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Issue Brief

Title V Program Approaches to Lower Non-Medically Indicated Deliveries before 39 Weeks Gestation

Introduction

Overview

Title V of the Social Security Act is the only federal program that focuses solely on improving the health of all women, children, including children and youth with special health care needs, and families. State Title V programs administer and fund numerous public health efforts that are natural access points for building and strengthening integrated service delivery systems. This unique role provides a strong foundation from which Title V can engage with other stakeholders, such as providers, payers, and consumers, to work together on issues such as lowering the rate of non-medically indicated deliveries before 39 weeks gestation.[*]

This issue brief focuses on recent efforts to reduce non-medically indicated deliveries before 39 weeks, and presents various methods that Title V programs can utilize to improve birth outcomes.

Background

In recent years, the U.S. has experienced declines in the national rates of preterm birth and cesarean delivery. The Centers for Disease Control and Prevention (CDC) estimates that in 2014, nearly 1 in 10 babies was born premature.[1] This estimate represents a decrease from the 2013 preterm birth rate of 11.39 percent, and it is significantly lower than the 2006 peak of 12.80 percent.[2] Similarly, in 2011, the U.S. witnessed its first decline in cesarean deliveries in more than a decade; cesarean deliveries accounted for 32.8 percent of all deliveries, down slightly from 32.9 percent in 2009.[3] The cesarean birth rate dropped again in 2013, accounting for only 32.7 percent of all births.[4] These positive changes are the result of national, state and local efforts to improve health outcomes for both mothers and babies.

Despite these declines, many births still occur by inducing labor or cesarean delivery before 39 weeks gestation, sometimes without medical indication. Recent large cohort studies have generated additional supporting data that indicate many risks are associated with preterm and early term deliveries. This research

[*] Note that the terminology “non-medically indicated deliveries before 39 weeks” is sometimes referred to as “early elective delivery.” The two terminologies are often used interchangeably. For the purposes of this issue brief, non-medically indicated deliveries before 39 weeks will be used, with rare exception.

demonstrates that preterm and early term births lead to higher rates of infant mortality, poorer health outcomes and increased morbidity, as well as increased health care spending.

Risks of Non-Medically Indicated Deliveries before 39 Weeks Gestation

Health Implications

The risk of infant mortality rises for babies who are born even a few weeks early, according to data from the CDC National Center for Health Statistics. In 2013, 1.85 infant deaths occurred per 1,000 live births at 39–40 weeks gestation, compared to 7.23 per 1,000 live births at 34–36 weeks (Figure 1).[5] Preterm and early term deliveries are also associated with higher rates of morbidity when compared to full term births.

Mothers can also experience adverse side effects from non-medically indicated deliveries before 39 weeks. Induction of early term labor may increase a woman's risk for obstetric hemorrhage or unplanned cesarean delivery.[6] Cesarean delivery, in turn, can increase the risk for postpartum complications as well as poor maternal outcomes such as infection or blood clots in subsequent pregnancies.[7] Recovering from these deliveries can take longer than recovery from vaginal birth. Furthermore, early elective deliveries may increase the risk for neonatal complications, some of which also negatively impact a woman's ability to breastfeed.[8]

Financial Implications

In 2011, 13.5 million women of reproductive age were enrolled in Medicaid nationwide, accounting for nearly 70 percent of all female Medicaid beneficiaries.[9] Medicaid covers upwards of 44 percent of all U.S. births, with wide variation among the states.[10] The increasing number of women enrolled in Medicaid — coupled with the higher rates of preterm, early term and low birth weight infants born to this group of women compared to those born to women with private insurance (10.4 percent and 9.1 percent, respectively) — contributes to exorbitant amounts of health care spending (Figure 2).[11,12]

According to the Institute of Medicine, preterm and early term births cost the United States an average of $26.2 billion each year, including $16.9 billion in medical and health care costs for the infant and $1.9 billion in labor and delivery fees for the mother.[13] Investing in efforts to lower non-medically indicated deliveries before 39 weeks can improve birth outcomes and result in savings at the federal and state levels. Medicaid and Title V should take the lead to drive system-wide change by incentivizing providers and rewarding quality-based care, in order to help reduce the use of early elective deliveries before 39 weeks.[14]

