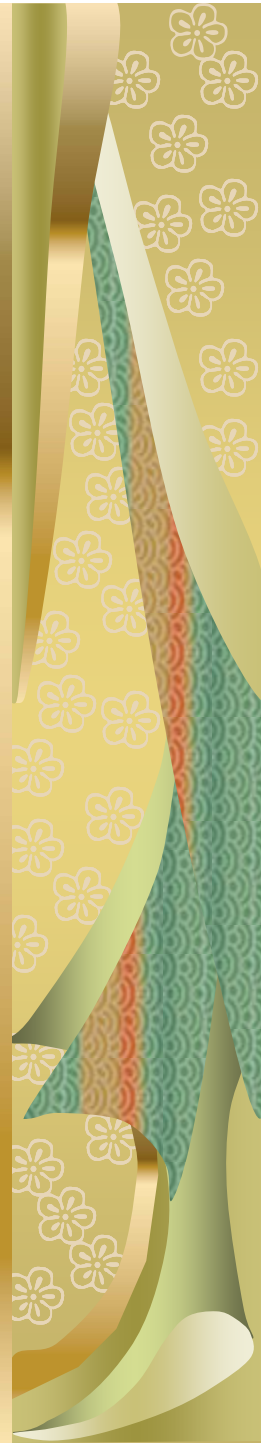
Division of Medical Assistance

Pregnancy Medical Home Initiative

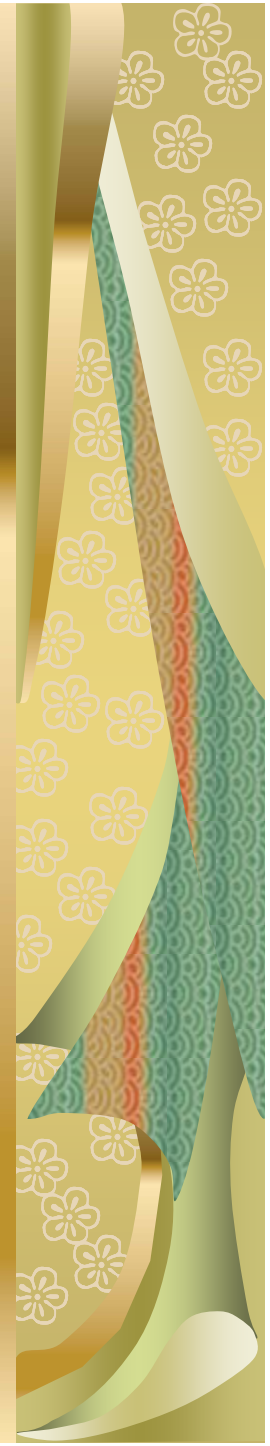
Social Services Institute

October 27, 2010



Did You Know…

- In 2009, there were 126,785 births in NC
- 71,067 Medicaid deliveries
- *Overall infant mortality rate: 7.9 per 1000 live births for 2009
  - Decrease of 3.7% from previous year
  - Minority infant mortality rate rose by 4.4%
- Cesarean section rate: 28.1%

