



Pregnancy Medical Home and Care Management under Managed Care

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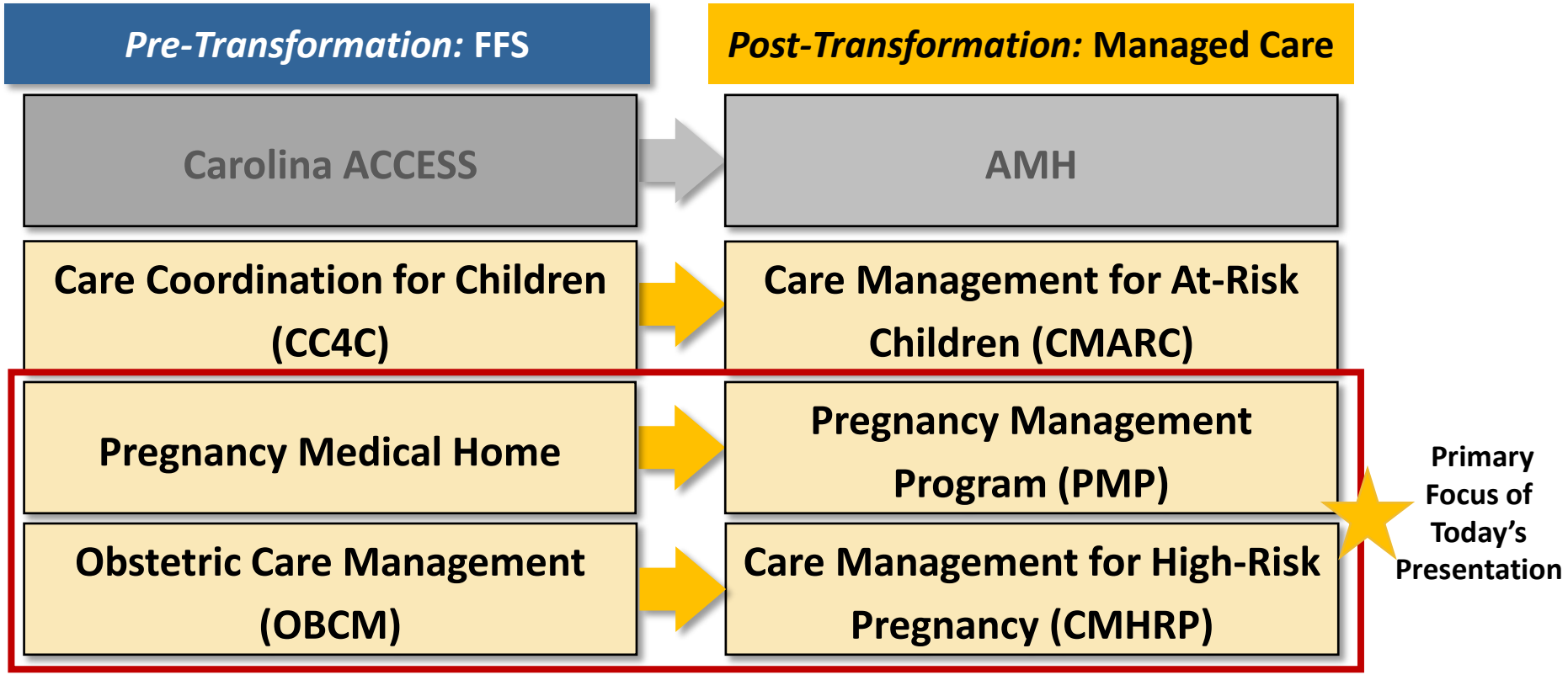
Evolution of Existing Programs Under Managed Care

The State will build on existing care management infrastructure under managed care



*Note: These programs will **remain in place post-transformation** for populations that remain in FFS coverage*

Note: Local Health Departments, Pediatric providers and Pregnancy Care providers can also be AMH providers

DHHS and PHP Role in Pregnancy Care in North Carolina

DHHS Role

The Division of Health Benefits (DHB) is responsible for **setting the vision (priorities/alignment) for all pregnancy and pediatric programs** under Medicaid managed care—contracts with PHPs; MOA with DPH; contract for Virtual Health.

