

Community Care of North Carolina

Template for an Agreement between the Community Care of North Carolina Network's Administrative Entity and Providers Participating in the Network as a Pregnancy Medical Home

THIS AGREEMENT is entered into as of _____ (date) between the _____ (Community Care of North Carolina Network Name), whose principal office is located in the City of _____, County of _____, State of North Carolina, hereinafter referred to as the "Network" and

(name of participating provider / practice)

located in the city of _____, county of _____, State of North Carolina or _____, hereinafter referred to as the "Participant".

WHEREAS, the Network has entered into an agreement with the Department of Health and Human Services, the Division of Medical Assistance, to participate in Community Care of North Carolina, a Medicaid population management program; and

WHEREAS, Community Care of North Carolina is a population management program that is designed to build on Carolina ACCESS by assisting local providers to develop organized managed care systems that coordinate the full continuum of care with processes to influence cost and quality of care; and

WHEREAS, the Participant, a licensed, qualified private physician or private or public clinic organized for the delivery of obstetrical care, employs or contracts for the services of health care providers duly licensed in the State of North Carolina and wishes to participate and cooperate with the Network in the development and implementation of a pregnancy home initiative that will positively impact the cost and quality of providing health care to pregnant Medicaid recipients.

NOW, THEREFORE, it is agreed between the Network and the Participant, as follows:

Section 1 – General Statement of Purpose and Intent

Community Care of North Carolina is a population management program that involves testing reimbursement methodologies, building care management support systems, and implementing network development efforts. Community Care offers a fee-for-service model with incentive payments for pregnancy home providers. Providers are expected to achieve performance goals and benchmarks through the application of best practices and evidence-based maternity care. Community Care of North Carolina is implementing an initiative to improve birth outcomes through networks which have demonstrated the capacity to do the following for enrolled Medicaid recipients:

- develop a pregnancy home program to target needed services to all pregnant Medicaid patients with a focus on those at risk for poor birth outcome;

- develop care management systems in partnership with the Network, and entities engaged by the network to provide pregnancy case management, to manage pregnancy-related services and to target pregnant patients at risk of poor birth outcome;
- promote improved care coordination strategies, including population stratification, universal risk screening of pregnant patients to identify a target population, and appropriate follow up of patients with risk factors for poor birth outcome;
- implement quality improvement (QI) initiatives and participate in program-wide QI activities related to maternity care;
- focus on high cost and high risk pregnant Medicaid enrollees; and
- ensure coordination of care with primary care providers as appropriate to manage chronic illnesses among pregnant patients.
- participate in a chart auditing process when appropriate to evaluate performance metrics.

This Agreement describes the terms and conditions under which the agreement is made and the responsibilities of the parties thereto.

Section 2 – General Statement of the Law

Community Care of North Carolina is a community-based care management plan implemented by the Division of Medical Assistance under Title XIX of the Social Security Act, and is subject to the provisions of North Carolina Statutes and North Carolina Administrative Regulations.

Section 3 – Functions and Duties of the Participant

The Participant agrees to do the following:

3.1. Cooperate with the Community Care of North Carolina Network in the development and utilization of evidence-based and best practice approaches to comprehensive, coordinated maternity care through the Pregnancy Home program. Such cooperation shall include:

- the identification of a “practice champion” for the Pregnancy Medical Home Program;
- identification of all providers of obstetric care at this practice (See Exhibit C of this Agreement)
- active participation at meetings detailing pregnancy-related initiatives, expectations, and performance, as requested by the network;
- communication and cooperation with community-based providers of pregnancy case management services;
- the provision of clinical information necessary to establish effective case management processes for the provision of cost-effective and quality health care (subject to all applicable requirements regarding confidential medical information);
- facilitating early entry into prenatal care;
- screening of all pregnant patients at the first OB visit to identify those at increased risk for poor birth outcome;
- provision of twenty-four hour phone consultation/triage for pregnant patients;
- conducting an evidence-based postpartum visit that incorporates best practices, including but not limited to:
 - Postpartum depression screening using a validated screening instrument;
 - Reproductive life planning, and

- Ensuring the patient is connected to a primary care medical home, if the patient is eligible, the Family Planning Waiver, and/or other available health services to promote interconception health
- provision of information about prenatal self-management (Healthy Mom, Healthy Baby book and other materials) and how to obtain the following benefits: WIC, MPW and Family Planning Waiver to all pregnant Medicaid patients.