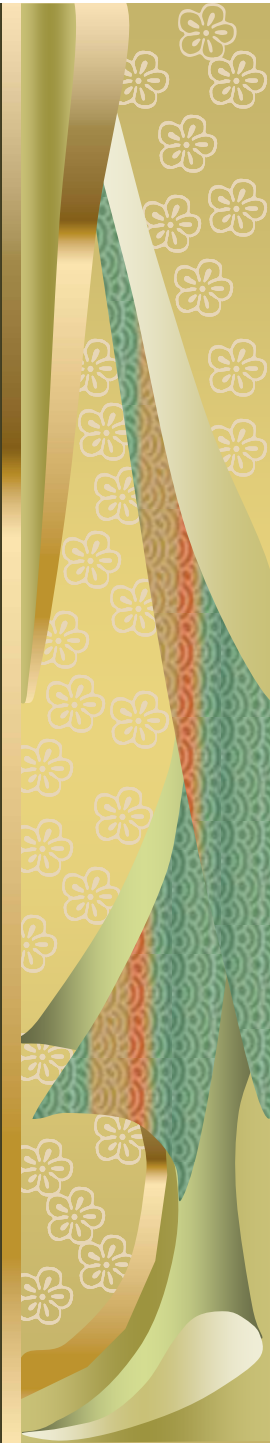


*Source: http://www.schs.state.nc.us/SCHS/deaths/ims/2009

New Initiative

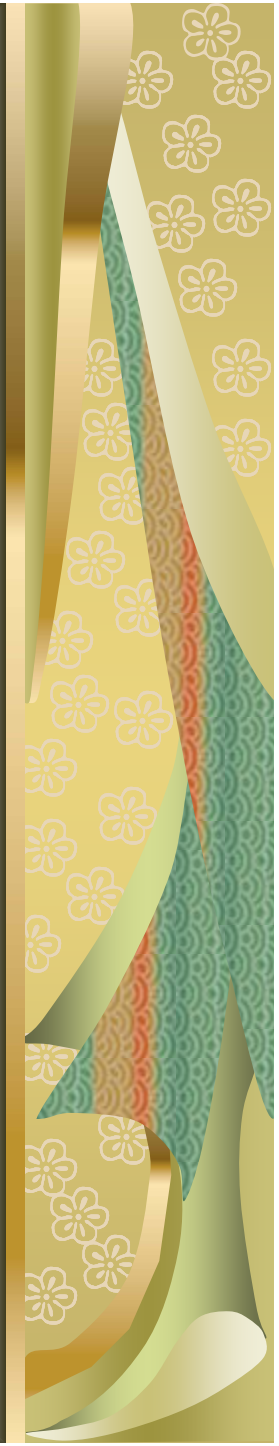
- Community Care of NC (CCNC), Division of Public Health (DPH) and Division of Medical Assistance (DMA) have embarked on a new initiative to address some of these issues

- Create a program that provides pregnant recipients with a pregnancy medical home (PMH) and case management services to those identified as high risk



Working Together

- Division of Medical Assistance (DMA)
  - Administer and oversee PMH Initiative
  - Funding
  - Policies
- CCNC
  - Recruit physicians
    - Develop marketing and outreach materials
  - Enroll physicians in local CCNC networks
    - Each network will have an OB coordinator (nurse) and OB clinical champion (physician)

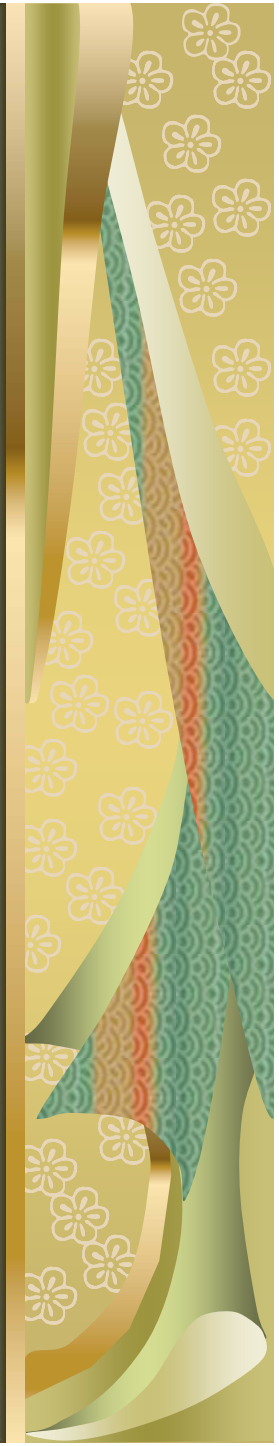


Working Together

- CCNC cont;d
  - Provide support to local CCNC networks
  - High risk case management
    - Work in collaboration with the health dept to create a high risk case management program
  - Monitor and audit PMHs
  - Implement quality improvement initiatives
- Department of Social Services (DSS)
  - Vital component in promoting PMHs

