CCNC's Pregnancy Medical Home: Focusing on improving maternal health, maternity care, and birth outcomes

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What is the PMH program?

- Partnership among Division of Medical Assistance (DMA), Division of Public Health (DPH), Community Care of North Carolina (CCNC) and maternity providers across the state
- Goal is to improve birth outcomes, improve quality of maternity care, reduce costs in the Medicaid population
  - ***Preterm birth prevention*** is primary focus
  - Quality improvement in perinatal care setting (prenatal, intrapartum, and postpartum)
  - Cost savings resulting from healthier babies, improved utilization of maternity care resources
- 380 practices, representing >1600 individual providers, have joined CCNC networks as Pregnancy Medical Homes since program launch in April 2011

PMH Benefits

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- Incentive payments from DMA ($50 for initial risk screening, $150 for postpartum visit if completed within 60 days of delivery)
- Enhanced rate of reimbursement for vaginal delivery
- Bypass of MedSolutions medical necessity review for OB ultrasound
- Informatics (practice-level data) for quality improvement and practice support from local CCNC network
- Designated pregnancy care manager to work with at-risk Medicaid patients in each PMH practice

PMH practice expectations

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- Complete standardized risk screening on all OB patients
- Offer/provide 17p to eligible patients
- Avoid elective delivery <39 weeks
- Meet primary c-section rate benchmark (as above)
- Include standardized depression screening, reproductive life planning and referral for ongoing care in postpartum visit
- Coordinate/collaborate with pregnancy care manager

Key Performance Indicators

- **CCNC must report to the state (DMA) quarterly on the following measures:**
  - Rate of low birth weight, very low birth weight
  - Rate of primary cesarean delivery
- **Based on deliveries with a birth certificate that were covered by non-emergency Medicaid**
  - CCNC and State Center for Health Statistics work together to create the “matched file” of Medicaid births/birth certificates
  - Data challenges for FY14 with transition to new claims processing system
  - Plan for upcoming year: link Medicaid moms to Medicaid babies

PMH Quality Metrics

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- Timing of entry to prenatal care
- Pregnancy intendedness
- Rate of risk screening of pregnant women
- Care manager intervention for priority patients
- Mode of delivery
- Gestational age at delivery
- 17p utilization
- Postpartum visit rate
- Contraception in the postpartum period
  - LARC in postpartum period, contraception among women unintended pregnancies

North Carolina Delivery Metrics, CY 2012	#	% of state deliveries	% of all Medicaid deliveries	% of non-Emergency Medicaid deliveries
Total NC deliveries	119,767			
NC deliveries covered by Medicaid	62,816	52.4%		
NC deliveries covered by non-Emergency Medicaid	53,670	44.8%	85.4%	
NC deliveries covered by Emergency Medicaid	9,146	7.6%	14.6%	
Deliveries attributed to a PMH	45,366			84.5%
PMH-attributed patients with a risk screen entered in CMIS	35,033			65.3%

Prenatal care settings: types of Pregnancy Medical Home practices by volume of Medicaid pregnancies attributed to each setting