Figure 1: US Infant Mortality Rates by Gestational Age, 2010-2013
Source: CDC National Vital Statistics Report

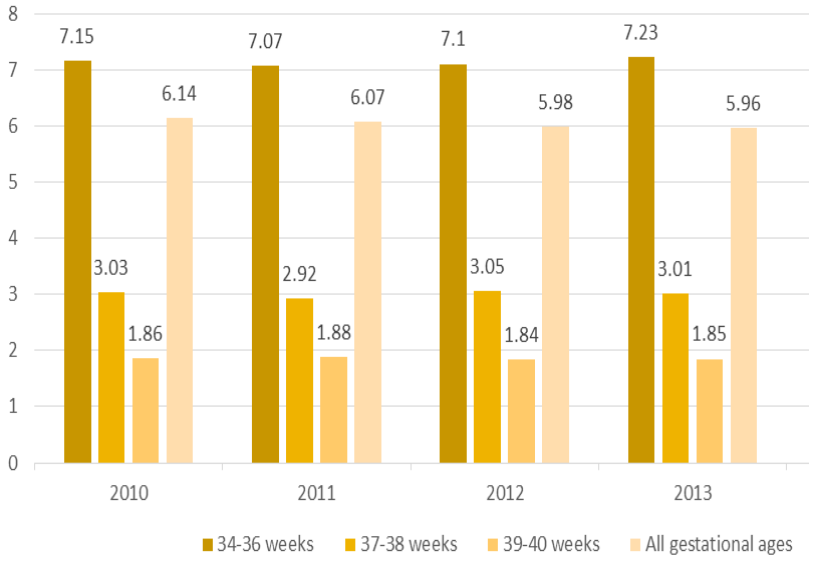
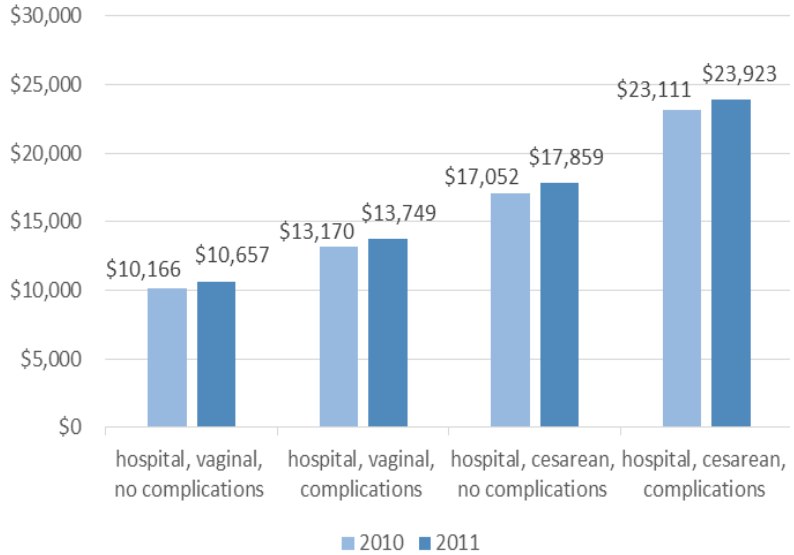


Figure 2: Average Labor & Delivery Charges by Type & Method, 2010-2011
Source: AHRQ Healthcare Cost and Utilization Project



Key Priorities at the National Level

Efforts to reduce prematurity are gaining momentum as a means to lower rates of infant mortality and morbidity and curtail health care costs.[†] One national initiative is the Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality. The Infant Mortality CoIIN is a partnership between HRSA/MCHB, ASTHO, AMCHP, the CDC, CityMatCH, CMS, MoD, NGA, the National Institute for Children's Health Quality and the states that focus on five strategies for reducing infant mortality. One of the priorities of the CoIIN effort is the reduction of non-medically indicated deliveries before 39 weeks gestation.

