MOM Workgroup
Covered Topics

- Don’t Leave Money on the Table: slide deck and recording
  - PMH Incentives
  - Smoking Cessation
  - Depression Screening
- Sterilizations: slide deck
- Ultrasound denials: slide deck and recording
- Managed Care High Level Overview: slide deck and recording
- Beneficiary Enrollment/Newborn Eligibility/Updated Circumcision Policy: slide deck and recording
- Managed Care & OB Specific Q&A: slide deck
PREGNANCY MEDICAL HOME

Pregnancy Medical Home: Improving Maternal & Infant Outcomes in the Medicaid Population

Evaluation of Outcomes from MIIS Implementation
Method 2: Comparing Implementation Periods

Year Prior to MIIS implementation
First Year of MIIS implementation

Low Birth Weight Rate

Community Care
of North Carolina

*statistically significant difference

CLICK HERE TO LEARN MORE!

Community Care of North Carolina (CCNC) launched the Pregnancy Medical Home (PMH) program in 2011, to enhance access to comprehensive care for pregnant Medicaid beneficiaries and to improve birth outcomes. The PMH program promotes evidence-based, high-quality maternity care in more than 400 practices across the state. PMH practices represent 95% percent of prenatal care providers who serve the Medicaid population.

PMH Care Pathways
Clinical guidance on management of conditions related to pregnancy

OB Guidance Documents
A collection of resources created by CCNC for PMH providers

Monthly PMH Newsletters

Monthly PMH Newsletters
- September 2020
- October 2020
- November 2020
- December 2020
- January 2021
- February 2021
- March 2021

Majority OB Medicaid "MOM" Workgroup
- December 9, 2020 - Don't Leave Money on the Table: slide deck and recording
- January 14, 2021 - Sterilization Denials: slide deck
- February 11, 2021 - OB Ultrasound Denials: slide deck and recording
- March 11, 2021 - Managed Care High Level Overview: slide deck and recording
- April 11, 2021 - Beneficiary Enrollment/Newborn Eligibility/Updated Circumcision Policy: slide deck and recording
- May 13, 2021 - Managed Care & OB Specific Q&As: slide deck

The PMH model includes six core components:

Statewide Provider Network
There are currently more than 450 practices and 2,500 individual providers, with PMH practices in 95 of 100 counties. These practices serve pregnant women with Medicaid.

Standardized Risk Screening
NC DHHS announced 97% of Medicaid beneficiaries have been enrolled in a plan that includes their current primary care provider (PCP). A summary of NC Medicaid Managed Care enrollment by plans and regions can be found here.

Confirmation notices and health plan welcome packets will be mailed to beneficiaries through June 12. Beneficiaries have until Sept. 30, 2021 to change plans for any reason by contacting the NC Medicaid Enrollment Broker website by calling 833-870-5500 (TTY: 833-870-5588). After September 30th, beneficiaries must wait until their next Medicaid recertification date to change health plans, unless there is a special reason.
OB Relevant Managed Care Guidance

- **Beneficiary Enrollment**
  - Medicaid Beneficiary Outreach Materials
  - Do I need to choose a Health Plan?
  - Health Plan Auto Enrollment
  - PCP Auto Assignment

- **Care Management**
  - CMHRP Pregnancy Risk Screening Form – English & Spanish
  - CMHRP Program Guide in Managed Care

- **Claims Submission Guidelines**
  - Managed Care Eligibility for Newborns: What Providers Need to Know

- **Provider Resources**
  - All Provider Fact Sheets
  - Day One Provider Quick Reference Guide
  - Fireside Chat Slides
  - Medicaid Provider and Health Plan Look-Up Tool
  - Provider FAQs
  - What Providers Need to Know Before & After Launch

- **Services**
  - Non-Emergency Medical Transportation Part-1 & Part 2
PHP Pregnancy Management Program Presentations

- AmeriHealth Caritas
- Carolina Complete Health
- Healthy Blue
- UnitedHealthcare
- WellCare
PHP Contact Information

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Standardized Risk Screening

CMHRP Pregnancy Risk Screening Form English
CMHRP Pregnancy Risk Screening Form Spanish
Intensive Care Management Improves Birth Outcomes Among Very High-Risk Women, but Significant Disparities Remain

Carlos Jackson, PhD, Divya Mallampati, MD, MPH, and M. Kathryn Menard, MD, MPH

1 Community Care of North Carolina, 2 Division of Maternal Fetal Medicine, University of North Carolina at Chapel Hill

Abstract

Research Question: This research aims to (1) Evaluate the association between intensive care management and low birth weight rates and (2) Determine racial disparities in low birth weight rates and response to intensive care management.