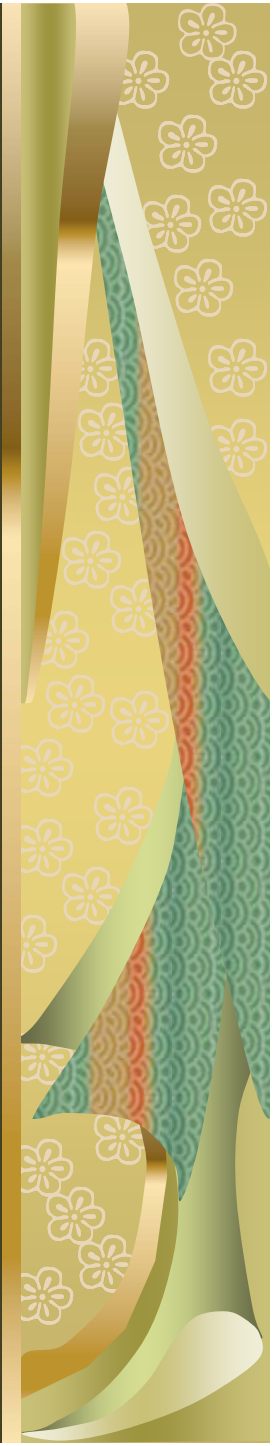
Working Together

- DSS cont;d
  - Provide current listing of PMHs to recipients
  - Discuss the program with pregnant recipients
    - Explain the benefits of PMHs
- Local Health Departments (LHD)
  - Provide care (population) management and case management services to the pregnant woman population
  - Partner with PMHs



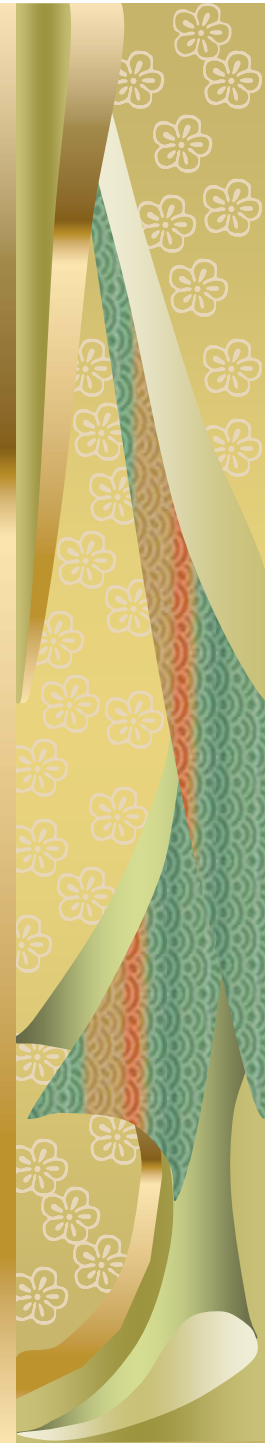
Who Can Be a PMH?

- Any provider that bills global, package or individual pregnancy procedures is eligible to participate
  - OB/GYN practices
  - Local health departments
  - Family medicine
  - Nurse practitioners
  - Certified nurse midwives
  - Federally qualified health centers



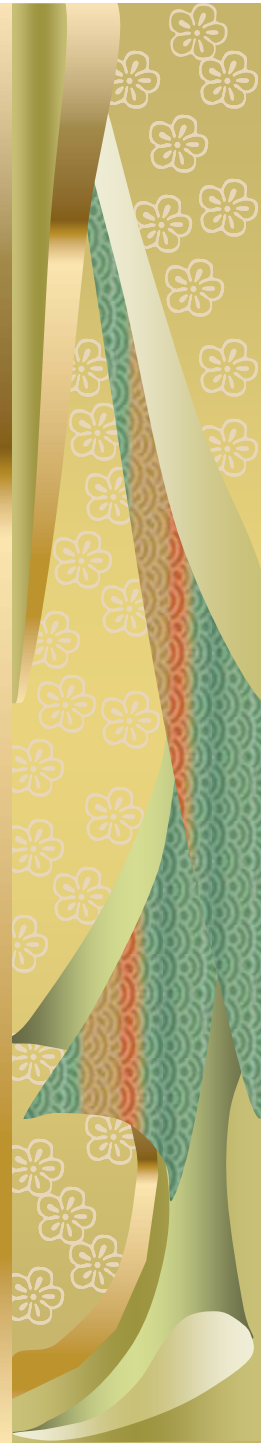
PMH Requirements to Participate

- Ensure no elective deliveries are performed before 39 weeks gestation by agreement with all providers in the practice
- Engage fully in the 17P project
  - (17-hydroxyprogesterone caproate)
  - weekly intramuscular injection used to prevent preterm labor



