Partnership between Division of Medical Assistance, Community Care of North Carolina and the Division of Public Health
New Initiative

- Provide pregnant recipients with a pregnancy medical home (PMH) and pregnancy care management services to those identified as high risk
- Replicate a similar model to the primary care case management program developed by CCNC
- Improve birth outcomes and improve quality of perinatal care given to Medicaid recipients
- Reduce c-section rate
- Incentivize providers to become PMH and provide continuity of care to Medicaid recipients
Working Together

- Division of Medical Assistance (DMA)
  - Administer and oversee PMH Initiative
  - Funding
  - Policies

- CCNC
  - Recruit and enroll physicians
  - Provide support to local CCNC networks
Working Together

• CCNC cont.
  – Work in collaboration with the health dept to create a high risk case management program
  – Monitor and audit PMHs
  – Implement quality improvement initiatives

• Division of Public Health
  – Monitor and oversight of the performance of LHDs offering pregnancy care management services
  – Train all current MCCs who will transition to pregnancy care managers in the PMH model
Working Together

- **Local Health Departments (LHD)**
  - Provide population management and care management services to the pregnant woman population
  - Partner with PMHs

- **Department of Social Services (DSS)**
  - Provide listing of PMHs to recipients
  - Discuss the program with pregnant recipients
Who can participate as a PMH?

- Licensed qualified private physicians and public or private clinics organized for the delivery of obstetrical care
  
  General/family practice
  OB/GYN practices
  Multi-specialty
  Federally Qualified Health Clinics (FQHC)
  Rural Health Clinics (RHC)
  Local Health Departments (LHD)
  Nurse practitioners
  Certified nurse midwives
PMH Responsibilities

• Performance measures
  – Eliminate elective deliveries before 39 weeks gestation
  – Offer and provide 17P to eligible patients
  – Reduce primary c-section rate
  – Complete an initial risk screening on all patients
  – Agree to chart audits
  – Affiliate member of CCNC
PMH Responsibilities

- Provide information on how to obtain MPW, WIC, Family Planning Waiver
- Refer high risk pregnant women to Pregnancy Care Management for thorough assessment
- Communicate and coordinate care with Pregnancy Care Manager assigned to the practice
- Provide 24/7 phone support for emergencies
- Provide educational materials on healthy pregnancy
Incentives

- $200 per Medicaid delivery
  - $50 for completing high risk screening tool at initial visit
    - Bill HCPCS S0280 – medical home program, comprehensive care coordination and planning, initial plan
  - $150 paid after billing postpartum visit
    - Bill HCPCS S0281 – medical home program, comprehensive care coordination and planning, maintenance of plan
## Incentives

<table>
<thead>
<tr>
<th>VAGINAL DELIVERY CODES</th>
<th>PROCEDURE</th>
<th>CURRENT RATES Facility</th>
<th>CURRENT RATES Non Facility</th>
<th>FUTURE RATES Facility</th>
<th>FUTURE RATES Non Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>59400</td>
<td>Global (includes antepartum, delivery &amp; postpartum care)</td>
<td>$1368.59</td>
<td>$1368.59</td>
<td>$1549.75</td>
<td>$1549.75</td>
</tr>
<tr>
<td>59425</td>
<td>Antepartum care 4 -6 visits</td>
<td>268.96</td>
<td>340.20</td>
<td>304.46</td>
<td>385.11</td>
</tr>
<tr>
<td>59426</td>
<td>Antepartum care 7 + visits</td>
<td>475.94</td>
<td>608.62</td>
<td>538.76</td>
<td>688.96</td>
</tr>
<tr>
<td>59409</td>
<td>Delivery only</td>
<td>607.68</td>
<td>607.68</td>
<td>687.89</td>
<td>687.89</td>
</tr>
<tr>
<td>59430</td>
<td>Postpartum Care only</td>
<td>99.08</td>
<td>109.17</td>
<td>112.16</td>
<td>123.58</td>
</tr>
<tr>
<td>59410</td>
<td>Delivery w/ postpartum care</td>
<td>704.66</td>
<td>704.66</td>
<td>797.68</td>
<td>797.68</td>
</tr>
</tbody>
</table>
Incentives

