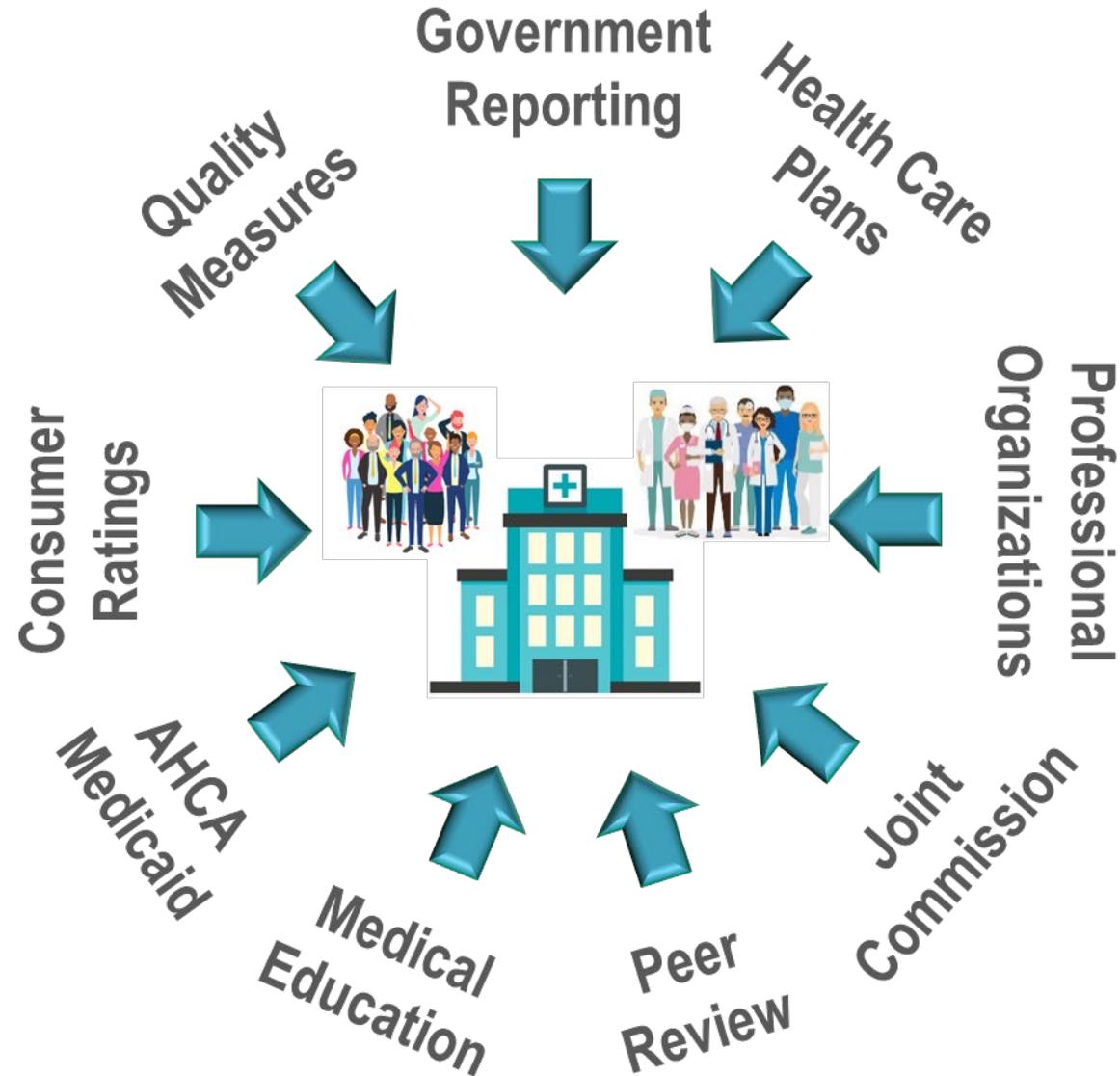
NTSV Cesarean Rates by Birthing Facility, Florida 2021



