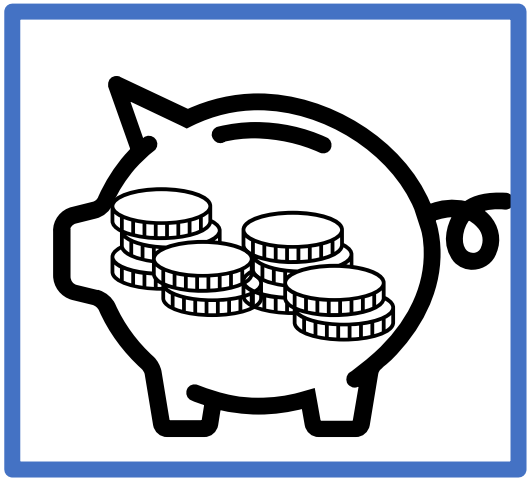
Community Care
OF NORTH CAROLINA

Majority OB Medicaid “MOM” Workgroup
6/10/2021

MOM Workgroup Covered Topics

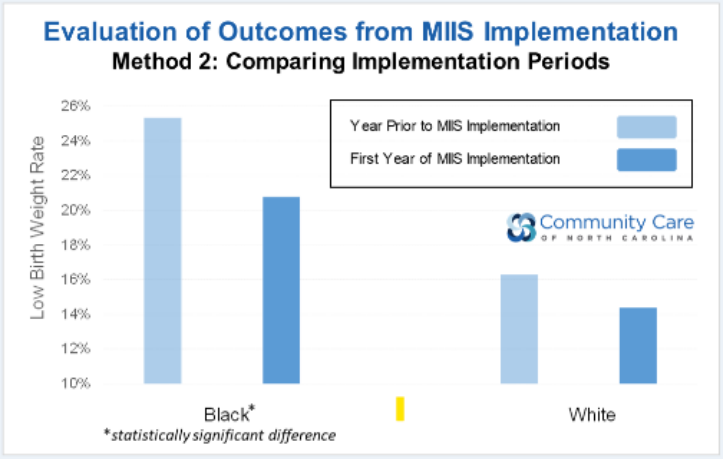
- Don't Leave Money on the Table: slide deck and recording
  - PMH Incentives
  - Smoking Cessation
  - Depression Screening
- Sterilizations: slide deck
- Ultrasound denials: slide deck and recording
- Managed Care High Level Overview: slide deck and recording
- Beneficiary Enrollment/Newborn Eligibility/Updated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



PREGNANCY MEDICAL HOME

HOME / WHAT WE DO / CLINICAL PROGRAMS / PREGNANCY MEDICAL HOME

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



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

LEARN MORE

OB Guidance Documents

A collection of resources created by CCNC for PMH providers

LEARN MORE

Monthly PMH Newsletters

https://www.communitycarenc.org/what-we-do/clinical-programs/pregnancy-medical-home

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&A*: **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. Th of practices that serve pregnant women with Medicaid.

Standardized Risk Screening

NC Medicaid Managed Care Health Plan Assignments Completed for Beneficiaries

- 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
  - Claims Submission (in-network and out-of-network) Part 1 & Part 2
  - 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

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Standardized Risk Screening

*Practice Name: _____

Practice Phone Number: _____

*Today's Date: _____ /_____/_____

Date of next prenatal appointment:_____/_____/_____

Care Management for High-Risk Pregnancies (CMHRP) Pregnancy Risk Screening Form

Date of birth:_____/_____/_____

First name:_____ MI:_____ Last name:_____

*EDC:___/___/_____*Determined by what criteria*: ❑ LMP ❑ 1st trimester U/S ❑ 2nd trimester U/S

Height:____ft____in Pre-pregnancy weight:_____ Gravidity:_____Parity:____,____,____,____