• Support from local CCNC network

• Exemption from medical necessity on prior approval for ultrasounds:
  – 76801, 76802, 76805
  – 76810-76821
  – 76825-76828
Ultrasound Guidelines

- All Ultrasoundscan only be registered with MedSolutions.
- Wait 48 hours before billing.
- All other high tech imaging still requires prior approval.
- Procedure codes 76811 and 76812:
  - Providers must meet one of the following criteria:
    - Certified with the American Institute of Ultrasound Medicine (AIUM).
    - American College of Radiology (ACR) accredited practice.
    - Sub-specialty in Maternal Fetal Medicine Specialist (Perinatology) or Radiology.
Global Outcomes

- Decrease primary c-section rate
  - c-section rate at or below 20% by end of year 3 (SFY12)
- Decrease the rate of low birth weight and very low birth weight babies delivered
  - 5% improvement in very low birth weight and low birth weight by end of year 3
  - 10% improvement in very low birth weight and low birth weight by end of year 4
Priority Risk Factors

- History of preterm birth (<37 weeks)
- History of low birth weight (<2500g)
- Multiple gestation
- Fetal complications
- Chronic conditions which may complicate pregnancy (diabetes, HIV, substance abuse diagnosis, sickle cell, etc)
- Unsafe living environment (homelessness, violence, etc)
- Substance use
- Missing two or more prenatal appointments without rescheduling
- Inappropriate hospital utilization (Emer. Dept/Labor & Del triage visits by pregnant woman with no prenatal care provider)
MMIS Changes

• 3 PMH date segments will be displayed on the P1 and P6 browser screens

• Claims will be identified as PMH or non-PMH on the PD browser screen
  – PMH indicator will be at the claim detail level

• PMH indicator on the claim detail will be sent to Drive on the claims file
# P1 Screen Layout

## Most Recent Action/Reason Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>51</td>
<td>10/29/2010</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>[View History]</td>
</tr>
<tr>
<td>50</td>
<td>10/29/2010</td>
<td>10/29/2010</td>
</tr>
<tr>
<td>51</td>
<td>08/28/2009</td>
<td>10/28/2010</td>
</tr>
</tbody>
</table>

## DSH Eligibility

<table>
<thead>
<tr>
<th>DSH Eligibility</th>
<th>DSH Effective Date</th>
<th>DSH End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>10/01/2009</td>
<td>12/31/9999</td>
</tr>
</tbody>
</table>

## Operation Code

<table>
<thead>
<tr>
<th>Operation Code</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 7</td>
<td>10/01/2005</td>
<td>12/31/9999</td>
</tr>
</tbody>
</table>

## Type, Specialty, Effective Date

<table>
<thead>
<tr>
<th>Type</th>
<th>Specialty</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>060</td>
<td>079</td>
<td>07/01/1977</td>
</tr>
<tr>
<td>062</td>
<td>079</td>
<td>00/00/0000</td>
</tr>
</tbody>
</table>

## Locality: 00 District: 95 County: 066 Pay Cycle: 50 PSRO: 08

## Acute # of Beds: 316 Long Term # of Beds: 0

## Group Number: Group Name:

## Total Related Provider Nbrs.: 0 Attending Provider Number Required: No

## School Based Health Care Indicator: No School Based Health Care Sponsor Number:
# Screen Layout

## PMH History

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>End Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2010</td>
<td>12/31/2010</td>
<td></td>
</tr>
<tr>
<td>07/01/2009</td>
<td>12/31/2009</td>
<td>Inactive</td>
</tr>
<tr>
<td>01/01/2009</td>
<td>03/15/2009</td>
<td></td>
</tr>
</tbody>
</table>