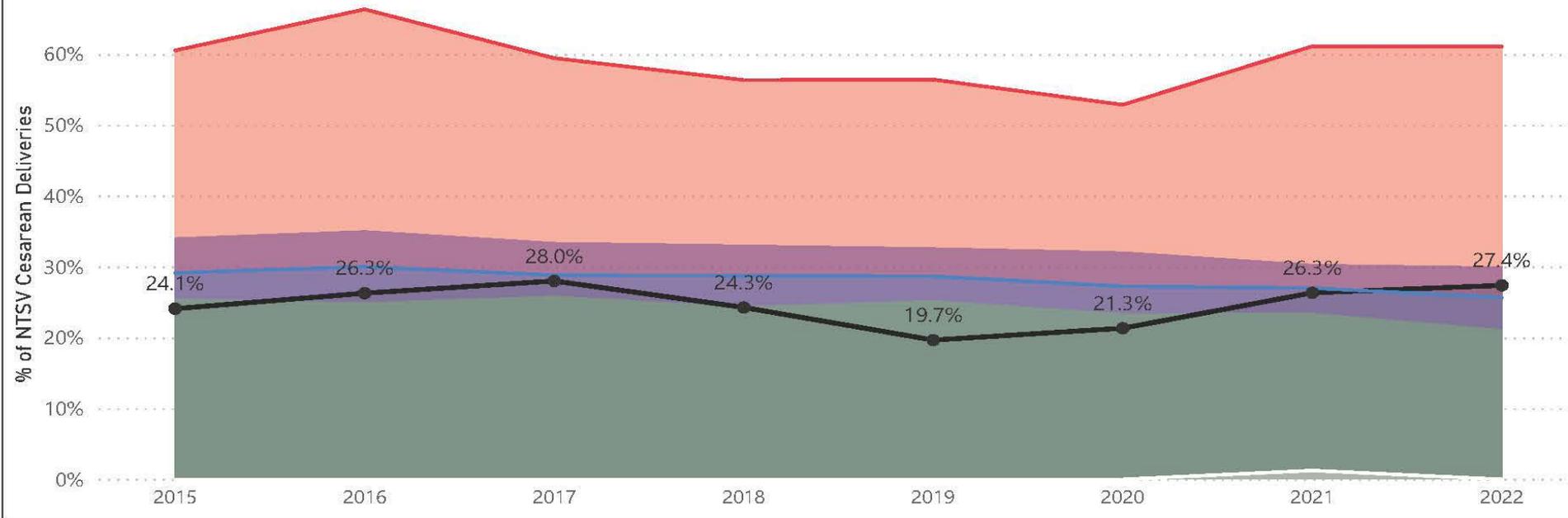
Percentage of Cesarean Deliveries Among All NTSV Births For All Delivery Hospitals in Florida QUARTERLY



Multiple Pressure Points to Improve Quality



TC Percentage of Cesarean Deliveries Among All NTSV Births For All Delivery Hospitals in Florida



● Your hospital (%)

Your hospital is among...

- The highest 25% of hospitals
- The highest 50% of hospitals
- The lowest 50% of hospitals
- The lowest 25% of hospitals

