Timeliness of Prenatal Care Guidance Document

Oregon Health Plan

Version 3, published July 2014

Updated to reflect 2014 measurement

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Introduction

The purpose of this document is to provide Coordinated Care Organizations (CCOs), Oregon clinics and administrative staff with guidance on improving the timeliness of prenatal care, including coding and billing information and details on the CCO Incentive Measure specifications for the first and second measurement years (CY 2013 and 2014). This document will be updated as appropriate to reflect the ongoing changes in policy and regulation.

Executive Summary

Prenatal care is important for the health of both the mother and the baby. Mothers who do not receive any prenatal care are three times more likely to deliver a low birth weight baby than mothers who received prenatal care, and infant mortality is five times higher.[1,2]

During prenatal care, health care providers monitor the health of the mother and baby and identify and treat health conditions and issues that could impact the pregnancy. It is also an important time for providers to educate mothers on a variety of health issues related to pregnancy, such as smoking, alcohol use, exercise, nutrition, preparing for childbirth, and infant care and feeding.

For CY 2013, the CCO incentive measure specifications focus on women who delivered a live birth and who received a prenatal care visit in the first trimester of pregnancy, or within 42 days of enrollment (if they enrolled after their first trimester).

For CY 2014, the CCO incentive measure is based on HEDIS® hybrid methodology and incorporates medical record review.

Denominator: All live birth deliveries from members of the CCO, who meet the continuous enrollment criteria and fall in the identified measurement time frame for the measurement year.

Numerator: A prenatal visit in the first trimester, or within 42 days of enrollment, depending on the date of enrollment in the organization and the gaps in enrollment during the pregnancy.

Note: The 2013 measure specifications include the global OB care CPT codes that have been allowed since July 2009.

1 Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services. Prenatal services. http://www.mchb.hrsa.gov/programs/womeninfants/prenatal.htm

2 Berg CJ. Pregnancy-related mortality in the united states, 1998 to 2005. Obstet Gynecol. 2010;116(6):1302.

Prenatal Care Overview

Early prenatal care is especially important to the health outcomes of mothers and their babies. Substantial fetal development takes place during the first trimester, and health assessments and screenings can identify babies or mothers at risk for complications. This period also represents a key opportunity for health care providers to educate and support mothers for later pregnancy and motherhood.

The early prenatal care CCO incentive measure is based on HEDIS® specifications and measures prenatal care provided in the first trimester of pregnancy or within 42 days of enrollment (if the member is enrolled after the first trimester). The 2013 benchmark for the CCO incentive measure is 69.4 percent and the 2014 benchmark is 90 percent, the 2013 national Medicaid 75th percentile using hybrid data.

In addition to the timing of prenatal care initiation, focus has been given to the adequacy of prenatal care in promoting healthy outcomes for women and their infants.[3] Prenatal care adequacy takes into account both the timing of initiation of prenatal care and the number of visits. However, measures of adequacy of care do not take into account the content or quality of care that is delivered. There is growing evidence that the quality of prenatal care is important in promoting good outcomes; however consensus regarding what constitutes quality prenatal care has not been achieved.[4]

The role of prenatal care in achieving both improved maternal and child outcomes directs attention to the importance of a Life Course Perspective, preconception and interconception health. The Life Course Perspective suggests that perinatal outcomes are determined by the entire life course of the woman prior to pregnancy, not just the nine months of pregnancy.[5] Preconception and interconception care are designed to assure that women are healthy before becoming pregnant, that pregnancies are planned or intentional, and that they are spaced at intervals that promote healthy birth outcomes for babies and good health for mothers.[6]

[3] Alexander, G.R., Kotelchuck, M. (2001).Assessing the role and effectiveness of prenatal care: History, challenges, and directions for future research.*Public Health Reports, 116*(4). 306-16.

[4] Sword**, W**. et al.Women's and care providers' perspectives of quality prenatal care: a qualitative descriptive study. BMC Pregnancy Childbirth. 2012 Apr 13;12:29. doi: 10.1186/1471-2393-12-29. http://www.ncbi.nlm.nih.gov/pubmed/22502640

[5] Lu M, Kotelchuck M, Hogan V, Jones L, Jones CP, Halfon N. Closing the black-white gap in birth outcomes: A life-course approach. Accepted for publication in Ethnicity and Disease. 2010

6 Moos MK et al. Healthier women, healthier reproductive outcomes: Recommendations for the routine care of all women of reproductive age. Am J ObstetGynecol 2008. Dec (6 Suppl 2): S 280-289.