The Division of Public Health (DPH) will continue to play a critical role, including **continued use of Regional consultants** to provide technical assistance, training and quality improvement to Local Health Departments.

Support State Advisory Group.

PHP Role

PHPs will have overall accountability and risk for program outcomes. **PHP responsibilities include:**

- Develop and execute contracts w/ providers;
- Reimburse providers (including incentive payments);
- Permit direct referral to LHDs for CM without prior authorization;
- Identify and refer high-risk pregnant women/at-risk children for care management;
- Administer quality and process measure program;
- Conduct contract oversight and issue corrective action plans for underperformance; and,
- Ensure non-duplication of services

Overview: Pregnancy Management Program (PMP)

PMP will continue its commitment to clinical excellence through the provision of comprehensive, coordinated pregnancy care services to pregnant women enrolled in the state's managed care program.

Participation & Standard Contracting Terms

- **Participation Requirements:** There will no longer be a process to opt into the program
  - All providers that bill global, packaged or individual pregnancy services will contract with PHPs under standard contracting terms

Providers of pregnancy care must contract with each PHP to receive payment for services

- **Contracting Terms:** Remain the same and include, for example*:
  - Required use of current clinical care pathways for pregnancy care (for example, induction of labor in nulliparous women);
  - Completion of the standardized risk-screening tool at each initial visit;
  - Deploying efforts to decrease primary cesarean delivery rate;
  - Ensuring comprehensive post-partum visits within 56** days of delivery

*Full contracting terms located in Appendix A
**Change from 60 days to align with quality measurement

Pregnancy Management Program Payments and Incentives

Providers will continue receive payment at levels consistent with today's payment model

Payments and Incentives to Providers

- Pregnancy Management Program providers will **receive regular fee schedule payments** in addition to incentive payments
  - Providers will receive, at a minimum, the same rate for vaginal deliveries as they do for caesarian sections
- Provider **incentive payment structure will be remain at the same** levels during the transition period
  - $50 for the completion of the standardized risk screening tool at each initial visit;
  - $150 for completion of postpartum visit held within 56* days of delivery
- **PHPs may offer both additional contracting terms and provide additional incentive payments** to PMPs; participation in any additional programs is optional for the provider
- **No prior authorization** needed for ultrasounds

In Managed Care, PHPs will pay providers. Providers must contract with PHPs to receive both payment for services and incentive payments.

*Change from 60 days to align with quality measurement.

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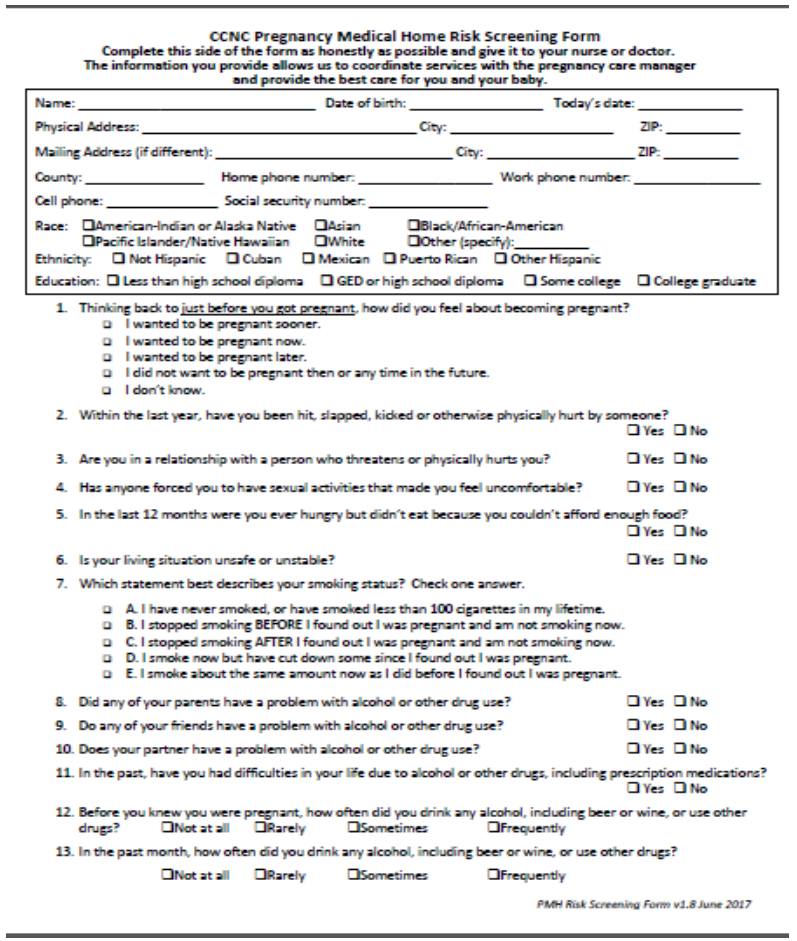
Risk Screening Tool for High-Risk Pregnancies