— Highest hospital rate

— Median

— Lowest hospital rate

NICU LEVEL

- 1
- 2
- 3

Race - ethnicity

- NH-White
- NH-Black
- Hispanic

Payor

- Medicaid
- Private
- Self-Pay

DATA QUALITY ISSUE

Agreement Unknown

13

Note: Data included on this page is through March 2022

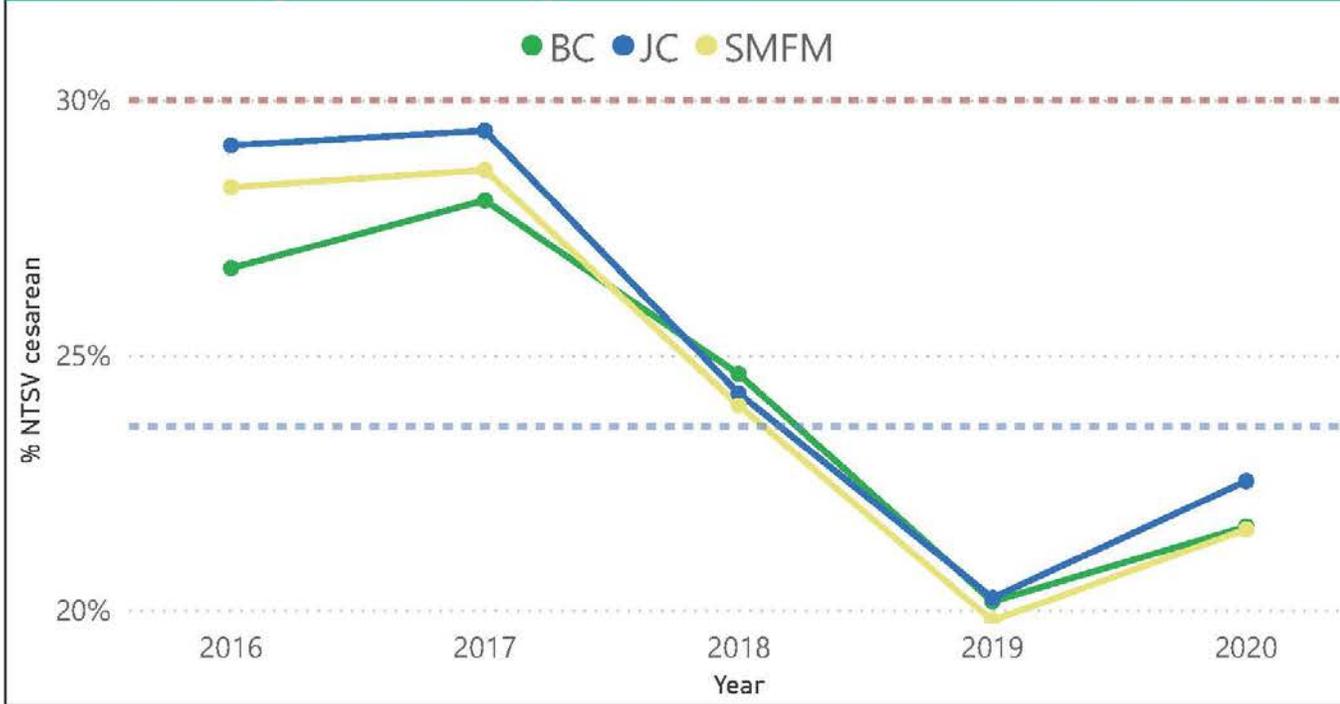
Your Hospital

	2015	2016	2017	2018	2019	2020	2021	2022
Percentage	24.1%	26.3%	28.0%	24.3%	19.7%	21.3%	26.3%	27.4%
Numerator	446	475	479	419	344	386	530	147
Denominator	1852	1808	1711	1727	1750	1810	2013	537

All delivery Hospitals

	2015	2016	2017	2018	2019	2020	2021	2022
Percentage	31.4%	31.6%	31.1%	30.5%	29.7%	28.9%	29.3%	28.5%
Numerator	22288	22238	21874	21305	20775	19737	20581	5096
Denominator	70997	70430	70248	69803	69911	68378	70316	17854

TC Your Hospital Comparative NTSV Cesarean Rate



NTSV cesarean rates calculated by using:

1. Birth certificate data only (BC);
2. Birth certificate and inpatient hospital discharge data for The Joint Commission (JC) measure or for the Society for Maternal Fetal Medicine (SMFM) measures.

	2016	2017	2018	2019	2020
NTSV cs rate - BC	26.7%	28.0%	24.6%	20.2%	21.6%
NTSV cs rate - JC	29.1%	29.4%	24.3%	20.2%	22.5%
NTSV cs rate - MFM	28.3%	28.6%	24.0%	19.8%	21.6%