## Electronic Funds Transfer Information

<table>
<thead>
<tr>
<th>ABA Number</th>
<th>Bank Account Number</th>
<th>Bank Account Type</th>
<th>Bank Account Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>053101121</td>
<td>000510138559</td>
<td>Checking</td>
<td>2 - Active</td>
</tr>
</tbody>
</table>

## Exception Indicators

<table>
<thead>
<tr>
<th>B</th>
<th>E</th>
</tr>
</thead>
</table>

## Internal Revenue Service Information
Pregnancy Care Management (PCM)
MCC Program Changes

- Receive a Per Member Per Month (PMPM); no longer Fee for Service (FFS) model
- Focus on high risk pregnant women
- Services based on level of need
- More intensive services to fewer pregnant women
Transition of Current MCCP Clients

- **February** – Notification sent to all current MCCP clients by DMA. MCCs to reinforce information on transition during monthly contacts.
- **March** – Pregnancy Care Managers to complete Pregnancy Assessments on all current MCCP clients and provide ongoing PCM services based on client need and status.
Collaboration with local CCNC Network

- Work with the local CCNC network Pregnancy Home OB Coordinator to ensure program goals are met.
- Review and monitor CCNC and/or NCCCN, Inc. reports created for the PMH program to determine individuals at greatest risk.
- Communicate with local CCNC network regarding challenges with cooperation and collaboration with PMH and non-PMH prenatal care providers.
Outcome Measures

Ensure the following measures are met and reported:

• Increase the pregnancy risk screenings entered into CMIS by 3% annually until achieving a rate of 95%.

• Increase the number of pregnant women meeting CCNC priority criteria who receive the pregnancy assessment by 3% annually until achieving 95%.
Outcome Measures (cont.)

- Increase the post partum visit rate 3% annually for patients who receive pregnancy care management services or whose infant was admitted to the NICU.

- Increase percent of women who receive 100% of the 17P injections they are eligible to receive by 5% annually until achieving a rate of 90%.

- Increase the percent of PMH patients, who receive pregnancy care management services, referred for Family Planning Waiver or full Medicaid coverage until achieving 95%.
Notice to Recipients

February 15, 2011

Re: Maternity Care Coordination Program Changes
Dear Maternity Care Coordination Program Participant:

As of March 1, 2011, the Maternity Care Coordination Program will change to a new service called Pregnancy Care Management (PCM). The current Maternity Care Coordination Program will end as of February 28, 2011. The Pregnancy Care Management Program, just like the Maternity Care Coordination Program, is designed to help you have a healthy pregnancy and a healthy baby. PCM services will be provided by a Pregnancy Care Manager working at your local health department or other provider agency just as they are now. To receive Pregnancy Care Management services you do not need to do anything at this time. Your Pregnancy Care Manager will contact you beginning in March to discuss your current and ongoing medical and community referral needs. They will establish a plan of care and a schedule of contacts with you based on your individual situation. The Pregnancy Care Managers will be working closely with your doctor to make sure that you are able to keep your medical appointments and follow your doctor’s medical advice.

For more information or to answer any questions you have about the program, please call your current Maternity Care Coordinator.

Sincerely,

Tara R. Larson
Chief Clinical Operating Officer
Division of Medical Assistance
Care Coordination for Children (CC4C)
CSC Program Changes

• No longer Targeted Case Management; Population Care Management Model
• Focus on neediest children and those that are high cost/high users
• Funding no longer FFS; CC4C Providers will receive a PMPM for services
• Services provided are based on level of need
Transition to CC4C Services

• February - Notification sent to all current CSC clients by DMA.
• February - CSCs will inform families of written notice and review information
• March and April - Assess current CSC clients and new referrals to the program using new assessment tools
Notice to Recipients
February 15, 2011
Re: Child Service Coordination Program Changes
Dear Child Service Coordination Program Participant:

As of March 1, 2011, the Child Service Coordination (CSC) Program will change to a new service called Care Coordination for Children (CC4C). The current CSC Program will end as of February 28, 2011. The CC4C Program, just like the CSC Program, will help you and your family to improve health outcomes. CC4C services will be provided by a CC4C Care Manager working at your local health department or other provider agency just as they are now.