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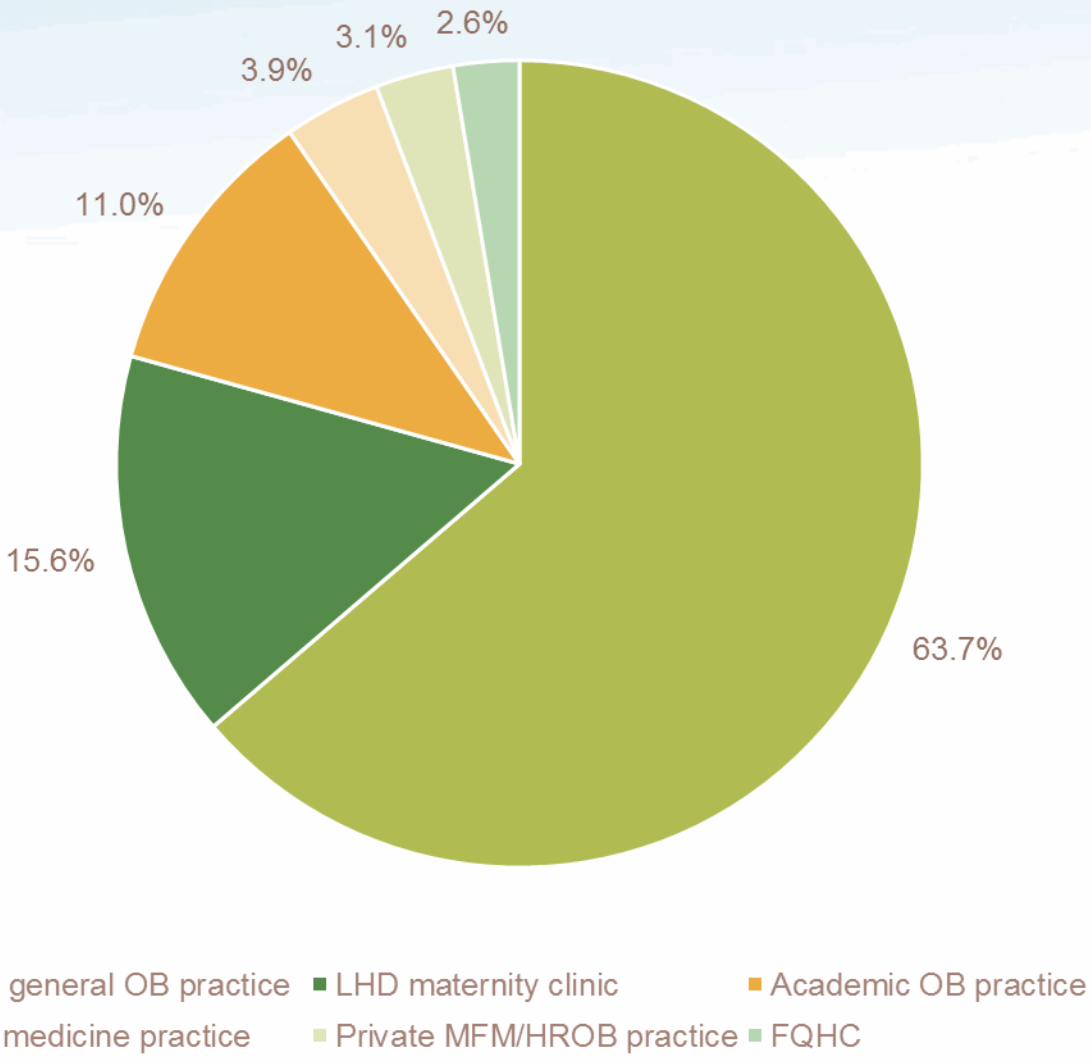

Timing of entry into prenatal care among Medicaid patients receiving care from a Pregnancy Medical Home who delivered 4/1/12 – 3/31/13

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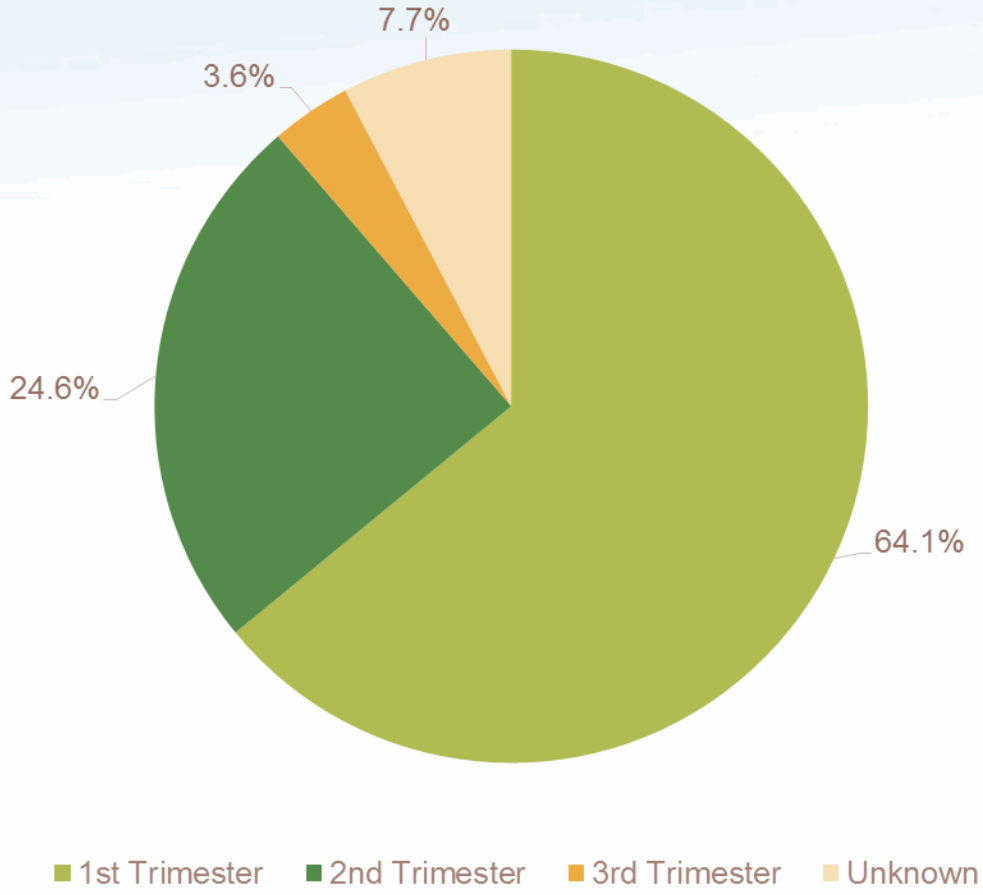