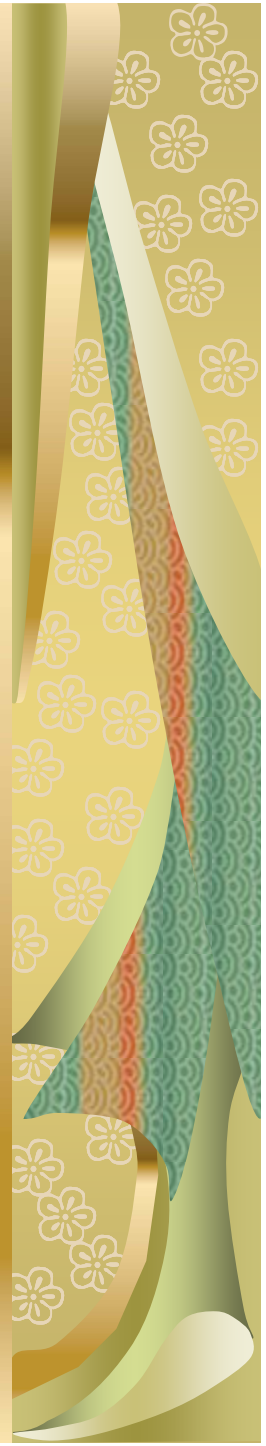
PMH Requirements to Participate

- Decrease cesarean section rate
- Complete a high-risk screening on each pregnant Medicaid recipient in program and integrate plan of care with local care/case management
- Agree to open chart audits
- Affiliate member of CCNC



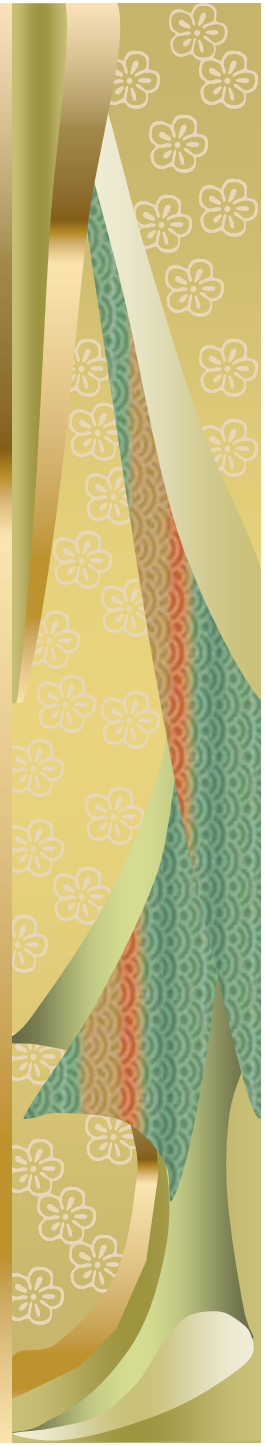
PMH Incentives

- $200 per Medicaid delivery
  - $50 for completing high risk screening tool at initial visit
  - $150 paid after billing post partum visit
- Exemption from prior approval on ultrasounds
  - Ultrasounds must be registered with MedSolutions