To receive CC4C Care Management services you do not need to do anything at this time. Your CC4C Care Manager will contact you starting in March to discuss your current and ongoing medical and family needs. They will establish a plan of care and a schedule of contacts with you based on your individual situation. The CC4C will be working closely with your doctor to make sure that you are able to keep your medical appointments and follow your doctor’s medical advice.

For more information or to answer any questions you have about the program, please call your current Child Service Coordinator.

Tara R. Larson
Chief Clinical Operating Officer
Division of Medical Assistance
Target Population

• Children ages 0 up to 5 years old with:
  - Special health care needs
  - Increased risk or has a chronic physical, behavioral or emotional condition and also requiring health and related services of a type and amount beyond that required by children generally
  - exposed to toxic stress in early childhood including, but not limited to extreme poverty in conjunction with continuous family chaos, recurrent physical or emotional abuse, chronic neglect, severe and enduring maternal depression, persistent parental substance abuse, or repeated exposure to violence in the community or within the family
  who are in the foster care system
  high cost/high user of services
Outcomes

• Increase rate of first visits by NICU (Neonatal Intensive Care Unit) graduates within 1 month of discharge
• Increase rate of comprehensive assessments completed for children/families with a priority risk factor
• Decrease number of hospital admissions, readmissions and ED visits
Outcomes

• Increase number of infants ≤ 1 year of age referred to (Early Intervention) EI

• Increase number of children who have a medical home who are:
  - Children with special health care needs, and/or
  - Children in foster care
What to do with Calls

• PMH Provider Questions:
  - Refer to Local CCNC Network
• PMH Recipient Questions:
  - Refer to DMA Managed Care - 919-855-4780
• Pregnancy Care Management (MCC):
  - Refer them to their current PCM
• Care Coordination for Children (CSC):
  - Refer them to their current Care Manager
# CCNC Local Networks Contact Information

<table>
<thead>
<tr>
<th>Name of Network</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access Care, Inc</td>
<td>919-380-9962</td>
</tr>
<tr>
<td>Access II Care of Western NC</td>
<td>828-348-2818</td>
</tr>
<tr>
<td>Access III of Lower Cape Fear</td>
<td>910-763-0200</td>
</tr>
<tr>
<td>Carolina Collaborative Community Care</td>
<td>910-485-1057</td>
</tr>
<tr>
<td>Carolina Community Health Partnership</td>
<td>704-484-5216</td>
</tr>
<tr>
<td>Community Care of Wake and Johnston Counties</td>
<td>919-792-3626</td>
</tr>
<tr>
<td>Community Care Partners of Greater Mecklenburg</td>
<td>704-512-2289</td>
</tr>
</tbody>
</table>
## CCNC Local Networks Contact Information

<table>
<thead>
<tr>
<th>Name of Network</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Care Plan of Eastern Carolina</td>
<td>252-847-7476</td>
</tr>
<tr>
<td>Community Health Partners</td>
<td>704-853-5069</td>
</tr>
<tr>
<td>Northern Piedmont Community Care 4 County Community Care</td>
<td>252-436-1051</td>
</tr>
<tr>
<td>Northern Piedmont Community Care Durham Community Health Network</td>
<td>919-613-6529</td>
</tr>
<tr>
<td>Northwest Community Care Network</td>
<td>336-716-5654</td>
</tr>
<tr>
<td>Partnership for Health Management</td>
<td>336-235-0930</td>
</tr>
<tr>
<td>Sandhills Community Care Network</td>
<td>910-246-9806</td>
</tr>
<tr>
<td>Southern Piedmont Community Care</td>
<td>704-403-1516</td>
</tr>
</tbody>
</table>
Are there any QUESTIONS?