Additionally, the recent transformation of the Title V Block Grant prioritizes reducing non-medically indicated deliveries before 39 weeks through National Performance Measure (NPM) #2: percent of cesarean deliveries among low-risk first births. Eleven state Title V programs chose NPM #2 as a priority area in their 2016 Block Grant applications.[15]

Driven by both national efforts and local initiatives, states have started to see positive results in reducing early elective deliveries. Many of these initiatives are the result of collaborative partnerships among state and local maternal and child health (MCH) programs, community health centers, providers, hospitals and other key stakeholders.

Effective State Strategies

Voluntary Provider/Hospital Reform

There are many opportunities within the hospital setting to implement quality improvement programs to reduce non-medically indicated deliveries before 39 weeks. Nationwide, more than 3,200 hospitals are participating in the national Partnership for Patients program, a public-private partnership with the U.S. Department of Health and Human Services (HHS) and hospital engagement networks (HENs) to facilitate the adoption of evidence-based clinical practices that lead to improved patient safety. Reduction of non-medically indicated deliveries before 39 weeks is a focus within some HENs across the country, providing an example of how hospitals can engage in voluntary efforts that improve patient safety and lower costs for hospital care.[16] State Title V programs are well situated to provide input as well as bring other stakeholders to the table to help these efforts succeed.

Organizations such as the Joint Commission, the Leapfrog Group, the National Quality Forum, and the National Perinatal Information Center are recognizing the importance of measuring, reporting and analyzing perinatal indicators that include quantitative measures of non-medically indicated deliveries before 39 weeks.[17,18,19,20] Reporting on quality indicators related to obstetric services will ultimately improve care and outcomes for mothers and babies.

California

The 2013 infant mortality rate in California was 4.7 infant deaths per 1,000 live births, down significantly from its peak of 5.4 per 1,000 in 2000.[21] In collaboration with MoD and the California Maternal Quality Care Collaborative (CMQCC), the California Department of Public Health (CDPH) Maternal, Child and Adolescent Health Program (MCAH) developed a toolkit to reduce non-medically indicated deliveries before 39 weeks gestation.

The quality improvement toolkit, "Elimination of Non-Medically Indicated (Elective) Deliveries before 39 Weeks Gestational Age," is designed to help determine and disseminate best practices for prevention as well as effective strategies for supporting California health care providers in implementing those practices.

The creation and dissemination of the toolkit was made possible with funding from the Title V MCH Block Grant. The toolkit became the basis for a MoD collaborative project in which 25 hospitals in the "Big 5" states (California, Florida, Illinois, New York and Texas), representing 40 percent of all births in the nation, demonstrated a reduction in elective singleton early term deliveries from 17.8

[†] See the attached appendix for a matrix of national and regional efforts to improve birth outcomes

percent to 4.8 percent during the one-year project period.[22]

Recognizing the necessity of improving perinatal care for mothers and infants in order to improve health outcomes, CDPH/MCAH contracted with CMQCC to produce two additional toolkits focused on the health care response to leading causes of preventable death among pregnant and postpartum women. These toolkits are "Improving Health Care Response to Obstetric Hemorrhage" (released in 2010, updated in 2015) and "Improving Health Care Response to Preeclampsia" (2014).

Oklahoma

In 2011, the Oklahoma State Department of Health collaborated with MoD, the Office of Perinatal Quality Improvement and the Oklahoma Hospital Association to launch the "Every Week Counts" (EWC) project. This effort operated as part of the "Preparing for a Lifetime" initiative aimed at reducing infant mortality and other adverse birth outcomes. Title V and Medicaid representatives served as co-chairs of the Perinatal Advisory Task Force, providing oversight and coordination for EWC program implementation.