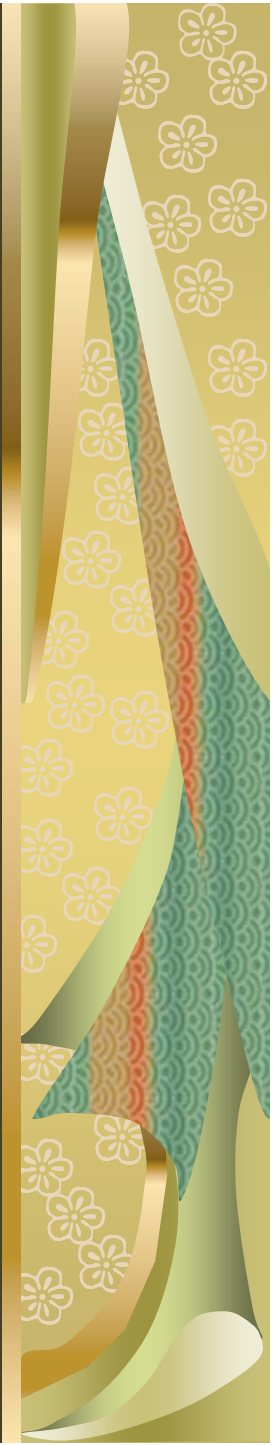
PMH Incentives cont;d

- Increased rate for Vaginal Deliveries
  - Global rate for vaginal delivery will increase from $1368.59 to $1549.75 (same rate as cesarean delivery); increase of 13.2%
  - Package and individual rates will increase by 13.2% also (applies to facility and non facility rates)
- Cesarean delivery rates will remain the same



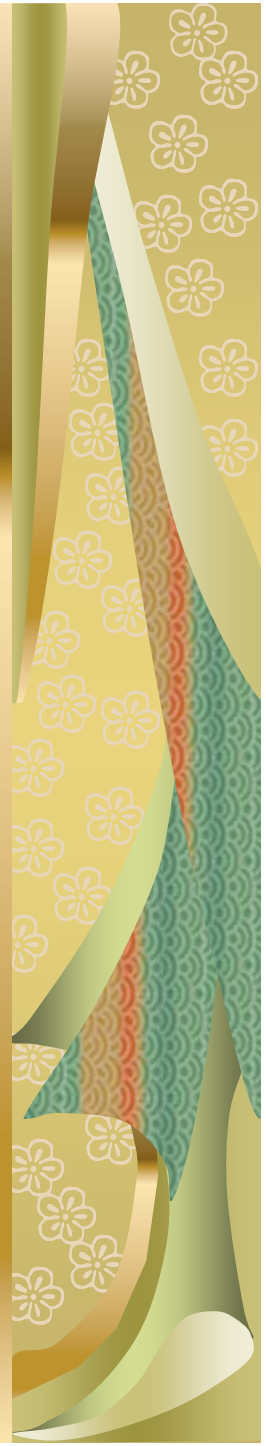
Additional PMH Services

- Pregnancy Medical Home
  - Provide continuity of care to all pregnant Medicaid recipients
  - Communicate with High Risk Case Manager assigned to the practice
  - Provide 24/7 phone support
  - Provide educational materials on healthy pregnancy
  - Assure that there are adequate capacity and services at the PMH



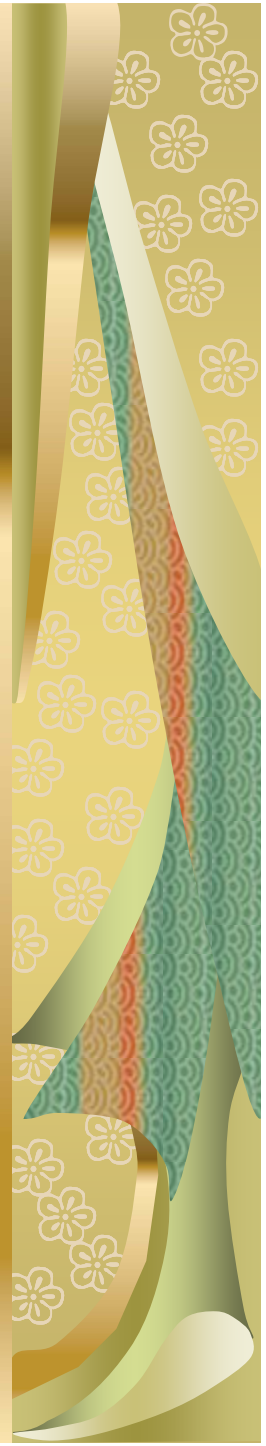
Case Management Today

- Maternal Care Coordination Program at LHD serves 28,690 number of Medicaid pregnant women
- Some of the services provided
  - Collaborate with other providers to make sure plan of care is followed
  - Refer clients to other services i.e.; WIC
  - Provide client/prenatal education
- FFS



