The Pregnancy Medical Home:
Use of the Power of the Medicaid Program to Improve the Standard of Care Across North Carolina

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The Pregnancy Medical Home (PMH) is a value-added, quality metrics–driven clinical program to improve the perinatal outcomes for pregnant women across the state of North Carolina. The PMH uses modest financial incentives to improve access to care, in a team approach led by obstetricians and supported by integrated aggressive care and case management.

North Carolina Medicaid is a major payer for obstetrical services in the state. In 2009, there were 126,785 live births in North Carolina [1]. The state Medicaid program covered the cost of 71,067 (56%) of these births. More than 11% of deliveries covered by North Carolina Medicaid involve infants with a low birth weight (ie, <2,500 g), which puts these newborn citizens at increased risk for complications throughout life [2]. The social and financial burden on the families of these children and on the state Medicaid program, for neonatal intensive care, social support, and rehabilitative services, is astronomical (according to unpublished data from the North Carolina Division of Medical Assistance, the total cost for neonatal intensive care stays in 2009 was more than $223 million for approximately 21,000 claims). Medicaid's Pregnancy Medical Home (PMH) initiative builds off the work of many other concerned clinical providers, to bring useful change and clinical improvement to the pregnant women and their newborn children across the state.

The PMH model is a value-added clinical program that applies the work of the Perinatal Quality Collaborative of North Carolina (PQCNC), in combination with the ideas of other thoughtful clinicians, to address the concerns about the state's increasing cesarean section (C-section) frequency and stubbornly high perinatal mortality rate, both of which are greater than those of other states [1]. The PQCNC's work with hospitals across North Carolina to reduce the number of elective inductions before 39 weeks and their data-driven encouragement to use 17 alpha hydroxyprogesterone caproate (17P) to reduce the incidence of prematurity are important elements of the PMH model. The PQCNC work to address the overuse of C-section deliveries is also complementary to what the PMH initiative expects to accomplish in the program [3]. The PMH program operationalizes these important clinical initiatives at the practice level, through outcome-driven metrics and financial incentives.

A value-added clinical program uses outcomes as the primary measure of success. PMH members receive a financial incentive to produce specific clinical outcomes. The quality outcome–driven metrics for clinical care are as follows: completion and integration of an obstetrical high-risk tool, reduction in the primary C-section rate to 20% or less, full clinical application of 17P in the treatment of premature labor and prematurity, and no elective induction of labor before the 39th week of gestation. Additionally, obstetricians are expected to integrate care/case managers as clinical partners in managing complicated cases. This concept turns case management right side up by expanding simple telephonic case management to a more clinically aggressive, in-the-home/on-the-street style of patient support. PMH providers will also receive some relief from prior authorization for obstetrical ultrasonography; however, the clinical imaging study will still require online registration to facilitate payment.

Each PMH is locally managed through joint agreements between the local provider, Community Care of North Carolina (CCNC), and the local health department care/case management group. Payment for the obstetrical provider is managed through an enhanced fee-for-service arrangement, with incentives based on full cooperation in the coordinated care program and outcome-driven metrics.

Care/case managers are paid on a per-member per-month arrangement, with the population of childbearing women as the denominator of the equation. The objective of using this population base is to have the care/case management group proactively seek out pregnant women in the community population to be enrolled early with an obstetrical provider. Local health departments have outcome met-

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rics that measure their effectiveness at the local level. Care/case managers also have accountability measures, which include increasing the number of pregnant women with positive risk-screen findings (ie, risk factors associated with adverse pregnancy outcomes) who enter the case management system by 3% annually, until a rate of 95% is achieved; increasing the number of pregnant women meeting CCNC priority criteria who undergo risk screening by 3% annually, until a rate of 95% is achieved; increasing the postpartum visit rate by 3% annually for patients who receive pregnancy care management services or whose infant was admitted to the neonatal intensive care unit; increasing the percentage of women who receive the 17P injections they are eligible to receive by 5% annually, until a rate of 90% is achieved; and increasing the percentage of PMH patients who receive pregnancy care management services, are referred for a family planning waiver, or receive full Medicaid coverage, until a rate of 95% is achieved. All of the selected quality metrics are tracked by the local provider, using claims data and chart surveillance. The local Area Health Education Center program provides annual in-office/clinic chart reviews to confirm the quality standards for each provider.

The PMH concept is a financially neutral program for the state. There is no new money in the program, and any enhanced payment to obstetrical providers is derived from the savings created by providing a higher standard of obstetrical care, by reducing any unnecessary care, and by converting obstetrical care into a clinically driven team process. There is no consideration in the PMH financial model of the subsequent future savings generated by reducing obstetrical complications and prematurity, or that created by delivering healthier newborn infants. This collateral benefit will eventually be seen in the reduced clinical damage to fewer premature children and the reduced subsequent health care costs that they would potentially incur.

The PMH model leverages the well-proven medical-home concept developed by CCNC during the past 15 years. The CCNC partnership with local primary care providers, local hospitals, and community-based health departments sets the pattern for the local management of obstetrical care through the PMH process. The introduction of the PMH is designed to bring more qualified obstetrical providers into this clinically driven medical-home system, as well as to improve obstetrical care standards across the state, as it moves the Medicaid program closer to its stated goal of being a value-added organization.

Porter and Teisberg [4p155] consider value as "health outcomes achieved per dollar of cost compared to peers." Just being competent is not enough. Value is delivering superior clinical results in a transparent environment where clinical data are shared and are mutually considered. Success can no longer be measured by income or by the volume of patients processed. In fact, there is sufficient evidence to suggest that patient value "can only be measured at the level of medical conditions" [4p155], as it is "assessed relative to peers" [4p156]. Balance in health care delivery is not achieved by comparing one competent, high-quality provider with a mediocre provider. Philosophically and practically, balance is achieved when all providers in a system of care achieve a high level of performance, generally in the 95th percentile [4].

The value-added PMH model does not ignore the financial impact on the provider or the state. In fact, the program demonstrates that Medicaid can pay the obstetrical providers a higher rate for obstetrical services because the outcome-driven metrics "pull" clinical improvements along. Limiting C-section costs, reducing neonatal intensive care expenses, and capturing savings by restraining collateral damage from poorly managed pregnancies will more than cover the modestly increased rate (unpublished financial projections from the North Carolina Division of Medical Assistance estimate $1.5 millions in savings for fiscal year 2012 and $9.9 million in saving for fiscal year 2013). More importantly, every thoughtful practitioner knows that, by keeping a pregnancy closer to normal, the newborn will be better off now and in the future. It then becomes clearer how, by using the power of the Medicaid program, we will improve the standard of care across North Carolina. NCMJ

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