3.2. Network involvement:

- Become an affiliate member of the local Community Care Network, including participation on appropriate Network committees.
- Participate, as requested by the Network, in interdisciplinary teams to help manage and optimize care of those pregnant patients at highest risk and cost.
- Comply with the policies and procedures developed by the Network's Medical Management Committee and/or Steering Committee that aim to effectively manage the quality, utilization, and cost of services, including but not limited to the following:
 - Inpatient admissions for antepartum patients;
 - Emergency room visits for pregnancy-related care;
 - Use of labor and delivery triage visits;
 - High-risk pregnancy care; and
 - Neonatal admission for intensive care.
- Work with the Network's clinical leadership, including the OB physician champion and OB coordinator, to review utilization data and identify opportunities for improvement in order to achieve program goals.

3.3. Risk Screening:

- Cooperate with the Network's patient risk screening process to identify and track those Medicaid recipients that would most benefit from pregnancy case management activities, and refer those at risk for poor pregnancy outcome to the pregnancy case management program.
- Complete standardized risk screening using the Pregnancy Risk Screening Form at the first prenatal care visit in order to allow the earliest possible intervention for high-risk patients and submit risk screening information to the local pregnancy care management provider within seven days.
- Provide risk screening information to the Network via the pregnancy case manager covering this Practice in a timely manner (within one week), including initial risk screening, any changes resulting from mid-pregnancy rescreening, or risk factors identified at any point during the pregnancy.

3.4. Integration of case management:

- Authorize and coordinate with the community-based pregnancy case managers in carrying out the case management activities targeting Medicaid recipients receiving maternity care from the Participant.
- Cooperate and coordinate services with entities providing pregnancy case management to patients served by the PMH, including referring patients at risk for poor pregnancy outcome to the case manager assigned to this Practice and sharing clinical information with the case manager.
- Identify and implement approaches to integrate the pregnancy case manager within the PMH care team to ensure coordination of care and facilitation of communication. This includes having clinical team members available by phone for case management consultation, communication and answering case managers' questions about the clinical care plan, and providing updates to the case manager when changes occur to the patient's clinical status or care plan.

3.5. Measurement:

- Adhere to performance measures specified by the Division of Medical Assistance for Pregnancy Medical Homes as described in the contract between Community Care and DMA, attached as Exhibit A of this Agreement.
- Allow access to medical records of Medicaid patients of this Practice for annual audit by Community Care or the local AHEC functioning as Community Care's auditing agent for network-based quality improvement initiatives, which will be determined through a collaborative process through local networks and the practices that are affiliated with the network. Auditing by DMA Program Integrity is separate and not affected by the Pregnancy Home Initiative.
- Review and use reports generated by Community Care related to utilization and performance measures.

3.6. Access to and coordination of care:

- Have a provider, such as a physician, physician assistant, nurse practitioner, certified nurse midwife, or enhanced role nurse, available at each practice site to see scheduled and non-scheduled patients a minimum of 30 hours per week (a clinician able to triage the patient if the prenatal care provider is not present during those hours).
- Provide a clear policy describing where and how patients should seek medical assistance when the practice is closed.
- For those participants not offering intrapartum care, develop agreements, within one year of becoming a pregnancy home, with the entities that provide this care to recipients receiving maternity care from the Participant, to ensure optimal coordination of care, availability of medical records at the time of delivery, and appropriate transition to and from the intrapartum care provider. When becoming a pregnancy home, these practices will need to describe their current arrangements for coordinating care with the intrapartum care provider.

3.7 Nothing in this Agreement shall interfere with or supersede Participant's obligation to provide health care services to Medicaid recipients under separate agreement with the Division of Medical Assistance.

