Pregnancy Medical Home

Partnership between Division of Medical Assistance, Community Care of North Carolina and the Division of Public Health

New Initiative

- Provide pregnant recipients with a pregnancy medical home (PMH) and pregnancy care management services to those identified as high risk
- Replicate a similar model to the primary care case management program developed by CCNC
- Improve birth outcomes and improve quality of perinatal care given to Medicaid recipients
- Reduce c-section rate
- Incentivize providers to become PMH and provide continuity of care to Medicaid recipients

Working Together

- Division of Medical Assistance (DMA)
  - Administer and oversee PMH Initiative
  - Funding
  - Policies
- CCNC
  - Recruit and enroll physicians
  - Provide support to local CCNC networks

Working Together

- CCNC cont.
  - Work in collaboration with the health dept to create a high risk case management program
  - Monitor and audit PMHs
  - Implement quality improvement initiatives
- Division of Public Health
  - Monitor and oversight of the performance of LHDs offering pregnancy care management services
  - Train all current MCCs who will transition to pregnancy care managers in the PMH model

Working Together

- Local Health Departments (LHD)
  - Provide population management and care management services to the pregnant woman population
  - Partner with PMHs
- Department of Social Services (DSS)
  - Provide listing of PMHs to recipients
  - Discuss the program with pregnant recipients

Who can participate as a PMH?

- Licensed qualified private physicians and public or private clinics organized for the delivery of obstetrical care
  - General/family practice
  - OB/GYN practices
  - Multi-specialty
  - Federally Qualified Health Clinics (FQHC)
  - Rural Health Clinics (RHC)
  - Local Health Departments (LHD)
  - Nurse practitioners
  - Certified nurse midwives

PMH Responsibilities

- Performance measures
  - Eliminate elective deliveries before 39 weeks gestation
  - Offer and provide 17P to eligible patients
  - Reduce primary c-section rate
  - Complete an initial risk screening on all patients
  - Agree to chart audits
  - Affiliate member of CCNC

PMH Responsibilities

- Provide information on how to obtain MPW, WIC, Family Planning Waiver
- Refer high risk pregnant women to Pregnancy Care Management for thorough assessment
- Communicate and coordinate care with Pregnancy Care Manager assigned to the practice
- Provide 24/7 phone support for emergencies
- Provide educational materials on healthy pregnancy

Incentives

- $200 per Medicaid delivery
  - $50 for completing high risk screening tool at initial visit
    - Bill HCPCS S0280 – medical home program, comprehensive care coordination and planning, initial plan
  - $150 paid after billing postpartum visit
    - Bill HCPCS S0281 – medical home program, comprehensive care coordination and planning, maintenance of plan

Incentives

VAGINAL DELIVERY CODES	PROCEDURE	CURRENT RATES Facility	CURRENT RATES Non Facility	FUTURE RATES Facility	FUTURE RATES Non Facility
59400	Global (includes antepartum, delivery & postpartum care)	$1368.59	$1368.59	$1549.75	$1549.75
59425	Antepartum care 4 -6 visits	268.96	340.20	304.46	385.11
59426	Antepartum care 7 + visits	475.94	608.62	538.76	688.96
59409	Delivery only	607.68	607.68	687.89	687.89
59430	Postpartum Care only	99.08	109.17	112.16	123.58
59410	Delivery w/ postpartum care	704.66	704.66	797.68	797.68

Incentives

- Support from local CCNC network
- Exemption from medical necessity on prior approval for ultrasounds:
  - 76801, 76802, 76805
  - 76810-76821
  - 76825-76828

Ultrasound Guidelines

- All Ultrasounds must be registered with MedSolutions
- Wait 48 hours before billing
- All other high tech imaging still requires prior approval
- Procedure codes 76811 and 76812
  - Providers must meet one of the following criteria:
    - Certified with the American Institute of Ultrasound Medicine (AIUM)
    - American College of Radiology (ACR) accredited practice
    - Sub-specialty in Maternal Fetal Medicine Specialist (Perinatology) or Radiology

Global Outcomes

- Decrease primary c-section rate
  - c-section rate at or below 20% by end of year 3 (SFY12)
- Decrease the rate of low birth weight and very low birth weight babies delivered
  - 5% improvement in very low birth weight and low birth weight by end of year 3
  - 10% improvement in very low birth weight and low birth weight by end of year 4

