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Evolution of Existing Programs Under Managed Care

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

**Pre-Transformation: FFS**
- Carolina ACCESS
- Care Coordination for Children (CC4C)
- Pregnancy Medical Home
- Obstetric Care Management (OBCM)

**Post-Transformation: Managed Care**
- AMH
- Care Management for At-Risk Children (CMARC)
- Pregnancy Management Program (PMP)
- Care Management for High-Risk Pregnancy (CMHRP)

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.

Primary Focus of Today’s Presentation
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.

**DHHS Role**

**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

- **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

*Change from 60 days to align with quality measurement.

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

- 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.
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.

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<tr>
<th>#</th>
<th>CMHRP Reach Measures</th>
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<tbody>
<tr>
<td>1</td>
<td>Expected penetration: ~4% of women in Medicaid</td>
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<table>
<thead>
<tr>
<th>#</th>
<th>CMHRP Performance Measures</th>
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<tr>
<td>2</td>
<td>(Engagement) Members with High priority will be contacted for engagement within 7 days of referral (minimum of 3 attempts or until successful contact made).</td>
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<tr>
<td>3</td>
<td>(Active Care Management) Members engaged in active care management will have a signed care plan within 15 days of engagement in CMHRP services.</td>
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<table>
<thead>
<tr>
<th>#</th>
<th>Outcome Measures</th>
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<tr>
<td>1</td>
<td>Prenatal and Postpartum Care: NQF 1517</td>
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<tr>
<td>2</td>
<td>Live Births Weighing Less than 2,500 g: NQF 1382</td>
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</tbody>
</table>
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.
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
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.