Study Design: This is a retrospective quasi-experimental observational study of Medicaid-eligible women identified as very high-risk for low birth weight (LBW) by the Maternal Infant Impactability Score (MIIS). The exposure of interest is intensive care management (ICM), defined as receiving ≥5 face-to-face encounters with a care manager during pregnancy. The primary outcome is LBW defined as a birthweight less than 2500 g. We employ two methods to assess the intervention's impact: Method 1 compares LBW rates of women who received ICM to those who did not. Method 2 compares outcomes by race prior to and following implementation of the MIIS.

Conclusion: Intensive care management was associated with a substantial reduction in LBW rates. Black women with or without care management delivered LBW infants at rates significantly lower than white women. Implications for Policy Practice: While there is a measurable benefit of ICM for very high-risk pregnant women, racial disparities persist. This research is timely and important as states and policy innovations are assessing issues in the United States. Understanding how programs, such as the North Carolina Pregnancy Medical Home, can influence obstetric outcomes enables further state-based policy change.

Methods

- **Background**: In 2011, North Carolina implemented the Pregnancy Medical Home, the only statewide public pregnancy medical home in the United States, to improve birth outcomes for women with Medicaid, a vulnerable population. Beneficiaries receive a standardized assessment for risk factors for preterm birth and receive care management according to risk.

- **Methods**: Two methods were employed to assess the intervention's impact: Method 1 compares LBW rates between those who received ICM and those who did not. Method 2 compares LBW rates by race prior to and following implementation of the MIIS. The MIIS identifies a subset of very high-risk pregnant women most likely to benefit from intensive care management (ICM).

Results

Table 1: Demographic Characteristics of Pregnant Women with Medicaid 2016-2017

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Black</th>
<th>White</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>15%</td>
<td>20%</td>
<td>35%</td>
</tr>
<tr>
<td>Maternal Age</td>
<td>16%</td>
<td>21%</td>
<td>20%</td>
</tr>
<tr>
<td>Average Age of Mother</td>
<td>21%</td>
<td>27%</td>
<td>20%</td>
</tr>
<tr>
<td>High School diploma or higher</td>
<td>66%</td>
<td>65%</td>
<td>66%</td>
</tr>
<tr>
<td>Food insecurity</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
</tr>
<tr>
<td>Unstable Housing</td>
<td>12%</td>
<td>19%</td>
<td>15%</td>
</tr>
<tr>
<td>Intimate Partner</td>
<td>31%</td>
<td>37%</td>
<td>34%</td>
</tr>
<tr>
<td>Violence</td>
<td>60%</td>
<td>74%</td>
<td>68%</td>
</tr>
<tr>
<td>Mental Health Condition</td>
<td>66%</td>
<td>79%</td>
<td>73%</td>
</tr>
<tr>
<td>Substance use</td>
<td>65%</td>
<td>82%</td>
<td>75%</td>
</tr>
<tr>
<td>Smoking</td>
<td>59%</td>
<td>74%</td>
<td>68%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>55%</td>
<td>44%</td>
<td>50%</td>
</tr>
<tr>
<td>Rate of Spont Preterm</td>
<td>25%</td>
<td>29%</td>
<td>27%</td>
</tr>
<tr>
<td>Average Number of Risk Factors</td>
<td>3.7</td>
<td>3.7</td>
<td>3.7</td>
</tr>
</tbody>
</table>

- **Results**: LBW rates among Black and White Women - Results from Two Different Methodologies

- **Conclusion**: Intensive care management for very high-risk pregnant women is associated with a significant reduction in LBW rates. Despite care management, Black women deliver LBW infants at significantly higher rates than White women. Policy can influence health outcomes yet more work to alleviate disparities needs to be done.

This work is timely as maternal/neonatal morbidity, racial disparities, and policy innovation are pressing issues in the United States.

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This concludes our MOM workgroup series.

Thank you for your participation and interest in this workgroup. We have enjoyed supporting your practice.