<p style="text-align: center;"><i>Section Four – Duties and Responsibilities of the Community Care of North Carolina Network</i></p>

The Network agrees to do the following:

- 4.1 Enroll practices to serve as Pregnancy Medical Homes and provide information about newly enrolled practices to the Division of Medical Assistance so that Participants are eligible to receive enhanced and incentive payments associated with this model of care, as described in Exhibit B of this Agreement.
- 4.2 Provide training and technical assistance regarding the Community Care of North Carolina pregnancy home program to participating practices when required.
- 4.3 Engage an "OB team" consisting of a physician champion and nurse coordinator in each Community Care network to serve as the primary liaisons for PMHs, pregnancy case management entities and community partners working with the pregnant Medicaid population.

- 4.4 Employ or contract with local case management entities to provide Pregnancy Case Management services as described above to Medicaid patients at risk for poor pregnancy outcome residing in the counties covered by that network.
- 4.5 Ensure that new PMHs are connected to the Pregnancy Case Management program and that a Pregnancy Case Manager is assigned to each PMH.
- 4.6 Ensure that, in concert with participating Practices and providers of Pregnancy Case Management, global performance measures and specific performance targets for both PMH and Pregnancy Case Management are achieved in the specified timeframes.
- 4.7 Develop and implement quality improvement activities, in concert with participating Practices and providers of Pregnancy Case Management, using data from the PMH and Pregnancy Case Management programs.
- 4.8 Monitor the performance and processes of PMHs within the network using reports generated from administrative, case management and chart audit data to identify and disseminate best practices and to identify and address outlier practices whose performance does not meet program standards.
- 4.9 Work directly with PMH practices that are not achieving program goals to provide education and identify strategies to improve outcomes.
- 4.10 Include PMH representatives in existing local CCNC network committees and/or in newly developed committees focusing on the care and management of the pregnant population.
- 4.11 Provide consultation and technical assistance regarding clinical issues affecting the care and case management of pregnant patients.
- 4.12 Provide or arrange for topic-oriented continuing education for PMHs regarding best practices and emerging evidence in maternity care as well as program procedures and processes.

Section Five – General Terms and Conditions

- 5.1 Audit: The Community Care of North Carolina Program and Network retains the right to periodically audit the Participant's information and medical records of Medicaid recipients as may reasonably be necessary to review Participant performance relative to the Community Care of North Carolina Program's goals and objectives, and other reasonable, necessary and appropriate purposes during the term of this Agreement and in accordance with state and federal law.
- 5.2 Non-Discrimination: The Participant shall comply with all applicable federal and state laws which prohibit discrimination on the grounds of race, creed, sex, religion, national origin, or physical or mental handicap.
- 5.3 Transfer of Agreement: This Agreement may not be transferred.
- 5.4 Contract Termination: This Agreement may be terminated under the following conditions:

- 5.41 Automatically upon termination for any reason of the Agreement between the Community Care of North Carolina Network, North Carolina Community Care Networks, Inc., and the Division of Medical Assistance;
- 5.42 Upon the Participant's failure to comply with Community Care of North Carolina Network policies and procedures; or
- 5.43 Upon the Participant's failure to identify and work on improvement opportunities to achieve the performance measures and program goals; or
- 5.44 By either party, with cause, upon at least thirty (30) days notice, in writing, and delivered by registered mail with return receipt requested or in person, except that a Participant may terminate participation effective only on the first day of each month; or
- 5.45 As to any health care provider employed or under contract by Participant, immediately upon a revocation of such employee's or contractor's license to practice medicine in the State of North Carolina, a revocation of a such employee's or contractor's certification as a participating provider under Title XIX (Medicaid) of the Social Security Act, and / or Cancellation of a such employee's or contractor's Liability Insurance; or
- 5.46 By mutual consent of both parties; or
- 5.47 By either party for any reason upon ninety (90) days written notice to the other party.

5.5 Supplements: No supplements, modifications or amendments of this Agreement will be binding unless executed in writing by both parties.

Section Six – Effective Date and Duration

This Agreement shall become effective on _____ and remain in effect until amended or terminated pursuant to the terms of this Agreement. If signed before the 19th day of the month, it will become effective on the first day of the following month. If signed on the 19th day of the month or later, the Agreement will become effective on the first day of the following month but claims will need to be held until the 15th day of that month. Any termination will take effect on the first day of the following month.