Priority Risk Factors

- History of preterm birth (<37 weeks)
- History of low birth weight (<2500g)
- Multiple gestation
- Fetal complications
- Chronic conditions which may complicate pregnancy (diabetes, HIV, substance abuse diagnosis, sickle cell, etc)
- Unsafe living environment (homelessness, violence, etc)
- Substance use
- Missing two or more prenatal appointments without rescheduling
- Inappropriate hospital utilization (Emer. Dept/Labor & Del triage visits by pregnant woman with no prenatal care provider

MMIS Changes

- 3 PMH date segments will be displayed on the P1 and P6 browser screens
- Claims will be identified as PMH or non-PMH on the PD browser screen
  - PMH indicator will be at the claim detail level
- PMH indicator on the claim detail will be sent to Drive on the claims file

P1 Screen Layout

Most Recent Action/Reason Code

Code	Effective Date	End Date	
51	10/29/2010		View History
50	10/29/2010	10/29/2010	
51	08/28/2009	10/28/2010	

DSH Eligibility	DSH Effective Date	DSH End Date
Y	10/01/2009	12/31/9999

Operation Code	Effective Date	End Date
7 7	10/01/2005	12/31/9999

Type	Specialty	Effective Date
060	079	07/01/1977
062	079	00/00/0000

Locality: 00 **District:** 96 **County:** 096 **Pay Cycle:** B0 **PSRO:** 08

Acute # of Beds: 316 **Long Term # of Beds:** 0

Group Number: **Group Name:**

Total Related Provider Nbrs.: 0 **Attending Provider Number Required:** No

School Based Health Care Indicator: No **School Based Health Care Sponsor Number:**

Screen Layout

PMH History

Effective Date	End Date	Status
01/01/2010	12/31/2010	
07/01/2009	12/31/2009	Inactive
01/01/2009	03/15/2009	

Electronic Funds Transfer Information

ABA Number	Bank Account Number	Bank Account Type	Bank Account Status
053101121	0005101385959	Checking	2 - Active

Exception Indicators

	B				F									

Internal Revenue Service Information

Pregnancy Care Management (PCM)

MCC Program Changes

- Receive a Per Member Per Month (PMPM); no longer Fee for Service (FFS) model
- Focus on high risk pregnant women
- Services based on level of need
- More intensive services to fewer pregnant women

Transition of Current MCCP Clients

- February – Notification sent to all current MCCP clients by DMA. MCCs to reinforce information on transition during monthly contacts.
- March – Pregnancy Care Managers to complete Pregnancy Assessments on all current MCCP clients and provide ongoing PCM services based on client need and status.

Collaboration with local CCNC Network

- Work with the local CCNC network Pregnancy Home OB Coordinator to ensure program goals are met.
- Review and monitor CCNC and/or NCCCN, Inc. reports created for the PMH program to determine individuals at greatest risk.
- Communicate with local CCNC network regarding challenges with cooperation and collaboration with PMH and non-PMH prenatal care providers.

Outcome Measures

Ensure the following measures are met and reported:

- Increase the pregnancy risk screenings entered into CMIS by 3% annually until achieving a rate of 95%.
- Increase the number of pregnant women meeting CCNC priority criteria who receive the pregnancy assessment by 3% annually until achieving 95%.

Outcome Measures (cont.)

- Increase the post partum visit rate 3% annually for patients who receive pregnancy care management services or whose infant was admitted to the NICU.
- Increase percent of women who receive 100% of the 17P injections they are eligible to receive by 5% annually until achieving a rate of 90%.
- Increase the percent of PMH patients, who receive pregnancy care management services, referred for Family Planning Waiver or full Medicaid coverage until achieving 95%.

Notice to Recipients

February 15, 2011

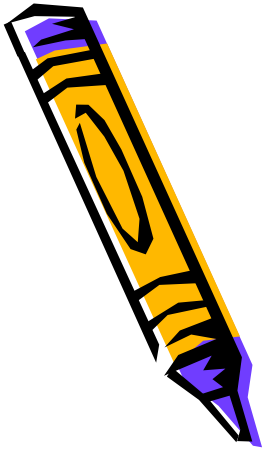
Re: Maternity Care Coordination Program Changes
Dear Maternity Care Coordination Program Participant:

As of March 1, 2011, the Maternity Care Coordination Program will change to a new service called Pregnancy Care Management (PCM). The current Maternity Care Coordination Program will end as of February *28,* 2011. The Pregnancy Care Management Program, just like the Maternity Care Coordination Program, is designed to help you have a healthy pregnancy and a healthy baby. PCM services will be provided by a Pregnancy Care Manager working at your local health department or other provider agency just as they are now. To receive Pregnancy Care Management services **you do not need to do anything** at this time. Your Pregnancy Care Manager will contact you beginning in March to discuss your current and ongoing medical and community referral needs. They will establish a plan of care and a schedule of contacts with you based on your individual situation. The Pregnancy Care Managers will be working closely with your doctor to make sure that you are able to keep your medical appointments and follow your doctor's medical advice.