Barriers to Prenatal Care

There are many possible reasons why women are not accessing prenatal care early in their pregnancy or upon enrollment in Medicaid.

- There are provider barriers to getting care early, such as providers who routinely do not start care until after the first trimester is completed, clinics who do not prioritize first trimester appointments in scheduling, and missed first prenatal appointments that are not rescheduled promptly. In addition, many health plans assign pregnant women to primary care providers who may not offer prenatal care services which adds to the time to find care.

- Women are ambivalent about being pregnant and need to sort through personal issues before deciding to get prenatal care.

- Women don't know that their primary care provider offers prenatal care, or they do not know where to find prenatal care in their community.

- Signing up for OHP is hard and time consuming (need financial documents, waiting to get assigned to a CCO and to a primary care provider).

Oregon PRAMS data from 2011 show that 15 percent of postpartum women could not get prenatal care as early as they wanted, and among women on Medicaid, 21 percent could not get prenatal care as early as they wanted. Among those women on Medicaid, the most frequently cited reasons for not getting care or early care were:

- I didn't have my Oregon Health Plan or Medicaid card (54.5%);
- I didn't have enough money or insurance to pay for my visits (50.5%);
- I couldn't get an appointment when I wanted one (41.9%);
- I didn't know I was pregnant (34%); and
- The doctor or my health plan would not start care as early as I wanted (30.8%).

Other reasons included lack of transportation, inability to take time off from work or school, no childcare, not wanting anyone to know about pregnancy, and too many other things occurring in their life.[7]

In another Oregon study, women who cited social/logistical barriers to care were the least likely to have early access to prenatal care.[8] These barriers included:

- Not realizing they were pregnant;
- Being younger than 18;

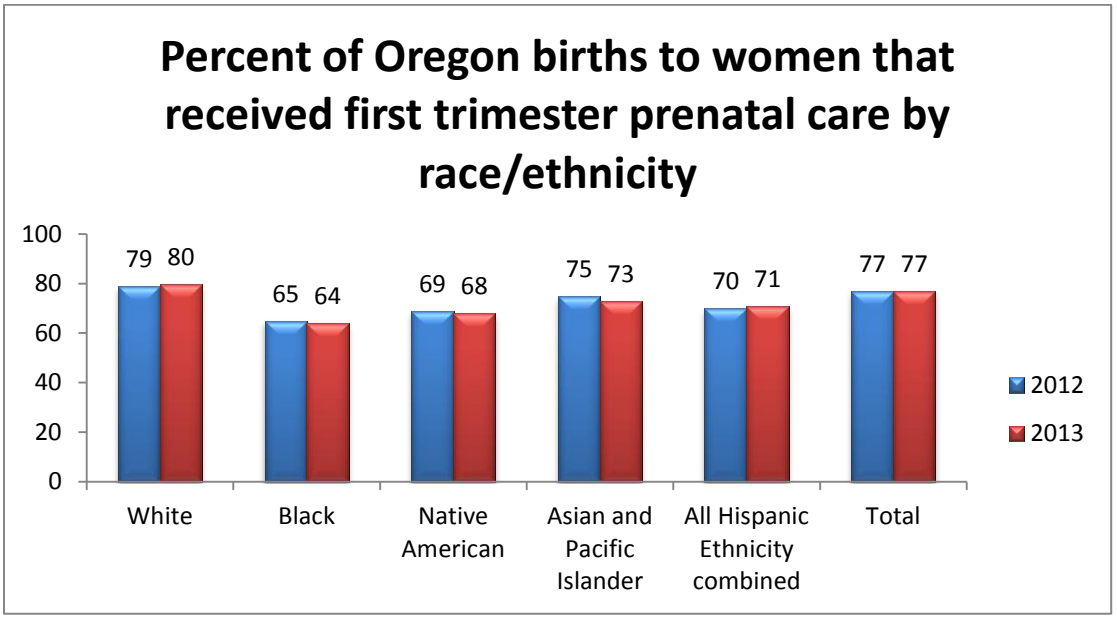
[7] Oregon Pregnancy Risk Assessment Monitoring System (PRAMS), 2011