The EWC collaborative began recruiting hospitals for a voluntary "hard stop" effort in January 2011.[23] In addition to the voluntary commitment from birthing hospitals to stop scheduling unnecessary cesarean deliveries and labor induction procedures, the collaborative invested in patient education and outreach through the use of MoD printed materials and a public service announcement.[24] This three-pronged effort proved highly successful, and by the project's conclusion in 2014, upwards of 95 percent of Oklahoma birthing hospitals voluntarily participated in the EWC initiative (52 total participants), providing quarterly data reports on the number of scheduled deliveries before 39 weeks gestation.[25] Based on these data, participating hospitals demonstrated a 96 percent decrease in early elective deliveries.[26]

The major success of this project can be attributed to stakeholder engagement, external funding and support from Title V and MoD, and the data collection and reporting system that allowed hospitals to identify areas for improvement and compare progress with other hospitals. Although the program funding expired in 2014, hospitals continue to share their non-medically indicated delivery data with CMS.[27] Moreover, the Oklahoma Perinatal Quality Improvement Collaborative (OPQIC) continues to work on perinatal quality improvement with birthing hospitals and perinatal care providers.

Payment Reform

Payments made to hospitals and providers are another lever that many states are using to lower the rate of non-medically indicated deliveries before 39 weeks. According to a recent report from NGA, at least 31 states are engaging in payment reform activities aimed at reducing non-medically indicated deliveries before 39 weeks through financial incentives or disincentives.[28] These state Medicaid payment reforms include policies that:

- Pay the same rate for a vaginal birth as a cesarean delivery.
- Lower the payment for non-emergency cesarean sections to a level below that of a vaginal birth.
- Offer hospitals a bonus payment for achieving a certain threshold reduction in non-medically indicated deliveries before 39 weeks.
- Provide non-payment for deliveries before 39 weeks that are not medically indicated.

With Medicaid paying for nearly half the births in the U.S., payment reform is another promising method to improve birth outcomes and potentially provide savings to the health care system.[29] Title V programs, required by statute to collaborate with state Medicaid offices, can bring valuable expertise such as data and metrics to the table. Payment reform is often part of a multi-faceted effort to improve birth outcomes at the state level.

North Carolina

Quality improvement strategies linked to payment reforms are two of the main approaches that North Carolina is using to lower the rate of elective deliveries and preterm births. The program is overseen and financed by the North Carolina

Division of Medical Assistance (DMA) — the state Medicaid agency — and operated by Community Care of North Carolina (CCNC), a private non-profit organization that contracts with DMA. A statewide program of community stakeholders that includes providers, local health departments, local CCNC networks, and the state Title V agency work together to manage a medical home for obstetric care, also known as a pregnancy medical home (PMH).

In partnership with local public health departments statewide, North Carolina also has implemented a pregnancy care management system for Medicaid recipients with risk factors for poor birth outcomes. By improving the quality of maternity care, the state hopes to improve birth outcomes, with a focus on preventing preterm birth.

Approximately 90 percent of North Carolina providers who care for pregnant Medicaid recipients are engaged in the PMH program.[30] Providers participating as PMHs must agree to certain performance expectations, such as avoiding non-medically indicated deliveries before 39 weeks gestation, reducing primary cesarean rates, using 17-alpha hydroxyprogesterone to prevent recurrent preterm births and collaborating with pregnancy care management to improve the postpartum visit rate. These providers receive both financial incentives for performance, including an increased reimbursement for vaginal deliveries to equal the rate of reimbursement for cesarean deliveries, as well as administrative reductions, such as no prior approval requirements for ultrasounds.[31]

More than 350 practices and clinics and more than 1,600 individual providers contract with their local CCNC network to provide PMHs.[32] With support from Title V and the Division of Public Health's Women's Health Branch, the PMH model and related pregnancy care management program is available in all 100 counties of North Carolina.

South Carolina

The South Carolina Birth Outcomes Initiative (BOI) is an effort by the South Carolina Department of Health and Human Services (SCDHHS) to improve health outcomes for mothers and newborns in the Medicaid program. The program launched in 2011 in partnership with the South Carolina Hospital Association (SCHA), MoD, and Blue Cross BlueShield of South Carolina (BCBSSC). The primary objectives of the BOI are to eliminate elective inductions for non-medically indicated deliveries prior to 39 weeks, reduce the number of admissions and the average length of stay in the neonatal intensive care unit (NICU), and reduce racial disparities in birth outcomes.[33]