Proportion of Medicaid patients with a postpartum visit* within 60 days of delivery, among patients who received care at a PMH, 2012 deliveries

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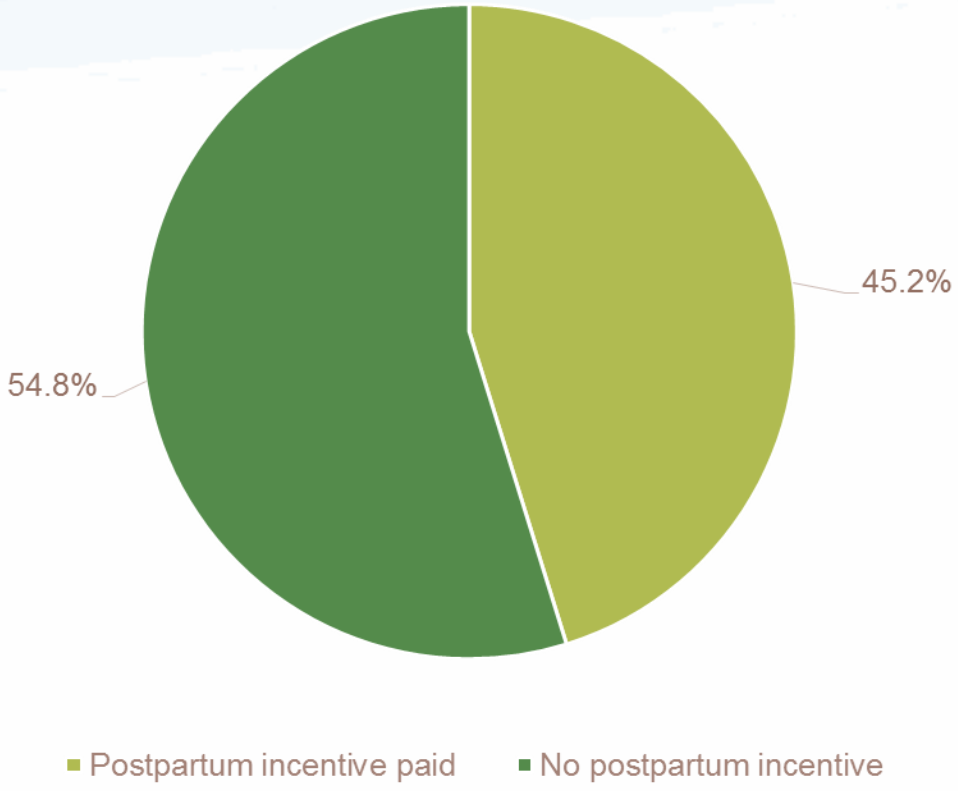
*Based on paid claims for PMH postpartum incentive



Short interpregnancy interval among Medicaid patients delivering May 2010 – April 2011 with two Medicaid deliveries