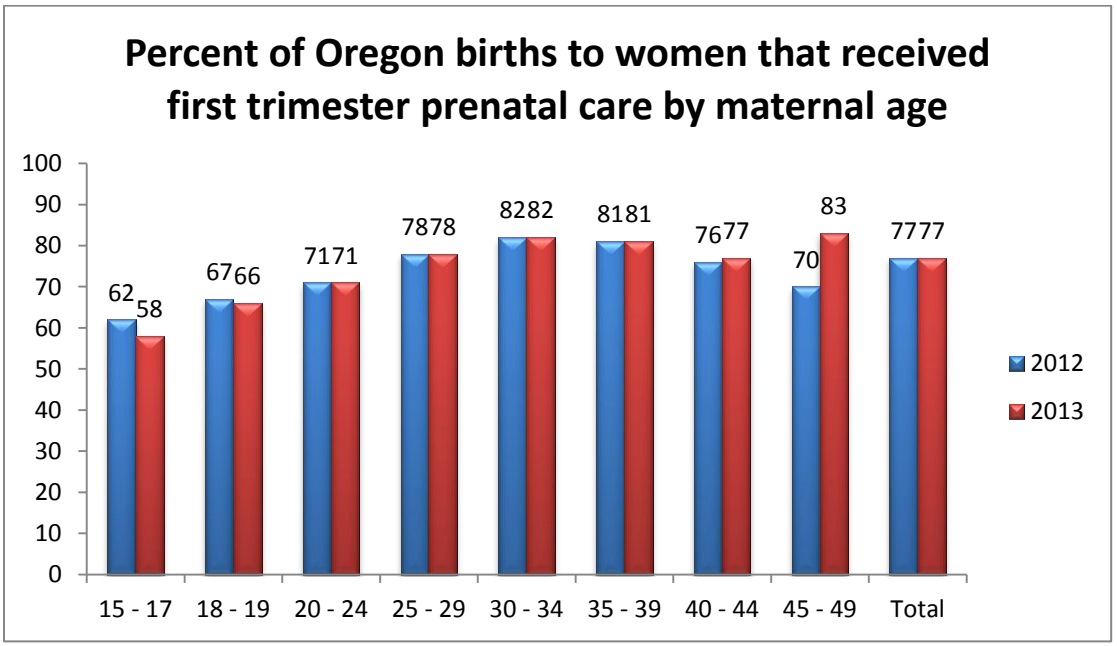
8 Epstein, B.; Grant, T.; Schiff, M.; Kasehagen, L. Does rural residence affect access to prenatal care in Oregon? *Journal of Rural Health*, Spring 2009. 25(2); 150-7.

- Unmarried;
- Having less than a 12th-grade education; and
- Either American Indian race or Latino ethnicity.

Prenatal Care in Oregon

In 2013, 77 percent of resident births in Oregon were to women who received prenatal care in the first trimester. However, 2012 and 2013 preliminary rates vary by race/ethnicity and maternal age.[9]