The primary catalyst for the BOI was a state financial crisis and a requirement to cut $30 million from the state's Medicaid budget.[34] At the time, Medicaid was paying for more than half the NICU admissions in the state as well as 50 percent of all births.[35] SCDHHS leaders knew that improving birth outcomes would lead to substantial cost savings. On January 3, 2013, South Carolina released a public notice about a new non-payment policy, becoming the first state in the nation to have both public (Medicaid) and private (BCBSSC) insurance providers implement a non-payment policy for early elective deliveries.[36]

South Carolina managed to cut the percentage of elective inductions at 37–38 weeks gestation from 8.81 percent in 2011 to 4.43 percent in 2013.[37] Additionally, 60 percent of all birthing hospitals in the state reported a zero percent rate for early elective inductions between 37 and 38 weeks.[38] Initial estimates show that in the first quarter of fiscal year 2013, the 39 week initiative of the BOI saved the state and the federal government a total of $6 million dollars.[39] This savings is due in large part to decreased NICU admissions and shorter average length of stay in the NICU among babies born at 37 and 38 weeks to mothers enrolled in Medicaid.

The South Carolina Title V director is a member of the BOI Vision Team, and all five of the MCH Bureau division directors sit on different work groups to ensure that the work of BOI is closely aligned and supported by each division within the state MCH Bureau. In addition, Title V financially supports four regional coordinators at the Perinatal Regionalization Centers who are instrumental in creating and disseminating the information to participating hospitals.

Texas

In an effort to curb its preterm birth rate, the Texas Department of State Health Services launched the Healthy Texas Babies Initiative in 2011, creating an expert panel to guide state efforts to improve birth outcomes. One of the first recommendations from the panel was to improve state efforts to reduce non-medically indicated deliveries before 39 weeks. Concurrently, Texas Medicaid was analyzing potential cost-savings with the elimination of payment for non-medically indicated deliveries at less than 39 weeks gestation.

To aid in the effort, the Texas Department of State Health Services and the Medicaid program provided technical expertise on House Bill 1983, which called for provider training and education to reduce non-medically indicated preterm deliveries. Medicaid changed its policy in October of 2011, requiring delivering clinicians to add a modifier to claims indicating medical necessity for deliveries prior to 39-weeks gestation.[40] Those that do not include this modifier or indicate that the delivery is non-medically indicated are denied Medicaid payment for the delivery.

To support changes in policy to Texas Medicaid, Title V staff provided valuable provider-level education through the agency's free Grand Rounds program. Title V staff also developed an online learning module for clinicians with an accompanying video demonstrating effective negotiation between clinicians and patients who desire a non-medically indicated delivery before 39 weeks. In addition to online provider education, Title V staff developed an in-person, multi-site training for nurses, midwives, social workers, community health workers and other stakeholders on the importance of a 39 week gestation period in healthy pregnancies and information about the change in Medicaid policy.

All of these efforts resulted in Texas surpassing the Healthy People 2020 infant mortality target of 6.0 infant deaths per 1,000 live births.[41] According to statistics from the Leapfrog Hospital Survey, Texas' statewide average of early elective deliveries has also decreased from 17.7 percent in 2012 to 5.9 percent in 2013.[42] Additionally, Texas has lowered its preterm birth rate to 10.7 percent of all births, as well as their primary cesarean delivery rate to 20.0 percent in 2013 (compared with 13.2 percent and 35.1 percent in 2010, respectively).[43,44]

The Title V Role in Reducing Non-Medically Indicated Deliveries

State Title V programs and their partners can use a range of strategies to reduce the rate of non-medically indicated deliveries prior to 39 weeks gestation. These strategies include:

- Convening statewide task forces comprised of Title V, the Medicaid agency, provider groups, insurers, hospitals, researchers and others to develop and advance a comprehensive plan for improving birth outcomes at the state and community level.

- Collaborating with partner organizations to obtain and leverage new funding strategies and opportunities presented by the Patient Protection and Affordable Care Act (ACA) and state-level health reforms to improve the funding of efforts to reduce non-medically indicated deliveries before 39 weeks, such as the Strong Start for Mothers and Newborns Initiative funded through CMS.