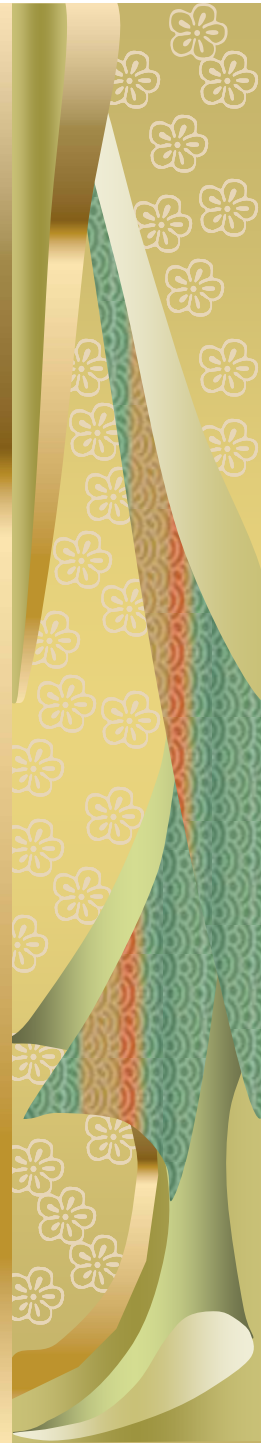
How is Case Management Changing?

- Focus on high risk
- More intensive services to fewer pregnant women
- Services based on level of need
  - Risk stratification will be used to determine the services needed.
- PMPM



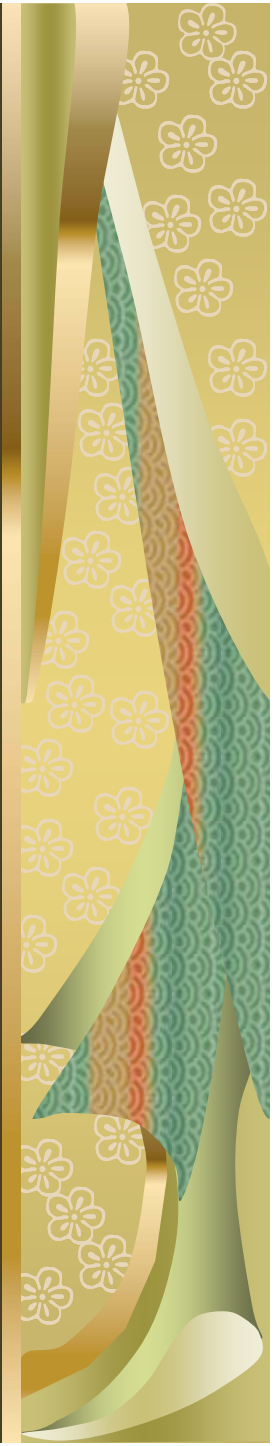
High Risk Case Management

- High Risk Screening
  - Physician, nurse, nurse midwife or nurse practitioner completes screening at initial visit
  - Identify high risk pregnant women
  - Refer any pregnant Medicaid recipients who meet at least one high risk criteria, according to the screening tool, for case management services
  - Referrals for case management services can be done at the provider's discretion