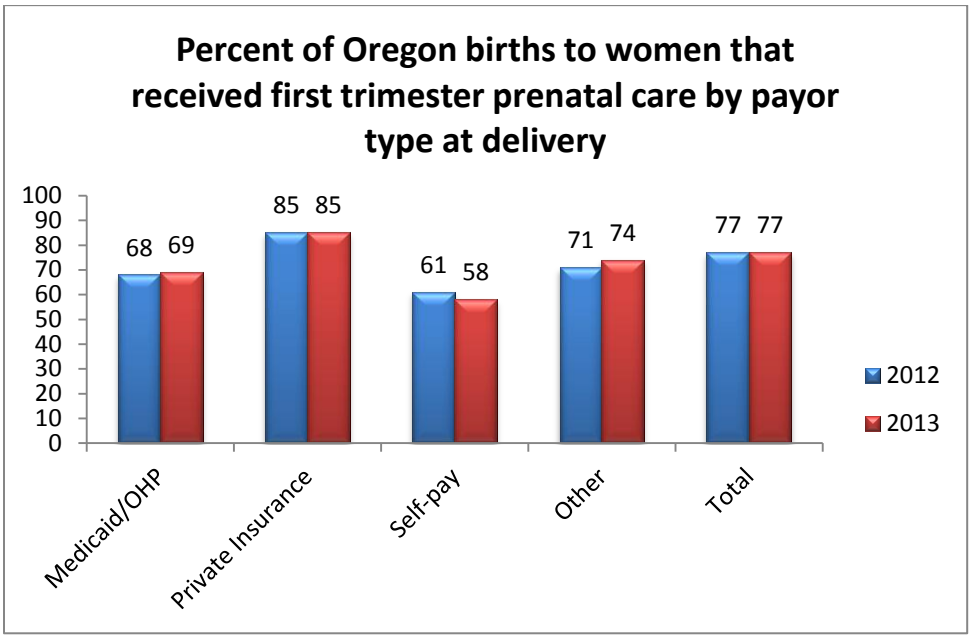


[9] Oregon Vital Statistics, 2012 final and 2013 preliminary rates

Prenatal Care and Medicaid

Medicaid currently finances a little more than 50 percent of Oregon births, which may increase with the 2014 Medicaid Expansion population. In 2013 to date, maternity case rate payments account for approximately 9-10 percent of CCO's total payment for Medicaid clients. We also know that in 2011, 18 percent of women were on the Oregon Health Plan before they conceived.[10]

First trimester prenatal care varies by payer type at delivery: women on Medicaid have a higher rate of first trimester prenatal care than women who are self-pay, but a lower rate than those women with private insurance and the state average.[11]



Until 2013, undocumented women in some Oregon counties had access to prenatal insurance coverage through the Oregon Health Plan, while those in other counties did not. The CAWEM (Citizen Alien Waiver Emergency Medical) program provides Medicaid coverage for emergency medical services for undocumented citizens. Labor and delivery coverage are included in CAWEM, although prenatal care is not covered. See Appendix B for more information on the CAWEM Plus program.

[10] Oregon Pregnancy Risk Assessment Monitoring System (PRAMS), 2011. http://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/prams/2011/Pages/prepins.aspx

[11] Oregon Vital Statistics, 2012 final and 2013 preliminary rates

Clinical Definitions

This section provides an overview of the key clinical definitions integral to the provision of timely prenatal care.

Adequacy of Prenatal Care – Adequacy of prenatal care can be defined in several ways. The number of total visits depends on when care began in the pregnancy. Calculations are often based on the Adequacy of Prenatal Care Utilization Index (APNCU), which measures the utilization of prenatal care on two dimensions. The first dimension, adequacy of initiation of prenatal care, measures the timing of initiation using the month prenatal care began, as reported on the birth certificate. The second dimension, adequacy of received services, is measured by taking the ratio of the actual number of visits reported on the birth certificate to the expected number of visits.[12]

First Trimester - First three months of pregnancy, from the first day of the last menstrual period through 13 weeks gestation.

Interconception Care - Interconception care addresses the continuity of maternal risk from one pregnancy to the next. Interconception care is conceptualized as a subset of preconception care.

Preconception Care – aims to promote the health of women of reproductive age before conception and thereby improve pregnancy-related outcomes. The main goal of preconception care is to provide health promotion, screening, and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies. Preconception care is part of a larger health-care model that results in healthier women, infants, and families.[13]

Preconception care is the only way to modify most conditions that result in adverse outcomes for pregnant women (diabetes, toxic exposures, neural tube defects from folic acid deficiency, teratogenic medications). By the time a woman knows she is pregnant, the harm to the fetus from many of these conditions has already occurred. This underscores the importance of preconception care as part of an overall strategy to reduce poor pregnancy outcomes.

Preterm – any neonate whose birth occurs through the end of the last day of the 37th week (259th day) following the onset of the last menstrual period.[14]

Post-term – any neonate whose birth occurs from the beginning of the first day (295th day) of the 43rd week following the onset of the last menstrual period.[15]

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12 http://www.marchofdimes.com/peristats/calculations.aspx?reg=&top=&id=23

[13] Recommendations to Improve Preconception Health and Health Care – United States: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. MMWR: Recommendations and Reports. April 21, 2006 / 55(RR06);1-23.

14 *Guidelines for Perinatal Care, Fifth Edition*, American Academy of Pediatrics and the American College of Obstetricians and Gynecologists

Prenatal Care Initiation – date of the first prenatal care visit.