- Using the flexibility of the Title V Block Grant to sustain services, resources and supports for improving maternity care and lowering non-medically indicated deliveries before 39 weeks that are not covered by other funding sources. These activities include convening stakeholder organizations, funding quality improvement initiatives and toolkits and extending services to women who are not eligible for Medicaid to ensure they receive quality prenatal care.

- Evaluating state data related to the new Title V NPM #2: percent of cesarean deliveries among low-risk first births. States must prioritize eight of a possible 15 NPMs every five years in their Title V Block Grant applications. By selecting NPM #2, states have an opportunity to reduce national outcome measures like the rate of infant mortality. Moreover, reduced Medicaid

spending due to improved birth outcomes could lead to financial savings for the state.

- Collecting, connecting and using public health and Medicaid data to inform policy and program development, and measuring the impact of efforts. This includes providing county-specific data to a range of stakeholders such as providers, advocates and state legislators to make the fiscal case for lowering non-medically indicated deliveries before 39 weeks.

- Working with Medicaid to implement a state option to finance pregnancy medical homes that include quality measures and incentives aimed at reducing non-medically indicated deliveries before 39 weeks.

Conclusion

Title V programs are well positioned to act as a conduit, expert advisor, expediter and sometimes funder of initiatives to improve birth outcomes and reduce non-medically indicated deliveries before 39 weeks. Reducing the number of early elective deliveries will in turn lower preterm and early term birth rates, improve health outcomes for mothers and babies, and reduce unnecessary health care costs. Success will require partnerships between Title V programs, payers, hospital engagement networks, local health departments, consumers, community-based organizations and many other stakeholders. MCH professionals must continue to advance these and other efforts to reduce the most at-risk and expensive births.

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Resources

- **Association of State & Territorial Health Officials:** Early Elective Delivery Issue Brief

- **Center for Medicaid & CHIP Services (CMCS):** Improving Maternal and Infant Health Outcomes in Medicaid and CHIP

- **Center for Medicaid & CHIP Services:** Perinatal Care in Medicaid and CHIP

- **Centers for Medicare & Medicaid Services (CMS):** Reducing Early Elective Deliveries in Medicaid and CHIP

- **Centers for Medicare & Medicaid Services (CMS):** Strong Start for Mothers and Newborns Toolkit

- **National Association of Medicaid Directors:** Low-Risk, Primary Cesarean Births in Medicaid

- **National Institute for Health Care Management Foundation (NIHCM):** Born Too Early: Improving Maternal & Child Health by Reducing Early Elective Deliveries

- **National Quality Forum:** Playbook for the Successful Elimination of Early Elective Deliveries

AMCHP Contact Information

This issue brief is part of a series of AMCHP tools, documents and resources on implementation of the Affordable Care Act and its impact on maternal and child health populations. For more information, please visit the National Center for Health Reform Implementation. All AMCHP staff can be reached via phone at (202) 775-0436.