Your 2020 NTSV Cesarean Rate

BC	JC	SMFM
21.6%	22.5% ▲	21.6% ▲

Your 2020 NTSV Cesarean Rate Rank

BC	JC	SMFM
10	20 ▲	17 ▲

Race-ethnicity

- NH-White
- NH-Black
- Hispanic

Payor

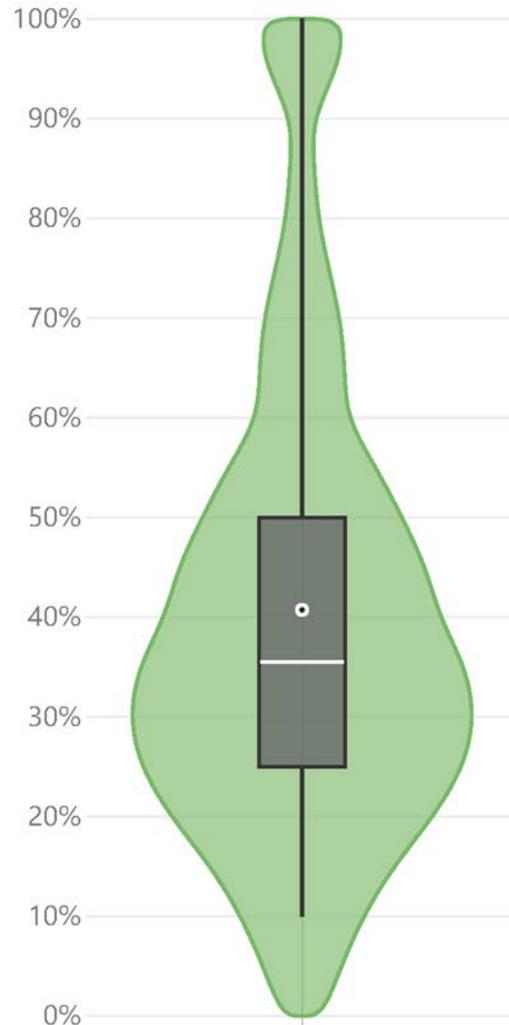
- Medicaid
- Private
- Self-Pay

DATA QUALITY ISSUE

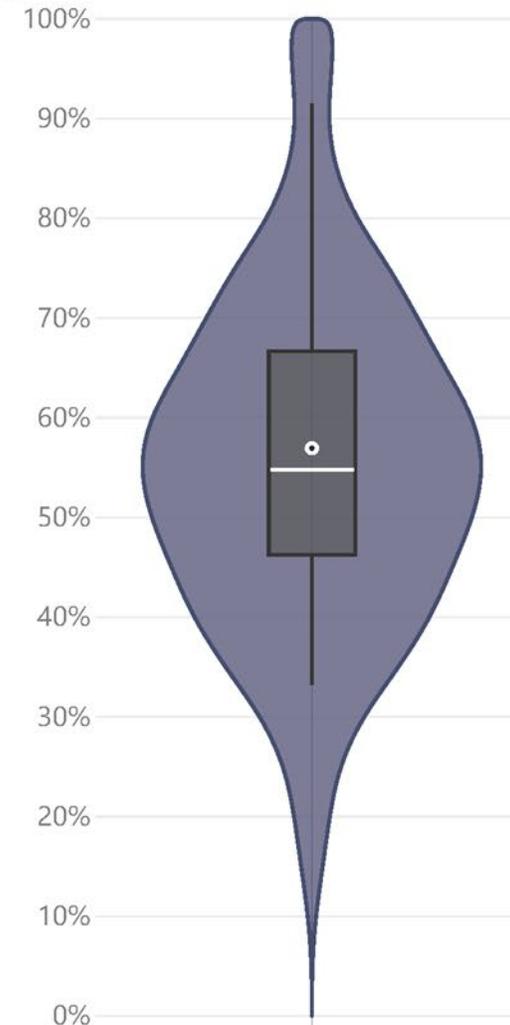
- Agreement
- Unknown

NTSV Cesarean Rates by Obstetric Provider, 2021

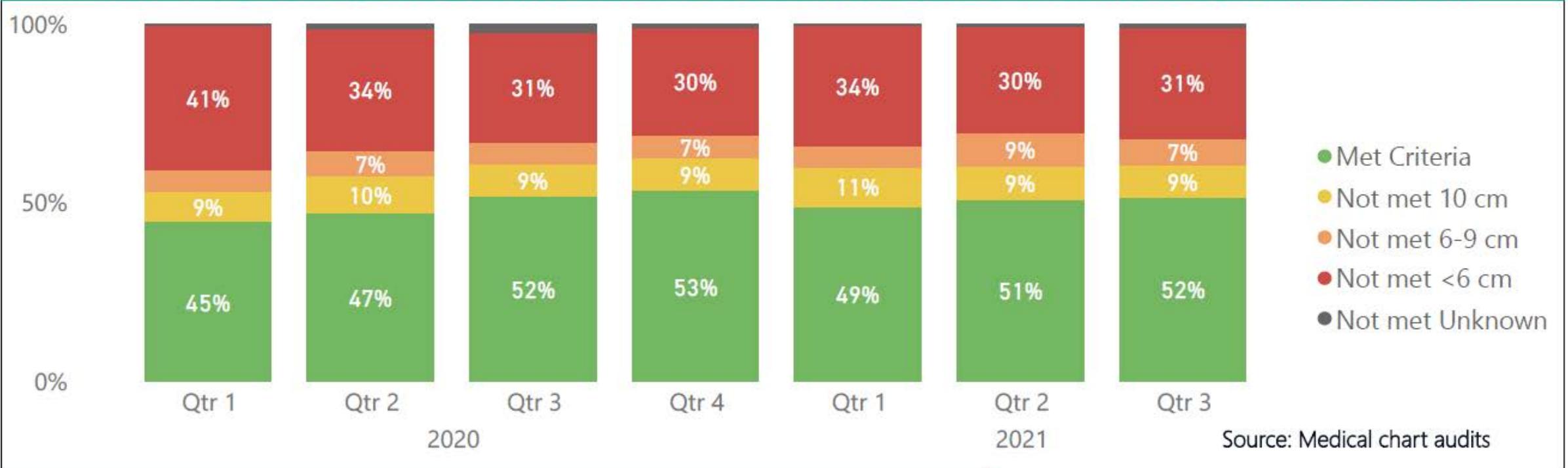
PROVIDE Hospitals



Example Hospital

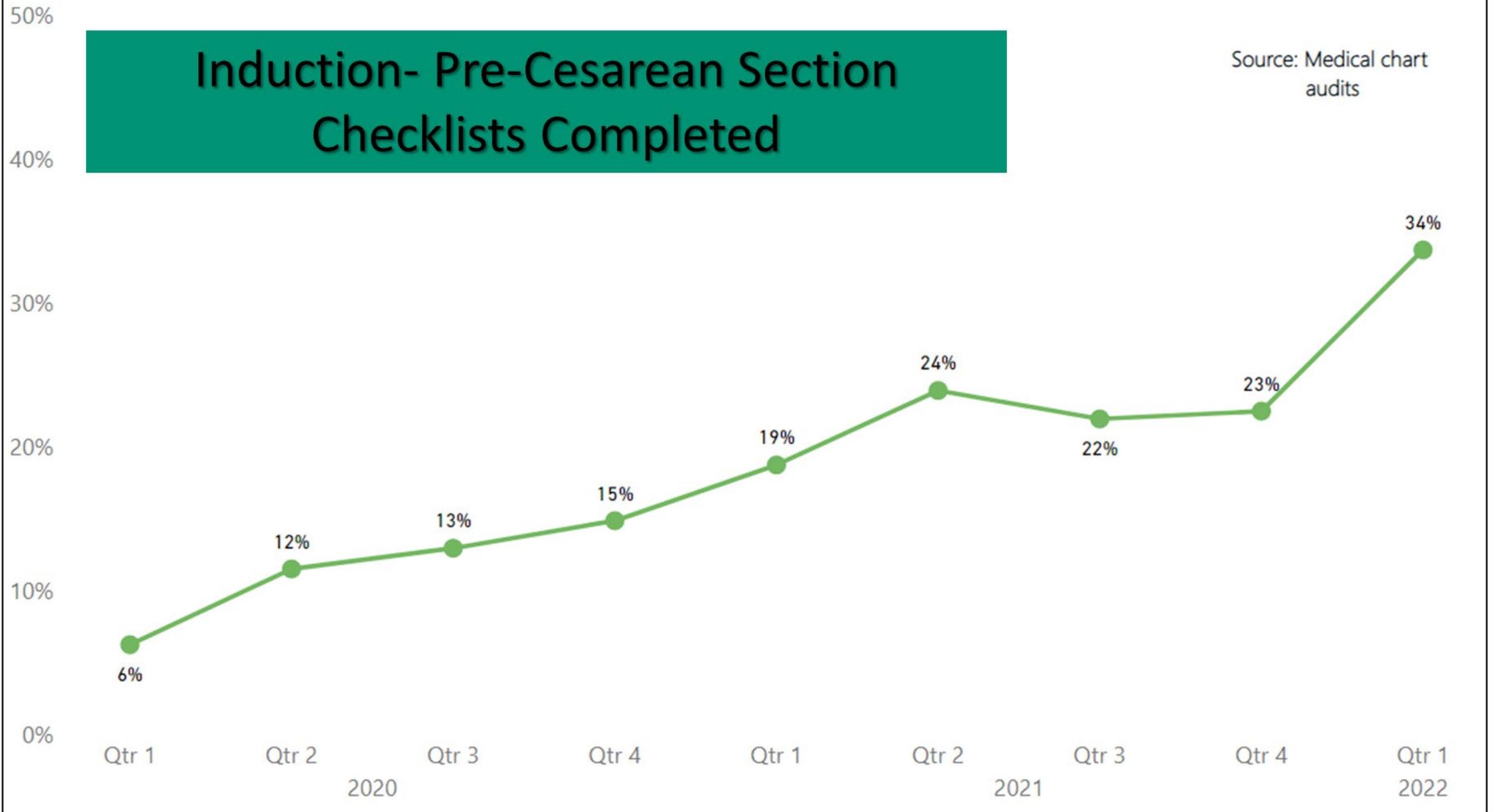


% NTSV Cesareans after Induction that Did NOT Meet ACOG/SMFM Criteria by Cervical Dilation



Induction- Pre-Cesarean Section Checklists Completed

Source: Medical chart audits



Hospital-Level Measures “Most Improved Change Components”

Non-Pharmacologic Comfort Techniques

Labor Strategies Ed.

Review Initiative Progress

Review Provider Rates

Review NTSV Charts



■ Not Started ■ Planning ■ In-place ■ Fully Implemented

Questions?

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fpqc@usf.edu

www.fpqc.org

 Florida Perinatal Quality Collaborative

 YouTube Florida Perinatal Quality Collaborative

 @TheFPQC



“To improve the health and health care of all Florida mothers & babies”