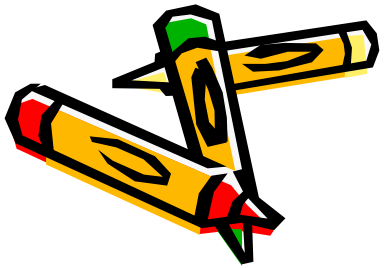
For more information or to answer any questions you have about the program, please call your current Maternity Care Coordinator.

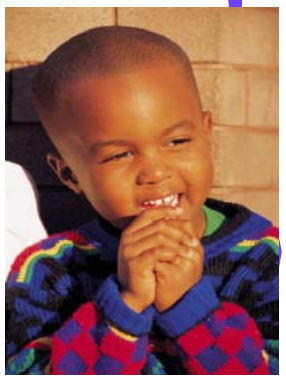
Sincerely,

Tara R. Larson
Chief Clinical Operating Officer
Division of Medical Assistance



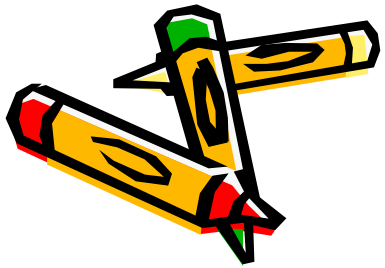
Care Coordination for Children (CC4C)





CSC Program Changes

- No longer Targeted Case Management; Population Care Management Model
- Focus on neediest children and those that are high cost/high users
- Funding no longer FFS; CC4C Providers will receive a PMPM for services
- Services provided are based on level of need



Transition to CC4C Services

- February - Notification sent to all current CSC clients by DMA.
- February - CSCs will inform families of written notice and review information
- March and April – Assess current CSC clients and new referrals to the program using new assessment tools

Notice to Recipients

February 15, 2011

Re: Child Service Coordination Program Changes

Dear Child Service Coordination Program Participant:

As of March 1, 2011, the Child Service Coordination (CSC) Program will change to a new service called Care Coordination for Children (CC4C). The current CSC Program will end as of February 28, 2011. The CC4C Program, just like the CSC Program, will help you and your family to improve health outcomes. CC4C services will be provided by a CC4C Care Manager working at your local health department or other provider agency just as they are now.

To receive CC4C Care Management services **you do not need to do anything** at this time. Your CC4C Care Manager will contact you starting in March to discuss your current and ongoing medical and family needs. They will establish a plan of care and a schedule of contacts with you based on your individual situation. The CC4C will be working closely with your doctor to make sure that you are able to keep your medical appointments and follow your doctor's medical advice.

For more information or to answer any questions you have about the program, please call your current Child Service Coordinator.

Tara R. Larson
Chief Clinical Operating Officer
Division of Medical Assistance

Target Population

- Children ages 0 up to 5 years old with:
  - Special health care needs
  - Increased risk or has a chronic physical, behavioral or emotional condition and also requiring health and related services of a type and amount beyond that required by children generally
  - exposed to toxic stress in early childhood including, but not limited to extreme poverty in conjunction with continuous family chaos, recurrent physical or emotional abuse, chronic neglect, severe and enduring maternal depression, persistent parental substance abuse, or repeated exposure to violence in the community or within the family
  - who are in the foster care system
  - high cost/high user of services

Outcomes

- Increase rate of first visits by NICU (Neonatal Intensive Care Unit) graduates within 1 month of discharge
- Increase rate of comprehensive assessments completed for children/families with a priority risk factor
- Decrease number of hospital admissions, readmissions and ED visits