Endnotes

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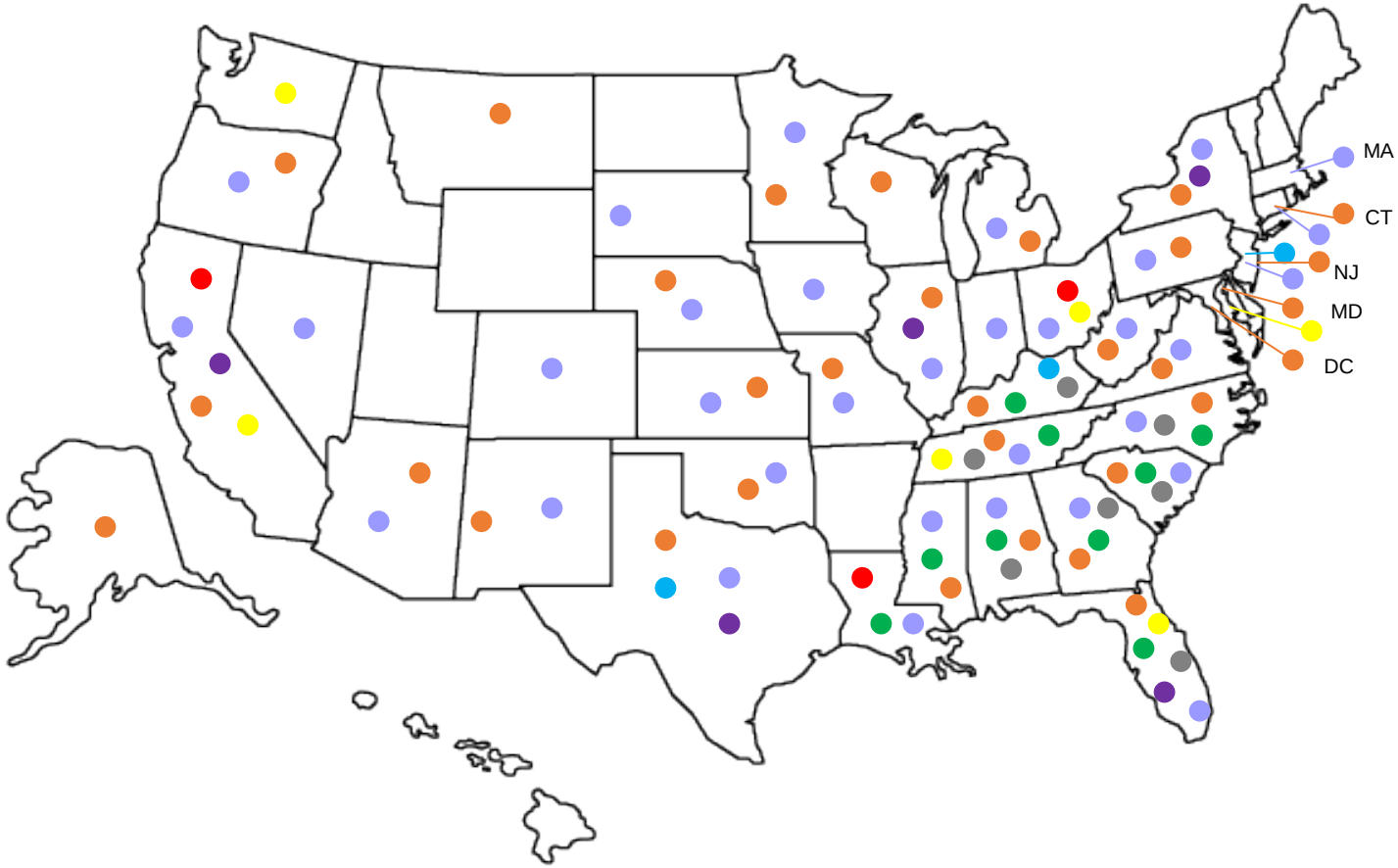
Appendices
National and State Initiatives to Improve Birth Outcomes

This matrix includes examples of initiatives, programs and strategies on the national, regional, and state level to improve birth outcomes in the Unites States. In general, initiatives and organizations included in this matrix make financial, organizational, or human resource investments in engaging partners to devise and implement strategies towards specific outcomes. This list is not intended to be comprehensive but rather a tool for considering the landscape of efforts to inform collective impact in improving birth outcomes.

Key

●	Best Babies Zone
●	Strong Start for Mothers and Newborns Initiative
●	Institute for Equity in Birth Outcomes
●	Every Woman Southeast Coalition
●	Healthy Babies are Worth the Wait
●	The Big 5
●	Healthy Start
●	Reaching Our Sisters Everywhere



In addition to the initiatives above, numerous taskforces, campaigns and research groups are working to improve birth outcomes at the national level. These include: HRSA Secretary's Advisory Committee on Infant Mortality; CMS Expert Panel on Improving Maternal and Infant Health Outcomes; HRSA's Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV); National Initiative on Preconception Health and Health Care (PCHHC); March of Dimes Prematurity Prevention 39+ Weeks Campaign; Text4Baby; The Raising of America; Birthing Project USA; It's Only Natural; and the HRSA/MCHB Collaborative Improvement and Innovation Network (CoIIN) to Improve Infant Mortality.