PMP providers will use a State-developed risk screening form consistent with today's tool

Risk Screening Form

Just updated!

- Providers will be required to adopt and administer a State-designated screening tool to identify high-risk pregnancies
- The content of the tool will be standardized across the State and will be the same as the tool currently used by providers enrolled in the PMH program *
- PMPs are required to share results of the completed screening with the LHD within 24 hours. It is critical that the form has been fully completed.
- **DHHS will be responsible for maintaining updates to the risk-screening tool in conjunction with key stakeholders.**



CCNC Pregnancy Medical Home 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 pregnancy 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: _____ Social security number: _____
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 <u>just before you got pregnant</u>, 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.
   - ❑ A. I have never smoked, or have smoked less than 100 cigarettes in my lifetime.
   - ❑ B. I stopped smoking BEFORE I found out I was pregnant and am not smoking now.
   - ❑ C. I stopped smoking AFTER I found out I was pregnant and am not smoking now.
   - ❑ D. I smoke now but have cut down some since I found out I was pregnant.
   - ❑ E. 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

PMH Risk Screening Form v1.8 June 2017

Identification of High-Risk Pregnant Women for CMHRP

Pregnancy care providers will be required to coordinate outreach and care management efforts with LHDs and PHPs for management of women determined to be "high risk."

- Similar to today, all PMP providers will ensure appropriate coordination and communication with LHD Care Managers for the sub-set of their practice populations that are deemed high-risk who receive services under CMHRP.
- Similar to today, the Division of Public Health (DPH) will continue to provide training and technical assistance to care managers at LHDs.
- Different from today, Network OB Nurse Coordinator and OB champions will no longer be available exactly like they are today*.
- Different from today, PMP providers should direct questions related to Medicaid policies and payment, or clinical questions, to each PHP with which they contract.

DHHS Led Quality Measurement of Programs for Pregnant Women

DHHS will track several process and outcome measures to ensure high-quality care for pregnant women enrolled in CMHRP.

#	CMHRP Reach Measures
1	Expected penetration: ~4% of women in Medicaid
#	**CMHRP Performance Measures**
2	*(Engagement)* Members with High priority will be contacted for engagement within 7 days of referral *(minimum of 3 attempts or until successful contact made).*
3	*(Active Care Management)* Members engaged in active care management will have a signed care plan within 15 days of engagement in CMHRP services.

#	Outcome Measures
1	Prenatal and Postpartum Care: NQF 1517
2	Live Births Weighing Less than 2,500 g: NQF 1382

PHP to Provider Reports on the Quality of Programs for Pregnant Women

PHPs will provide quality reporting to all providers in Managed Care, including those serving pregnant women.