Outcomes

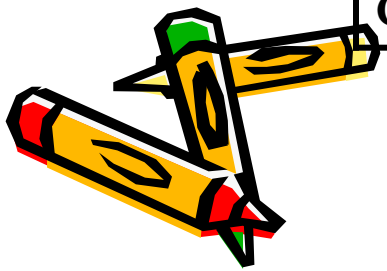
- Increase number of infants ≤ 1 year of age referred to (Early Intervention) EI
- Increase number of children who have a medical home who are:
  - Children with special health care needs, and/or
  - Children in foster care

What to do with Calls

- PMH Provider Questions:
  - Refer to Local CCNC Network
- PMH Recipient Questions:
  - Refer to DMA Managed Care – **919-855-4780**
- Pregnancy Care Management (MCC):
  - Refer them to their current PCM
- Care Coordination for Children (CSC):
  - Refer them to their current Care Manager

CCNC Local Networks Contact Information

Name of Network	Phone Number
Access Care, Inc	919-380-9962
Access II Care of Western NC	828-348-2818
Access III of Lower Cape Fear	910-763-0200
Carolina Collaborative Community Care	910-485-1057
Carolina Community Health Partnership	704-484-5216
Community Care of Wake and Johnston Counties	919-792-3626
Community Care Partners of Greater Mecklenburg	704-512-2289

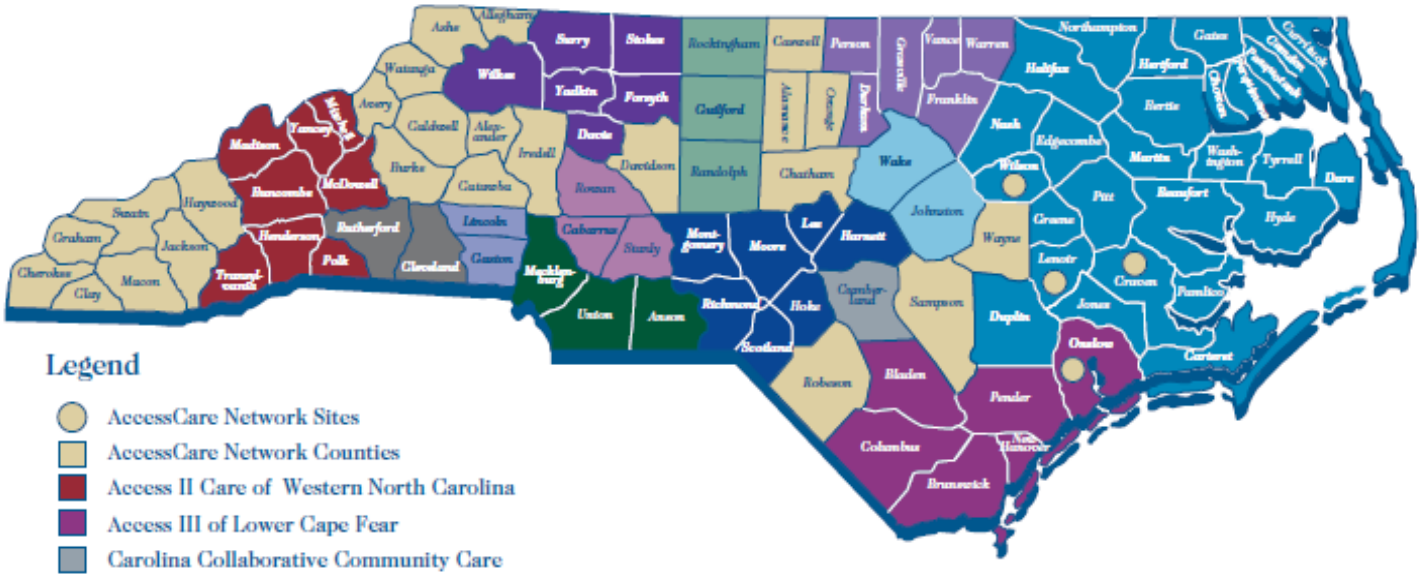


CCNC Local Networks Contact Information

Name of Network	Phone Number
Community Care Plan of Eastern Carolina	252-847-7476
Community Health Partners	704-853-5069
Northern Piedmont Community Care 4 County Community Care	252-436-1051
Northern Piedmont Community Care Durham Community Health Network	919-613-6529
Northwest Community Care Network	336-716-5654
Partnership for Health Management	336-235-0930
Sandhills Community Care Network	910-246-9806
Southern Piedmont Community Care	704-403-1516

Community Care of North Carolina

Access II and III Networks



Are there any QUESTIONS?