Insurance type: ❑ Medicaid (includes Presumptive) ❑Private ❑None

Medicaid ID#:_____ PHP Name: _____

***CURRENT PREGNANCY**

- ❑ Multifetal Gestation
- ❑ Fetal complications:
  - ❑ Fetal anomaly
  - ❑ Fetal chromosomal abnormality
  - ❑ Intrauterine growth restriction (IUGR)
  - ❑ Oligohydramnios
  - ❑ Polyhydramnios
  - ❑ Other(s): _____
- ❑ Chronic condition which may complicate pregnancy:
  - ❑ Diabetes
  - ❑ Hypertension
  - ❑ Asthma
  - ❑ Mental illness
  - ❑ HIV
  - ❑ Seizure disorder
  - ❑ Renal disease
  - ❑ Systemic lupus erythematosus
  - ❑ Other(s): _____
- ❑ Current use of drugs or alcohol/recent drug use or heavy alcohol use in month prior to learning of pregnancy
- ❑ Late entry into prenatal care (>14 weeks)
- ❑ Hospital utilization in the antepartum period
- ❑ Missed 2+ prenatal appointments
- ❑ Cervical insufficiency
- ❑ Gestational diabetes
- ❑ Vaginal bleeding in 2nd trimester
- ❑ Hypertensive disorders of pregnancy
  - ❑ Preeclampsia
  - ❑ Gestational hypertension
- ❑ Short interpregnancy interval (<12 months between last live birth and current pregnancy)
- ❑ Current sexually transmitted infection
- ❑ Recurrent urinary tract infections (>2 in past 6 months, >5 in past 2 years)
- ❑ Non-English speaking
  - Primary language: _____
- ❑ Positive depression screening
  - ○ Tool used: _____
  - ○ Score = _____

For LHD Use Only: Date RSF was received:_____

*Date RSF was entered: _____

***OBSTETRIC HISTORY**

- ❑ Preterm birth (<37 completed weeks)
  Gestational age(s) of previous preterm birth(s):
  _____weeks,_____weeks,_____weeks
- ❑ At least one spontaneous preterm labor and/or rupture of the membranes
  If this is a singleton gestation, this patient is eligible for 17P treatment.
- ❑ Low birth weight (<2500g)
- ❑ Fetal death >20 weeks
- ❑ Neonatal death (within first 28 days of life)
- ❑ Second trimester pregnancy loss
- ❑ Three or more first trimester pregnancy losses
- ❑ Cervical insufficiency
- ❑ Gestational diabetes
- ❑ Postpartum depression
- ❑ Hypertensive disorders of pregnancy
  - ❑ Eclampsia
  - ❑ Preeclampsia
  - ❑ Gestational hypertension
  - ❑ HELLP syndrome

❑ Provider requests care management

Reason(s):_____

Provider Comments/Notes: _____

*Person Completing Form: _____

*Credentials: _____

*Signature: _____

Care Management for High-Risk Pregnancies (CMHRP) Pregnancy Risk Screening Form

Complete this side of the form as honestly as possible and give it to your nurse or doctor. The information you provide allows us to coordinate services with the care manager and provide the best care for you and your baby.

Name:_____Date of birth:_____Today's date: _____

Physical Address:_____City:_____ ZIP:_____

Mailing Address (if different):_____City:_____ZIP:_____

County:_____Home phone number:_____Work phone number: _____

Cell phone number:_____ Social security number (ifavailable): _____

Race: ❑American-Indian or Alaska Native ❑Asian ❑Black/African-American ❑Pacific Islander/Native Hawaiian ❑White ❑Other (specify):_____

Ethnicity: ❑ Not Hispanic ❑ Cuban ❑ Mexican ❑ Puerto Rican ❑ Other Hispanic

Education: ❑ Less than high school diploma ❑ GED or high school diploma ❑ Some college ❑ College graduate

1. Thinking back to just before you got pregnant, how did you feel about becoming pregnant?
   - ❑ I wanted to be pregnant sooner
   - ❑ I wanted to be pregnant now
   - ❑ I wanted to be pregnant later
   - ❑ I did not want to be pregnant then or any time in the future
   - ❑ I don't know
2. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? ❑ Yes ❑ No
3. Are you in a relationship with a person who threatens or physically hurts you? ❑ Yes ❑ No
4. Has anyone forced you to have sexual activities that made you feel uncomfortable? ❑ Yes ❑ No
5. In the last 12 months were you ever hungry but didn't eat because you couldn't afford enough food? ❑ Yes ❑ No
6. Is your living situation unsafe or unstable? ❑ Yes ❑ No
7. Which statement best describes your smoking status? Check one answer.
   - ❑ I have never smoked, or have smoked less than 100 cigarettes in my lifetime
   - ❑ I stopped smoking BEFORE I found out I was pregnant and am not smoking now
   - ❑ I stopped smoking AFTER I found out I was pregnant and am not smoking now
   - ❑ I smoke now but have cut down some since I found out I was pregnant
   - ❑ I smoke about the same amount now as I did before I found out I was pregnant
8. Did any of your parents have a problem with alcohol or other drug use? ❑ Yes ❑ No
9. Do any of your friends have a problem with alcohol or other drug use? ❑ Yes ❑ No
10. Does your partner have a problem with alcohol or other drug use? ❑ Yes ❑ No
11. In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications? ❑ Yes ❑ No
12. Before you knew you were pregnant, how often did you drink any alcohol, including beer or wine, or use other drugs? ❑Not at all ❑Rarely ❑Sometimes ❑Frequently
13. In the past month, how often did you drink any alcohol, including beer or wine, or use other drugs? ❑ Not at all ❑Rarely ❑Sometimes ❑Frequently

*Required fields

Version 2 (Rev. 12/01/2020) Submit completed form to the CMHRP staff at the local health department in the patient's county of residence.