Maternal and Child Care: Incentivizing Health

Judy Zerzan-Thul, MD, MPH

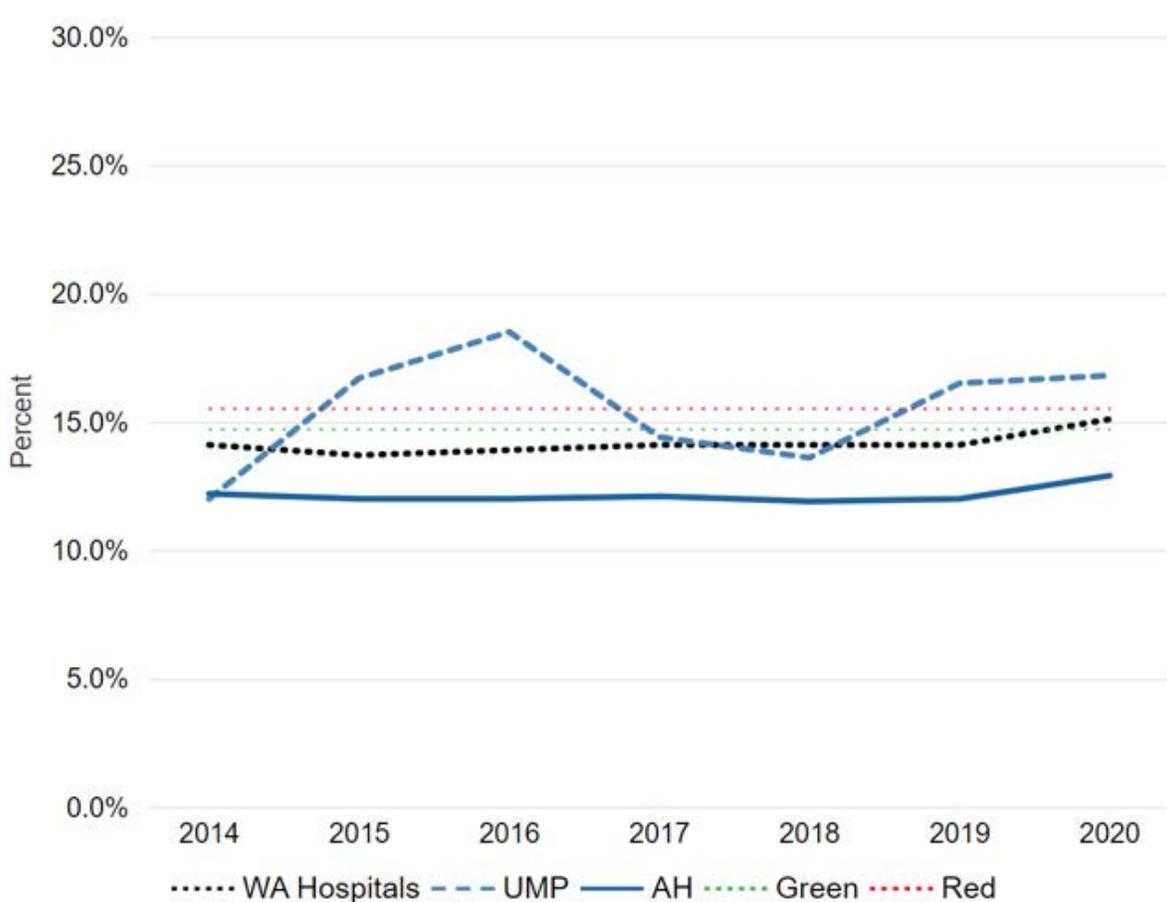
Washington State
Health Care Authority

The logo for the Washington State Health Care Authority features the text "Washington State Health Care Authority" in a blue sans-serif font. To the right of the text is a stylized green graphic consisting of a curved line that starts under the word "Authority" and loops back up and to the left, ending under the word "Health".

Context: Why We Care

- ▶ The US spends more than any other country on maternity care and yet has some of the worst perinatal and infant health outcomes.
 - ▶ The cesarean section rate in WA is 27.9%, which is substantially higher than the benchmark of 19% and even further from the rate of 10-15% recommended by the World Health Organization
 - ▶ Our preterm birth rate of 8.3% is lower than the national average of 9.85%, but we still lag behind the rates in the 5-6% range that Ecuador, Latvia, and Estonia have achieved.
- ▶ The Washington State Maternal Mortality Review Panel determined that 60% of maternal deaths here are preventable.
 - ▶ A significant number are tied to lack of access to behavioral health evaluation, treatment, and support.
 - ▶ Also found that Native American/Alaska Native women were nearly ten times as likely to die of a pregnancy-associated cause than white women.

UNWARRANTED PRACTICE VARIATION



WA Hospital Status

15.1%

Advocate for Problem Solving?

STATUS & CONTEXT

- Primary Cesarean Sections are now increasing statewide. The Results WA goal is 14.7% which was reached in 2013 but we are now slightly above for UMP.
- There is still variation across hospitals.
- Medicaid paid births have lower PTSV than commercially paid births. (17% vs. 13%)
- Medicaid C-sections are starting to increase and UMP C-sections are flat since the last measurement point.

RECOMMENDED ACTIONS

