
New Perspectives on C-Section Rates Lead to Revised Targets, Prompt New Measures

The utilization rate of cesarean sections and what constitutes "optimal" rates for both c-sections and vaginal births after c-sections (VBACs) have been hotly contested issues for more than a decade.

After c-section rates approached a quarter of all births in the late 1980s and early 1990s, the U.S. Department of Health and Human Services' Healthy People (HP) 2000 Work Group set the target overall c-section rate for the year 2000 at 15 percent.

More specifically, the year 2000 goals are 12 percent for primary (first time) c-sections, and 65 percent for repeat c-sections--(i.e., those for a woman who has had a previous c-section delivery). By extrapolation, then, the target VBAC rate for 2000 is 35 percent of births to women who had a previous c-section.

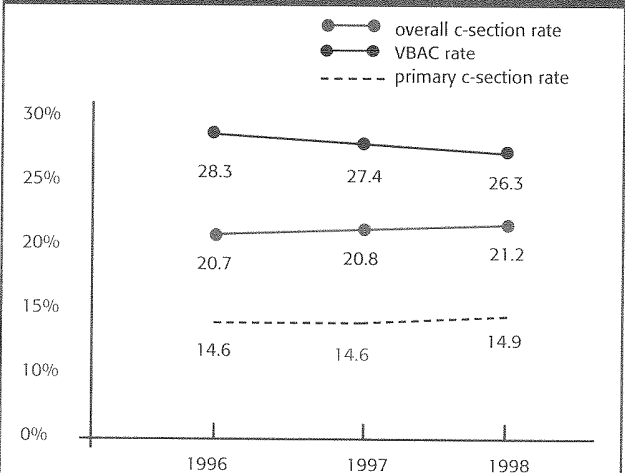
Both providers and payers have been pushing hard, in many regions, to meet these goals, with some payers even equalizing reimbursement for vaginal and cesarean deliveries to remove the financial incentive to do a c-section.

However, the most recent data show that most plans and providers will miss the mark. That's not such a problem, though, because right now the goals for and rules on c-section and VBAC utilization are changing.

Year 2000 Goals Won't Be Met

"It is evident that [the Healthy People 2000] goal [for c-section rates] will not be met," says the American College of Obstetricians and Gynecologists' Task Force on Cesarean Delivery Rates, in "Evaluation of Cesarean Delivery Rates," a report it released this spring.

National Rates for C-Section and Vaginal Birth After C-Section, 1996-1998



Source: "Births: Final Data for 1998," *National Vital Statistics Reports*, Centers for Disease Control and Prevention, National Center for Health Statistics, U.S. Department of Health and Human Services, Vol. 48, No. 3, March 2000.

Data on U.S. births in 1998 from the National Center for Health Statistics show just how far from those goals the station was a year and a half ago. (See figure 1, on page 5, and the tables on page 7, which show information from 1997 and 1998 claims in a data repository operated by Reden & Anders.)

The Reden & Anders data are based on all commercial inpatient hospital claims with diagnosis-related groups (DRGs) for c-section or vaginal delivery, and those with a VBAC diagnosis code, from July of 1997 through June of 1998, from 15 commercial health plans. In fact, in the three groups represented in the three tables, only one even came close to meeting any of the HP 2000 targets during the year studied: the Ohio plan, with a VBAC rate of 35.8 percent.

Paradigm Shift

In the meantime, the benchmarks, as well as the indicators used to measure c-section and VBAC rates, are changing. In part, this is due, to an important perceptual shift that has occurred in the last year about the risks and benefits of c-sections and VBACs, explains Stuart Weprin, MD, FACOG, chief executive officer of the Dayton, Ohio-based, specialty network management company OB/GYN Management, Ltd. (OGM).

As Weprin explains it, Ob/Gyns are beginning to question the rationale for lowering c-section rates. "Is vaginal delivery, with its risk of uterine prolapse and urinary and fecal incontinence later in life, [always]

worth it?" he asks. And, he notes, there's the even more serious risk of uterine rupture for a woman with a previous c-section who attempts a VBAC.