Section Seven -- Counties served by the PMH

While patients may choose to seek pregnancy-related care from a Practice regardless of its geographic location, this model will seek to connect patients with a local PMH at the time of their application for Medicaid coverage, if they are seeking coverage specifically for pregnancy. DMA will work with each county's Department of Social Services (DSS) to ensure the maintenance of a directory of PMH practices in that county and in the region that have identified themselves as available to patients residing in that county.

The counties listed below are those for which this Practice will be listed in the DSS directory of PMH providers:

Section Eight – Signatories

Community Care of North Carolina Network

*Pregnancy Home Affiliate Member
of Community Care*

(Signature – Authorized Official)

(Signature – Authorized Official)

(Title)

(Title)

(Date)

(Date)

(Mailing Address)

Exhibit A. Performance measures for the pregnancy home

Pregnancy Medical Home performance indicators
<p>1. <u>Measure</u>: Rate of elective deliveries <39 weeks (as a percentage of all deliveries between 37.0-38.6 weeks) <u>Goal</u>: Eliminate elective deliveries performed between 37.0-38.6 weeks <u>Objective</u>: Reduce rate of elective delivery between 37.0-38.6 weeks by 5% annually until achieving a rate at or below 3%. Maintain or decrease below 3% in subsequent years. <u>How to measure</u>: The Joint Commission has developed an algorithm using diagnosis codes to determine which deliveries are elective. Data will need to be drawn from the birth certificate and claims to capture the population who delivered between 37.0-38.6 weeks and then to determine if the delivery was scheduled (induction or cesarean section) and elective.</p>
<p>2. <u>Measure</u>: Percent of patients who received pregnancy risk screening <u>Goal</u>: 95% of patients will receive risk screening. <u>Objective</u>: Increase percent of patients receiving risk screening by 5% annually until achieving a rate of 95%. Maintain or exceed 95% completion of risk screening in subsequent years. <u>How to measure</u>: Claims submitted for risk screening incentive payment/claims submitted for prenatal care</p>
<p>3. <u>Measure</u>: Percent of eligible patients who initiated 17P <u>Goal</u>: An appropriate percentage of eligible patients will initiate 17P treatment. The target level will be establishing following an initial year of baseline data collection to establish a rate of patients offered 17P who choose to initiate treatment. <u>Objective</u>: Determine the baseline rate of patients who initiate 17P in the first fiscal year. Increase by 5% annually up to the target level. <u>How to measure</u>: Risk screening data in CMIS will indicate if the patient is eligible. If the patient initiated 17P, that will be entered in CMIS by the case manager.</p>
<p>4. <u>Measure</u>: Primary c-section rate (of the practice) <u>Goal</u>: Maintain primary cesarean delivery rate at or below 20%. <u>Objective</u>: Decrease primary cesarean delivery rate by 5% annually until at or below 20%. Maintain or reduce further in subsequent years. <u>How to measure</u>: AHRQ has created an algorithm using diagnosis codes.</p>

Exhibit B. Enhanced compensation for Participants (Obstetric care practices serving as Pregnancy Medical Homes)

1. Incentive payment for completing the initial Pregnancy Risk Screening Form:
\$50 per completed form, billed using CPT code S0280 (Refer to NC DMA Clinical Coverage Policy #1E-6)
2. Incentive payment for completing the postpartum visit, including the required components listed above (depression screen, reproductive life plan, referral for ongoing clinical care):
\$150 (Refer to NC DMA Clinical Coverage Policy #1E-6)
3. Enhanced rate of reimbursement for vaginal delivery:
13% increase in reimbursement rate for procedure codes reflecting obstetric care (global and package codes reflecting antepartum, delivery and/or postpartum care; see NC DMA Clinical Coverage Policy #1E-5).
4. Waiver of requirement to obtain prior authorization for OB ultrasound:
Participants will need to register OB ultrasounds with the DMA vendor, but prior authorization will not be required.