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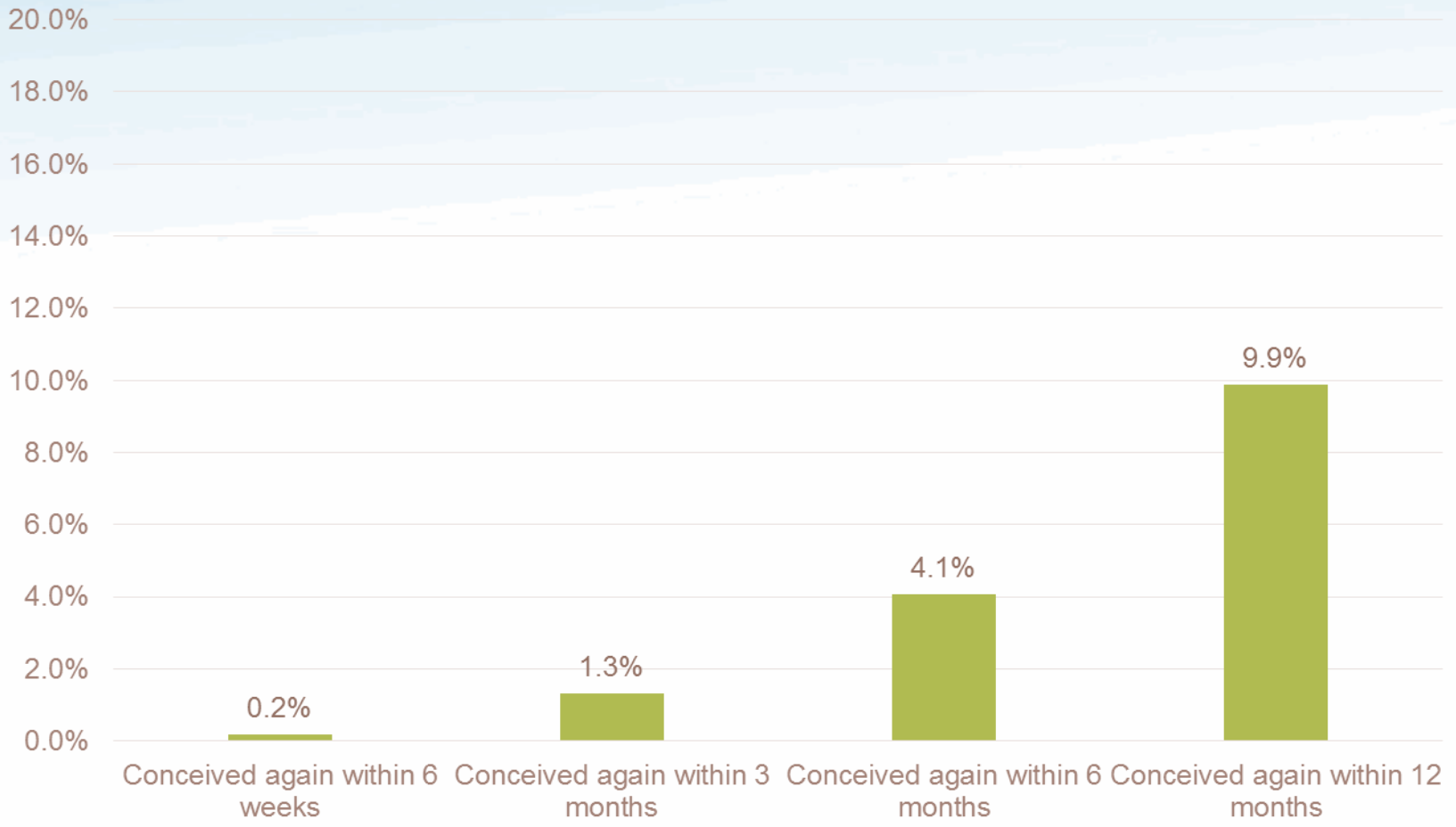

Each time interval includes patients from the prior interval (e.g., patients who conceived within 6 weeks of delivery are included in the rate of patients who conceived within 3 months of delivery).