In an editorial in the January 7, 1999 issue of the New England Journal of Medicine, physicians from Beth Israel Deaconess Medical Center and Massachusetts General cautioned against an overzealous advocacy of VBAC. They note that "between 1985 and 1995, the incidence of uterine rupture tripled in Massachusetts, according to hospital discharge data, with approximately 80 cases, or 1 in 1000 deliveries in 1995; over 90 percent of the cases were intrapartum events." In addition, they say the reported incidence of uterine rupture increased by 23 percent in Pennsylvania from 1993 to 1995, by 16 percent in New York from 1995 to 1996, and by 29 percent in Florida from 1993 to 1996.

Reflecting this paradigm shift, the expert working group on c-sections at the U.S. Department of Health and Human Services recently developed new, "evidence based" c-section goals for the year 2010. In part, these new targets were set by taking actual 1996 c-section and VBAC rates (as reported by the Center for Health Statistics), and raising the bar slightly. But what's just as important as the rates themselves is that the expert working group recommended that the number of fetuses and the presentation of the fetus also be taken into account when analysing c-section and VBAC rates.

Thus, according to "evaluation of Cesarean Delivery Rates," the new HP 2010 benchmarks are as follows:

1. For nulliparous women at 37 weeks of gestation or greater with singleton fetuses with vertex (head-first) presentation, the target e-section rate is 15.5 percent (the national rate in 1996 was 17.9 percent).
2. For multiparous women with one prior low-transverse cesarean delivery at 37 weeks of gestation or greater with singleton fetuses with vertex presentations, the target VBAC rate is 37 percent (the national rate, in 1996 was 30.3 percent).

New Measures

Why focus on single-fetus, headfirst deliveries?

"Because everyone agrees c-sections are often indicated for breech births and twins," says Weprin.

And a lower target VBAC rate also makes more sense, he says, because "VBAC rates are expected to drop ... because of concerns that VBACs may not always be safe. Health plans will have to back off their push for VBACs."

The new measures will mean that hospitals and Ob/Gyns may have to code their deliveries in more detail, and more accurately, if they want to track their c-section rates against the HP 2010 goals. And that's precisely what providers should be doing, both for duality and managed care contracting purposes. For instance, accurate diagnosis codes will be necessary to later omit from the analysis those cases with multiple fetuses (e.g., code 651.01 for delivery of twins) and those with "malposition or malpresentation of the fetus" (e.g., code 652.01 for unstable lie). And providers also must be sure to include the ICD-9-CM code for previous c-section (654.21) in claims, when appropriate.

In addition, physicians who obtain from their payers c-section and VBAC rate information that is based on physician claims need to double-check that claims for

assisting surgeons or other assisting physicians on cesarean deliveries have been eliminated from the count. Otherwise these claims will erroneously inflate c-section rates.

And perhaps just as important as tracking primary c-section and VBAC rates, the adverse outcomes of both cesareans and trials of labor must be tracked, as well--particularly the rate of uterine rupture and the sequelae of such incidents.

Beyond tracking c-section and VBAC rates is the ultimate goal of changing physician behavior to improve quality. In OGM's networks, each local board (consisting of five to 10 Ob/Gyns) develops longitudinal profiles of physicians' practice patterns by diagnosis. The boards also distribute these reports to all physicians often showing each physician's results by name.

Weprin says the longitudinal data erase the "I-had-a-bad-year" rationale, while being identified by name has made the Ob/Gyns much more cognizant of, and accountable for, their practice patterns.

Editor's Note: The chart on page 7 showing statistics on deliveries is based on DRGs. While we realize that Ob/Gyn practices do not use DRGs in their day-to-day business, we believe that Ob/Gyns and their coding staff will be interested in the statistics for the cesarean sections and vaginal deliveries.

Sources: Stuart Weprin, MD, chief executive officer, OB/GYN Management, Ltd., Dayton, Ohio; American College of Obstetricians and Gynecologists, Washington, DC, (202) 638-5577, and Web site at www.acog.org; Centers for Disease Control and Prevention, National Center for Health Statistics web site at www.cdc.gov/nchs; and Tim Feeser, principal, Reden & Anders, Ltd., Minneapolis, Minn.