- PHPs will provide quality measure reports to practices under managed care. The frequency and method at which the PHPs provide practices with data may vary between plans.
- PHPs will provide regular reports to PMP practices on at least the following measures:
  - Prenatal and Postpartum Care: NQF 1517
  - Live Births Weighing Less than 2,500 g: NQF 1382
- Providers may receive other measure reports from PHPs beyond the two NQF measures listed above.

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Q&A

Questions/Answers

How will the risk screening tools be managed after go live? Will the process of sending them to the local health be the same as today?

DHHS will continue to own/update the Pregnancy Risk Screening Tool. The referral process will remain the same as it is today. LHDs will be prioritizing patients referred by the PHPs, the triage process and who actually receives services may vary.

Will care management services continue to be prioritized based on risk and Impactability? If so, how will risk be determined? Will criteria be the same for all PHPs?

Care Management services will be prioritized based on referral lists sent by PHPs. PHPs have different risk criteria. LHDs will also use the MIIS as a data point but must prioritize PHP referrals. Provider request referrals will still be accepted and triaged as they are today.

PHPs will be providing additional pregnancy supports to all pregnant women (beyond those who receive CMHRP). *Let's flag this one as a future topic to bring back.*

Questions/Answers

How will the provider office know if their patient has been assigned a care manager and how to contact that individual?

LHDs are still expected to communicate with provider offices. Historically, local systems have been set up individually and agreed upon by provider office and CM. This requirement will not change. If there are concerns re: this area, please contact Tonya Dennis, CMHRP Program Manager.

Will LHD care managers continue to be embedded in practices (post pandemic, of course)? Will care managers be accountable to multiple PHPs, thus limiting the number of different care managers in an office?

It is expected that the current level of embedding continue. LHDs may have to adjust staffing to accommodate the Medicaid Transformation transition but the embedding model is still the expectation. 1 LHD will serve referrals (practices) across PHPs. So, the model should still only have 1 care manager per practice (not 5 care managers).

Questions/Answers

Will the PHPs be accountable for the patients receiving appropriate care management? Who should a provider office contact if care management expectations are not being met?

We do consider it best practice for the practice to work directly with the LHD care manager and supervisor for day-to-day questions and concerns. But, providers should contact the PHP for care management performance issues.

RESOURCES

- DHHS Care Management & PMP Webpage
  https://medicaid.ncdhhs.gov/transformation/care-management
- Program Guide for High Risk Pregnancy and At-Risk Children
  https://files.nc.gov/ncdma/documents/Providers/Programs_Services/care_management/Program-Guide-High-Risk-Pregnancy-and-At-Risk-Children-11072018.pdf

Questions/Answers

Will the practices have an assigned support staff from each PHP that will provide data, practice support and quality improvement support? Are there plans to have those support staff collaborate to decrease confusion and meeting time burden on practices?

PHPs are required to share data and quality measures with practices. *Let's flag this one as a future topic to bring back after we plan with PHPs more on what this would look like.*

Who will inform OB practices who are not currently Pregnancy Medical Homes of the importance of and process for risk screening, incentive codes and enhanced reimbursement for OB services?

PHPs are required to work with all OB practices on these required standardized elements. These program elements are required to be in all PHP contracts (see appendix).

Dr. Taormina/Dr. Menard:

Planning for OB Champions + PHPs

Appendix

Appendix A: PMP Standard Contracting Requirements

PHPs shall incorporate the following requirements into their contracts with all providers of perinatal care, including the following requirements for providers of the Pregnancy Management Program:

1. Complete the standardized risk-screening tool at each initial visit.
2. Allow PHP or PHP's designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators;
3. Maintain or lower the rate of elective deliveries prior to 39 weeks gestation;
4. Decrease the cesarean section rate among nulliparous women;
5. Offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation. Complete a high-risk screening on each pregnant Medicaid beneficiary in the program and integrating the plan of care with local pregnancy care management;
6. Decrease the primary cesarean delivery rate if the rate is over the Department's designated cesarean rate; (Note: the Department will set the rate annually, which will be at or below 20%); and
7. Ensure comprehensive post-partum visits occur within 56 days of delivery.