- Continue to encourage hospitals to participate in Safe Deliveries Roadmap through WSHA. Continue to require ACP hospitals to participate in registries and look to improve maternal outcomes.
- Continue to support outlier hospitals in their quality improvement efforts and related maternity outcomes.
- Consider what is driving increase in UMP and Medicaid. Normal variation? Regression to the mean? With an increased concern about health equity and maternal outcomes – this may be something we should take a closer look at.

Cesarean Sections by Race/Ethnicity Medicaid v. Non-Medicaid

Measure	2019	2020
C-Sections: TSV		
Medicaid		
African American	17.6%	17.2%
Asian	14.0%	15.6%
Hispanic	10.6%	11.3%
More Than One Race	13.6%	13.9%
Native American	9.3%	10.6%
Other/Unknown	9.2%	14.6%
Pacific Islander	12.4%	16.4%
White	11.9%	12.9%
Non-Medicaid		
African American	24.0%	25.6%
Asian	19.9%	20.1%
Hispanic	15.0%	18.8%
More Than One Race	17.8%	17.7%
Native American	15.9%	14.5%
Other/Unknown	18.6%	20.8%
Pacific Islander	17.0%	20.6%
White	14.5%	15.3%

C-Sections by Race/Ethnicity Statewide

Measure	2017	2018	2019	2020
C-Sections: TSV				
African American	19.0%	18.1%	19.4%	19.6%
Asian	19.1%	18.5%	18.7%	19.2%
Hispanic	11.6%	12.0%	11.6%	13.1%
More Than One Race	15.0%	14.0%	15.4%	15.6%
Native American	10.2%	11.2%	10.7%	11.4%
Other/Unknown	14.2%	11.5%	12.3%	17.2%
Pacific Islander	15.8%	14.8%	13.2%	17.2%
White	13.6%	13.8%	13.5%	14.4%

Maternity VBP: Building from a host of complementary work and initiatives

- ▶ The Bree Collaborative (a group of WA based providers and advocates) developing/refining a maternity episode of care.
- ▶ The recent legislative extension of post-partum (PP) Apple Health/Medicaid coverage from two months to twelve months.
- ▶ Implementation of a maternity episode of care in WA based commercial lines of business.
- ▶ HCA/WA participation in a three-year Institute for Medicaid Innovation learning collaborative on increasing access to midwifery led care.
- ▶ Hiring of HCA dedicated resources.