[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

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Abstract

Research Question: This research aims to: (1) Estimate the association between intensive care management and low birth weight rates and (2) Examine 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) per 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 2500g. 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 the year prior to implementation of the MIIS (Y1) to similar women who became pregnant the year following (Y2). Chi-square tests were performed to compare study populations.

Population Studied: The population of this study was Medicaid-eligible women who became pregnant January 2016 – December 2017, and had a MIIS score >500 indicating high risk for LBW and thus eligible for ICM. Each woman had >3 of the following risk factors: prior spontaneous preterm birth, hypertension, smoking, substance abuse, mental health disorder, domestic violence, homelessness, and hunger. We used the mean number of risk factors to ensure equivalency across groups.

Principal Findings: There were 3,565 births in the cohort. ICM (Method 1) was associated with reductions in LBW rates for both Black and White women (Table 1). Black women had significantly lower rates of LBW in the year after implementation of the MIIS (Method 2). Despite controlling for clinical and social risk determinants, and level of intervention, Black women had higher rates of LBW compared to White women (Method 1 p=0.0004; Method 2 p=0.0002).

Conclusions: ICM for the highest risk pregnant women is associated with a substantial reduction in LBW rates. Black women with or without care management deliver LBW infants at rates significantly higher than White women.

Implications for Policy or Practice: While there is measurable benefit of ICM for very high-risk pregnant women, racial disparities persist. This research is timely and important as issues of racial disparities and policy innovation are pressing 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.

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
- In 2017, the program created and implemented the Maternal-Infant Impactability Score (MIIS) to identify a subset of very high risk pregnant women most likely to benefit from intensive care management (ICM)

Methods

- Retrospective quasi-experimental analysis of **Medicaid eligible women** who:
  - Had singleton pregnancies between January 2016 and December 2017
  - had a MIIS score ≥500 indicating high risk for low birth weight (LBW)
  - had ≥3 risk factors: prior preterm birth, hypertension, smoking, substance abuse, mental health disorder, domestic/intimate partner violence, homelessness, and food insecurity
- Exposure of interest: **Intensive care management** defined as ≥ 5 face-to-face encounters with a care manager
- Primary outcome: **Low birth weight** defined as a birthweight less than 2500 g

Methods

- Two methods were employed to assess the intervention impact:
  - ***Method 1:*** Compares LBW rates between those who received ICM and those who did not
  - ***Method 2:*** Compares LBW rates the year prior to implementation of the MIIS (Y1) to similar women the year following implementation (Y2)
- Women are categorized by self-reported race on the birth certificate
- Chi-square tests were performed

Results

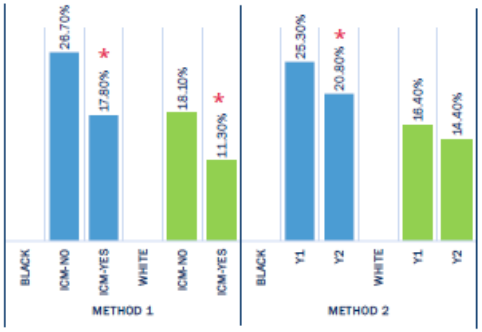
Table 1. Demographic Characteristics of Pregnant Women with Medicaid, 2016-2017

Characteristics	Black	White	Total
N	1536	2029	3565
Nulliparous	18%	21%	20%
Average Age of Mother	27.9	27.4	27.6
High School diploma or higher	68%	65%	66%
Food Insecurity	26%	26%	26%
Unstable housing	13%	8%	10%
Intimate Partner Violence	37%	37%	37%
Mental Health Condition	66%	79%	73%
Substance use	85%	85%	85%
Smoking	60%	74%	68%
Hypertension	55%	43%	48%
Hx of Spon Preterm	25%	22%	23%
Average Number of Risk Factors	3.7	3.7	3.7

- Overall, Black women had higher rates of LBW compared to White women (*Method 1:* p=0.0004; *Method:* p=0.0002)

Results

Figure 1. LBW Rates Among Black and White Women – Results from Two Different Methodologies



- ICM resulted in a reduction in LBW rates for both races. The implementation of the MIIS resulted in a significant reduction in LBW for Black women

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.

This concludes our MOM workgroup series.

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

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