Timing of Prenatal Care - Timing of prenatal care stratify the timing of the mother's entry into prenatal care into three categories. These categories include:

- "Early prenatal care," which is care started in the 1st trimester (0-13 weeks);
- "Second trimester care" (14-26 weeks); and
- "Late/no prenatal care," which is care started in the 3rd trimester (27-42 weeks) or no care received.

Calculations are based on the number of live births to mothers in a specific prenatal care category divided by all live births excluding those missing data on prenatal care, multiplied by 100.

Note that for the CCO incentive metric, timeliness of prenatal care is calculated for the first trimester, as well as within 42 days of enrollment.

15 Ibid.

Improving Timeliness of Prenatal Care

The following section includes strategies to improve the timeliness of prenatal care at both the CCO and practice level. Not all programs referenced are available across the state, so links have been provided for the most updated information.

Strategy 1: Overcome System Barriers that Prevent Women from Receiving Early Prenatal Care

The barriers described on page 5 above indicate that system issues are the number one reason women do not receive early prenatal care. They know they need it, they want to get it, but the top barriers include not being able to get their OHP card, not being able to pay for visits, and not being able to get appointments. While some of these barriers need to be addressed by OHA, addressing these system barriers is the most critical strategy CCOs can focus on for improving the timeliness of prenatal care.

(1) Streamline the process of OHP application and the first visit with a prenatal care provider.

CCOs can identify which of their primary care providers (PCP) offer prenatal care and which do not. When they assign women to a PCP that does not offer prenatal care, that assignment should be accompanied by a list of contracted prenatal care providers in the area.

(2) Provide proactive outreach from the CCO or from clinics to all women newly enrolled in Medicaid with pregnancy as their eligibility category (even women who are on Medicaid before pregnancy are supposed to inform their case worker if they become pregnant to switch their eligibility category).

CCOs can provide welcome calls to these newly enrolled women, or newly pregnant women, to inquire about their need for pregnancy-related services, and to inform them of clinics or providers in their area that are accepting clients. This would be a significant step to increasing timely enrollment in prenatal care.

Note some providers may not schedule appointments for pregnant women until they show up as eligible in MMIS.

(3) Ensure all clinicians are endorsing initiation of prenatal care before 13 weeks.

(4) First prenatal care visits in clinics should be high priority. Schedulers should be aware of the woman's estimated gestational age, and ensure that she has an appointment before 13 weeks. If the woman no-shows for that appointment, schedulers should fast-track her into the clinic via an outreach worker or case manager.

Strategy 2: Build Partnerships with Established Programs

Building partnerships with established programs that serve low-income, high-risk pregnant women can assist women accessing health insurance and a prenatal provider early in pregnancy. Recommended programs include:

Local Public Health Programs

(1) **Oregon Mother's Care (OMC)** provides patient navigation to newly pregnant women, assisting with insurance enrollment (OHP and QHP), and referring them to prenatal care, WIC services, dental care, home visiting services, and other pregnancy resources. OMC services are currently provided at 29 sites serving 26 counties.

More information available online at: https://public.health.oregon.gov/HealthyPeopleFamilies/Women/Pregnancy/OregonMothersCare/Pages/index.aspx

(2) **Maternity Case Management (MCM)** home visiting services are offered by local public health departments in most Oregon counties. Public Health Nurses work with pregnant women to identify and overcome barriers to receiving prenatal care and assist women with the psychosocial and socio-economic issues that may negatively impact pregnancy outcomes.

More information available online at: https://public.health.oregon.gov/HealthyPeopleFamilies/Women/Pregnancy/MaternityCaseManagement/Pages/index.aspx and http://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/Pages/nurse-home-visiting.aspx

(3) **Nurse-Family Partnership** (NFP) is an evidence-based, community health program that partners low-income first time mothers with a registered nurse early in her pregnancy and provides ongoing nurse home visits through her child's second birthday.[16] NFP services are currently provided through 9 local health departments in 9 counties; Multnomah, Deschutes, Jefferson, Crook, Umatilla, Morrow, Lincoln, Lane and Douglas.

More information available online at: http://www.nursefamilypartnership.org/

[16] Through multiple clinical trials, NFP has been documented to achieve lasting and significant effect including: improved prenatal health; fewer childhood injuries; fewer subsequent pregnancies; increased intervals between births; increased maternal employment; and improved school readiness.