Risk Screening

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- **Priority risk factors combine medical, OB and psychosocial risk and utilization issues (missing prenatal appts, late entry to care, hospital utilization)**
- **50-70% of Medicaid patients have at least one priority risk factor; tobacco use and late entry to prenatal care are most common**
  - 39% were smoking at time of pregnancy
  - 20% of population continues to smoke during pregnancy
  - 3.2% of population reports using drugs/alcohol “sometimes” or “frequently” in past 30 days
  - 3.9% reports past problems with drugs/alcohol
  - 2.7% reports partner has drug/alcohol problem
  - 3.4% reports experiencing physical violence in the past year
  - 52.4% of pregnancies are unintended

Care Management

- **Patients with priority risk factors are connected to pregnancy care managers in local health departments**
  - OBCMs support prenatal care plan, are integral part of prenatal care team, identify and refer to needed community resources
- **Pregnancy Care Management continues through postpartum period (approx. 90 days post-delivery)**
- **Care Coordination for Children (CC4C) care managers in LHDs serve at-risk children 0-5: CSHCN, foster care, toxic stress, NICU admission, CCNC priority population based on utilization**

Behavioral Health Referrals in Pregnancy

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- **OB providers face challenges in navigating the LME/MCO system**
- **Misinformation about Medicaid for Pregnant Women (MPW) coverage of BH – and other – services**
  - Some LME/MCOs have shared inaccurate information about Medicaid coverage of BH services for pregnant women
- **Bias against accepting women with MPW coverage because of perception that they will become self-pay after postpartum period**
  - Challenges of arranging specialty care, including psychiatry, for this population

Medicaid References

February 2013 Bulletin article: "As with other eligibility categories, behavioral health treatment (including treatment for substance abuse) is covered for MPW beneficiaries, as are other medical specialty services needed to maintain the health of the woman or fetus during pregnancy."

http://www.ncdhhs.gov/dma/bulletin/0213bulletin.htm#preg

NC DMA Clinical Coverage Policy 1E5, Obstetrics, Section 2.1.2 Medicaid for Pregnant Women: "Female beneficiaries of all ages with MPW coverage are eligible for pregnancy-related antepartum, labor and delivery, and postpartum care as well as services for conditions that — in the judgment of their physician — may complicate pregnancy. Conditions that may complicate their pregnancy can be further defined as any condition that may be problematic or detrimental to the well-being or health of the mother or the unborn fetus such as undiagnosed syncope, excessive nausea and vomiting, anemia, and dental abscesses (This list is not all-inclusive.). The eligibility period for MPW coverage ends on the last day of the month in which the 60th postpartum day occurs [42 CFR 447.53(b)(2)]."

Medicaid Coverage Beyond Pregnancy

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- **2/3 of Medicaid births are to women with MPW coverage**
  - 1/3 of births are to women with ongoing Medicaid coverage
- **Among women with regular Medicaid at time of delivery, 90% of patients remain covered at the end of the postpartum period, but 30% of these patients do not have Medicaid coverage one year later**
  - 6% of these patients obtain Family Planning Waiver coverage
- **Among women with MPW coverage at time of delivery, 36% have at least some regular Medicaid coverage in the year following the postpartum period**
  - An additional 16% obtain Family Planning Waiver coverage

Substance Abuse in Pregnancy

- **PMH Care Pathway for Management of Substance Use in Pregnancy under development**
  - CCNC, DMH, Governor's Institute, DPH, UNC collaboration
  - Planned release for fall 2014
- **In November 2012, CCNC started hosting and co-facilitating a workgroup, "Opioid Dependence in Pregnancy Stakeholders"**
  - Cross-disciplinary group of stakeholders came together out of concern for misinformation and inconsistent guidance being shared related to care of women with opioid dependence, including those in medication-assisted treatment programs

Opportunities to improve identification and management of psychosocial risk for children

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- **Improved linkage between pregnancy and pediatrics, including OBCM and CC4C care management programs, using informatics systems and new models for collaboration**
- **Preconception/interconception health focus:**
  - Promotion of improved family planning strategies/methods and use of Family Planning Waiver to reduce rate of unintended pregnancy and short interpregnancy interval
  - Use of informatics to identify women with various risk factors (e.g., chronic opioid use, severe chronic disease, what else?) who may be at risk for unintended pregnancy and provide care management and primary care intervention