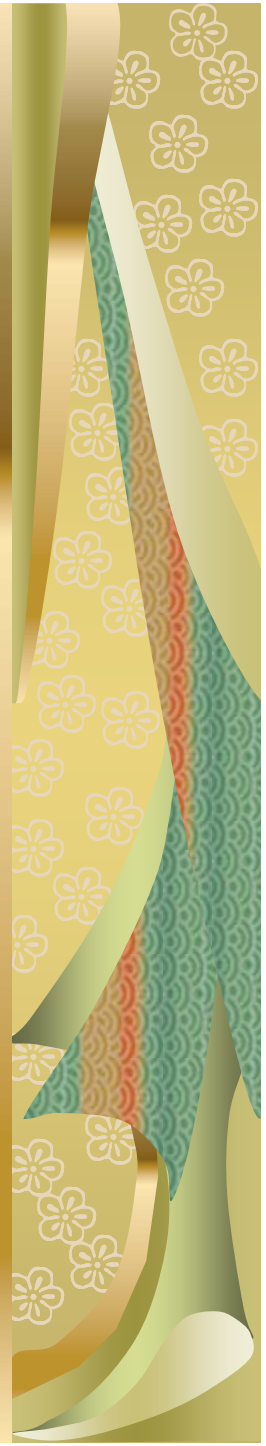
High Risk Case Management

- Case Managers
  - Determine the level of need
  - Assigned to a PMH practice and become an integral part of the care the PMH provides
  - Complete a detailed assessment of the recipient
  - Work in partnership with PMH to ensure proper care of recipients
  - Provide services to recipients as long as need exist during pregnancy



High Risk Case Management

- Case Managers cont;d
  - Refer recipients to Family Planning Services after delivery
    - Covers annual and periodic office visits, lab procedures, screening for HIV, STIs, treatment for STIs and FDA approved and Medicaid covered birth control methods
  - Capture high risk information to be used to develop other quality initiatives or changes to current model to promote healthy pregnancy outcomes



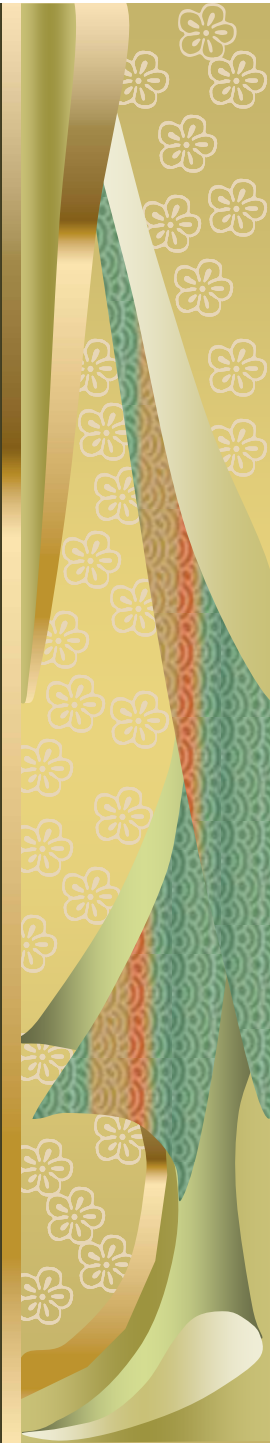
Case Management Outcomes

- 100% of all high risk screenings will be captured
- Assessments will be completed on at least 80% of all pregnant women referred as high risk
- 80% of all PMH women who delivered, will attend their postpartum visit

* Outcomes are not finalized. They are still being negotiated.

Case Management Outcomes

- 100% of women eligible to receive 17P will receive information regarding the program and receive high risk case management
- 80% of women started on 17P will receive 100% of the shots that they are eligible to receive
  - Beginning at 16 weeks gestation through 36 weeks and 6 days

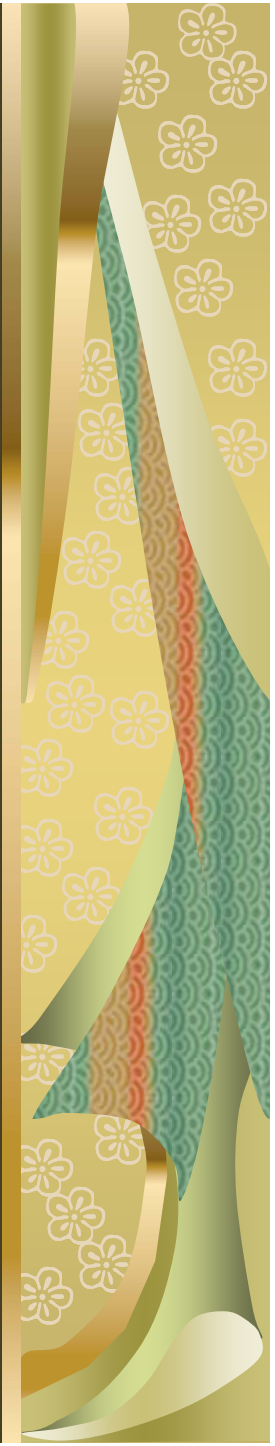


Overall Global Outcomes

- Reduce NICU admission rate from 28.3 to 25.3%
- Reduce Cesarean sections rate from 28.1 to 25.1%