Community-Based Programs

(1) **211Info** is a statewide program that provides comprehensive community based information and referrals. The line assists pregnant women in accessing health insurance and prenatal care in their community. More information available online at: http://211info.org/

(2) **Traditional Health Workers** improve access to care through outreach and enrollment, and improve health through education and support. Previously referred to as non-traditional health workers (NTHW), traditional health workers in Oregon include community health workers, peer wellness specialists, and personal health navigators.

To qualify for reimbursement by the Oregon Health Plan, traditional health workers must be certified by the Oregon Health Authority through successful completion of an approved training program and enrolled in the state's central registry. An update on traditional health workers in Oregon is available online at: http://www.oregon.gov/oha/docs/NTHW-brief.pdf.

There is some evidence that community health workers improve patient knowledge[17] and access to health care,[18] especially for minority women. Patient navigator programs may help women navigate the Medicaid system, find a provider, and obtain other services such as food and transportation assistance.

(3) **Doulas and Midwives**

Doulas provide personal, non-medical support to women and families throughout a woman's pregnancy, childbirth and postpartum experience. Numerous doula models have been developed across Oregon. A 2011 Oregon Legislative Bill directed OHA to explore options for utilization of doulas within the Medicaid program. The committee's report can be found online at: http://www.oregon.gov/oha/docs/NTHW-brief.pdf.

Many Oregon women seek prenatal care with midwives based on their personal preference, cultural traditions or access to services among others. There are many models of midwifery practice throughout Oregon, including services based in hospitals, birthing centers and community based programs. The scope of practice and role of the midwife in prenatal care can also vary based on educational and professional experience, as there are multiple types of midwives (e.g., direct-entry, certified professional, or nurse-midwife.) A 2013 law has mandated that all Oregon midwives (including "Direct-Entry") must obtain state licensure by January 1, 2015.[19]

[17] http://www.ahrq.gov/research/findings/evidence-based-reports/comhwork-evidence-report.pdf

[18] Andrews, J. O., Felton, G., Wewers, M. E. and Heath, J. (2004), Use of Community Health Workers in Research With Ethnic Minority Women. Journal of Nursing Scholarship, 36: 358–365.

[19] https://olis.leg.state.or.us/LIZ/2013R1/Measures/Text/HB2997/

Strategy 3: Provide Supports for Prenatal Care

(1) **Screen all women age 18-50 for their pregnancy intentions as a routine part of primary care.** The Oregon Foundation for Reproductive Health is promoting an initiative called One Key Question:

- ❖ Asking women "Would you like to become pregnant in the next year?" starts a conversation about preventive reproductive health.
  - o If a woman answers "yes", she can be advised to take folic acid and given information on health conditions, medications, substances and behaviors that may adversely a pregnancy. Her history can be reviewed to determine if she needs any immunizations, and any medications she takes can be assessed for their teratogenic potential. The U.S. Preventive Services Task Force recommends that all women planning or capable of pregnancy take a daily supplement of folic acid.[20]
  - o If a woman answers "no" and she is at risk for pregnancy, she can be assessed for whether or not she is using contraception and whether she is satisfied with her method. The provider can offer contraception counseling with emphasis on the most effective methods (IUDs, implants and sterilization).
  - o If a woman is unsure of her pregnancy intentions, the provider can recommend folic acid and other preconception or contraception services as indicated.

More information and technical support is available online at: http://www.onekeyquestion.org/

(2) Engage Patient-Centered Primary Care Homes (PCPCH) on the importance of early prenatal care.

- ❖ All PCPCHs are required to provide preventive services. The NCQA Primary Care Medical Home (and the Oregon PCPCH Standards which reflect them) say that those preventive services include contraception and preconception care.[21]

  If PCPCHs screen women for their pregnancy intentions, they can encourage women who want to conceive to enroll in prenatal care as soon as they know they are pregnant, and ideally offer other preconception care.

[20] http://www.uspreventiveservicetaskforce.org/uspstf/uspsnrfol.htm
[21] www.primarycarehome.oregon.gov/

(3) **Use incentives to motivate women to seek prenatal care**. Incentive programs are used both as an attempt to overcome barriers to receiving prenatal care and an effort to improve birth outcomes among Medicaid and privately insured populations.