HCA's Key Goals

- ▶ Incentivize high-quality, high-value care that improves perinatal health outcomes and addresses racial and ethnic disparities.

Specific targets:

- ▶ Increase quality and utilization of both prenatal and postpartum care
 - ▶ Increase the identification, coordination and services for patients with mental health and/or substance use disorder.
 - ▶ Assure that the care of the birth parent and infant are coordinated and linked
 - ▶ Increase integrated and team-based care, including doulas.
 - ▶ Expand the appropriate use of midwives for both hospital and community birth settings
- ▶ Controlling cost is a secondary consideration

Environmental Scan Key Takeaways

- ▶ Value-based payment models in other states are currently designed to address the period from pregnancy through 60 days postpartum
 - The majority of the statewide models are episode-based models focused on cost containment
 - North Carolina is the only state that currently offers a statewide maternity medical home, a few others offer them for high-risk pregnant people
- ▶ Dyadic Care
 - The episode-based model offers little that can be done to incentivize dyadic care
 - A medical home offers opportunities for improved care coordination

Decision point 1: Maternal episode of care

- Accountable provider is the OB or delivery provider
- Payment model or amount may differ based on beneficiary risk category (e.g., higher episode payment for pregnant person with higher risk of SUD or additional services needed)
- Phase-in quality measures linked to VBPs
 - Pay-for-reporting (P4R): New measures without historic/national data for benchmarks or targets, nor typical processes for quick implementation
 - Pay-for-performance (P4P): Standard maternity measures could be tied to payment immediately
 - Shared savings/Downside risk: Over time, consider further incentivizing providers with shared savings and then downside risk

Decision point 2: Measure Topics

- Screenings/Risk Assessments and Referrals/Modifiers
 - Depression (e.g., PHQ-9 and PPD)
 - Substance Use
 - Anemia/hemorrhage
 - Cardiovascular disease
 - SDOH (e.g., housing, food, and transportation)
 - Patient supports (e.g., birth centers)
- Birth outcomes (e.g., vaginal births)
- Care coordination

Next Steps

- ▶ Building out the components of the projects.
- ▶ Orienting and starting work with our contractor, NORC.
- ▶ Gathering information on our current payment.
- ▶ Designing and implementing a model to be adopted by providers and creating the measurement tools to track progress towards healthier parents, babies, families and communities.
- ▶ Talking with others about this work and getting their input.

Questions

Lekisha Daniel-Robinson, Mathematica

Reminder: How to Submit a Question

- **Use the Q&A function to submit questions or comments**
 - To submit a question or comment, click the Q&A pod and type in the text box.
 - Select “All Panelists” in the “Ask” field before submitting your question or comment.
 - Only the presentation team will be able to see your comments.
 - The moderator will read out your question and ask a panelist to answer.

The screenshot shows a chat window with a 'Chat' header and a close button. Below the header is a 'To:' dropdown menu currently set to 'Host'. Underneath is a text input field with the placeholder 'Enter chat message here'. A 'Q&A' section is visible, containing a dropdown menu set to 'All (0)'. Below this is another 'Ask:' dropdown menu set to 'All Panelists'. At the bottom, there is a text input field with the placeholder 'Select a panelist in the Ask menu first and then type your question here. There's a 256-character limit.' and a 'Send' button.

Announcements and Next Steps

Kate Nilles, Mathematica

Announcements and Next Steps

- **Webinar recording and slides will be posted on Medicaid.gov at <https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-infant-health-care-quality/index.html>**
- **Upcoming webinars**
 - Informational webinar: Improving Maternal Health by Reducing Low-Risk Cesarean Delivery Affinity Group: Overview and Process for Expression of Interest: **June 29, 2022, at 2:00-3:00 pm ET**
- **Register for the final webinar in the series at <https://mathematica.webex.com/mathematica/onstage/g.php?PRID=b8c2078478d3be51928f2d528cb7a26c>**

Thank you for participating!

- Please **complete the evaluation** as you exit the webinar.
- If you have any **questions**, or we didn't have time to get to your question, **please email** MACQualityImprovement@mathematica-mpr.com