Additional Outcomes

- Reduce number of NICU days
- Increase birth weight
- Decrease number of premature births
- Decrease the infant mortality rate
- Decrease the number of pregnancy related emergency room visits/triage



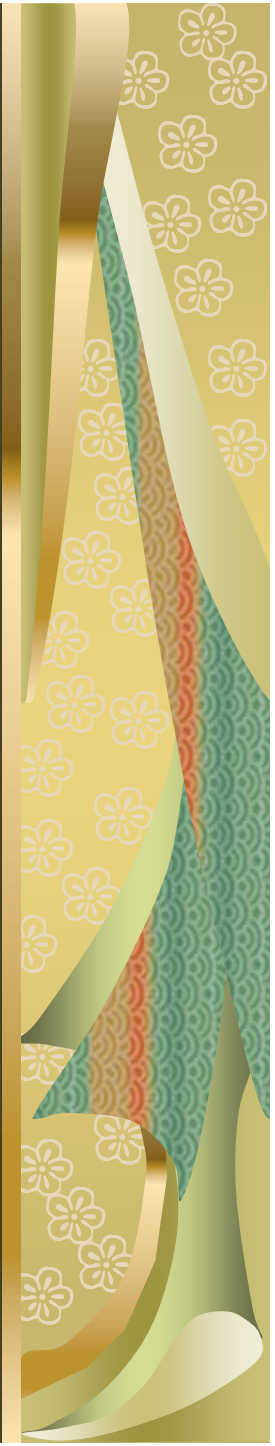
Current Expenditures

- Nursery
  - Cases 53,996
  - Hospital – Baby $29,827,554
  - Physician 5,027,408
  - **Total** **$34,854,962**
- NICU
  - Cases 21,326
  - Hospital – Baby $132,860,796
  - Physician 90,830,694
  - **Total** **$223,691,490**

Projected Expenditures

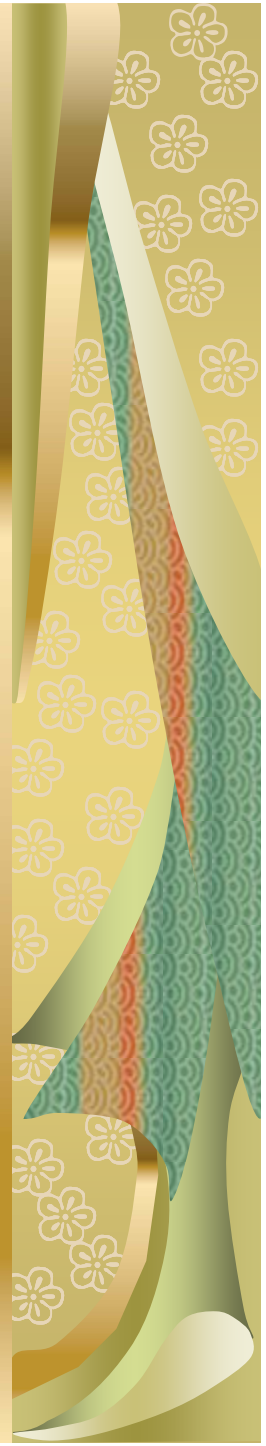
(after implementation)

- Nursery
  - Cases 56,256
  - Hospital – Baby $31,075,797
  - Physician 5,237,798
  - **Total** **$36,313,595**
- NICU
  - Cases 19,066
  - Hospital – Baby $118,783,134
  - Physician 81,206,457
  - **Total** **$199,989,591**



Work in Progress

- Contract Agreements and Amendments
  - DMA/CCNC/DPH/ORH
- Case Management Process
- Systems Changes
  - EIS, MMIS, HP
- Begin recruiting providers 1/1/2011
- Target effective date 3/1/2011



Questions