Potential interventions could include direct financial incentives, items such as baby supplies, or increased access to social services in exchange for initiation and maintenance of adequate prenatal care or participation in group education.[22,23,24]

However, many women may already be trying to seek prenatal care and are experiencing system barriers as described above. Addressing systemic barriers, screening for pregnancy intentions, and integrating behavioral health services into prenatal care may be more effective for this population than individual-based incentive programs.

Additional information about prenatal care models is included in Appendix C. The highlighted programs contribute to higher quality prenatal care and better outcomes, but these programs are not focused on addressing entry to prenatal care or timeliness or prenatal care.

[22] Ingram J, Rawls RD, Moberly HD Using incentives to motivate women to seek prenatal care: an effective outreach strategy. J Health Soc Policy. 1993; 5(1):23-32.

[23] Meredith B Rosenthal, Zhonghe Li, Audra D Robertson, and Arnold Milstein. Impact of Financial Incentives for Prenatal Care on Birth Outcomes and Spending on Health Serv Res. 2009 October; 44(5 Pt 1): 1465–1479.

[24] Laken MP, Ager J.Using incentives to increase participation in prenatal care. Obstet Gynecol. 1995 Mar; 85(3):326-9.

Oregon Health Authority and the CCO Incentive Measure

Intent

Early prenatal care services help identify babies or mothers at risk for complications, and prenatal care within the first trimester represents a key opportunity for health care providers to educate and support mothers for later pregnancy and mother hood.

Measure Specifications

The 2013 CCO incentive measure "Timeliness of Prenatal Care" was selected by the Metrics & Scoring Committee and generally follows HEDIS® 2012 specifications measuring prenatal visits in the first trimester of pregnancy (i.e., first three months), or within 42 days of a pregnant women enrolling in Medicaid. Enrollment in care during the first trimester of pregnancy is a reflection of timely initiation of prenatal care.

For 2014, the Metrics & Scoring Committee adopted the full HEDIS 2013 hybrid measure specifications. CCOs must conduct chart review and submit data to OHA. CCOs are responsible for all aspects of chart review. OHA will provide sampling frames and additional guidance on hybrid measurement later in 2014. Guidance will be posted online at: http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx.

Measure specifications are online at http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx.

Numerator:
Prenatal care provided in the first trimester or within 42 days of enrollment, depending on the date of enrollment in the organization and the gaps in enrollment during the pregnancy.

Denominator:
All women with a live birth between November 6 of the year prior to the measurement year, and November 5 of the measurement year, who meet the continuous enrollment criteria, are included.

What are the continuous enrollment criteria:
Women must be enrolled 43 days prior to delivery through 56 days after delivery.

What are allowable gaps in enrollment:
None.

Define Anchor Date:
Estimated Date of Delivery (see below).

Measurement Period
The timeliness of prenatal care metric measures whether women who had live births received early prenatal care. Most prenatal care is bundled (4 or more prenatal visits by the same provider) or paid via global claims (prenatal care, delivery and postpartum care by same provider), so claims for prenatal care are often not available until after delivery.

The denominator is the number of live births, but to find the numerator we have to look at the 9 months prior to the date of delivery. To look at delivery of prenatal care in 2013 (the first measurement year), then there will only be a fraction of the total births that year that will have delivered (and have submitted and processed claims) in time for the incentive payments in June 2014.

On October 11, 2013, the Metrics & Scoring Committee voted to modify the 2013 measure specifications to look for live births from September 6, 2013 through February 2014. Births in this timeframe would have received early prenatal care in January through June 2013. While this only measures performance for the first half of the measurement year, it is not possible to examine the second half of the year because women who start prenatal care then would not have delivered and had a claim processed until after June 2014.

For the 2014 measure, OHA will use the HEDIS 2013 measurement period, looking for live births on or between November 6, 2013 and November 5, 2014. This will result in a four-month overlap with the 2013 modified measurement period.

Identifying Deliveries

Identification of the exact estimated date of delivery (EDD) in administrative (claims) data is difficult. To assist with this process, OHA uses a table within MMIS (the "Natural Mother" table. This table is populated by case managers during the eligibility process to insure consistent plan enrollment for the mother and child. This table helps OHA assure a match between a mother and baby for a particular delivery. This is helpful when searching for prenatal care services. This table does have its limitations, and while it is considered accurate, it is not complete.

For births only found in administrative data, the claims service data was used to estimate the EDD. If there are both hospitalization claims and outpatient claims, the hospital claims were used to identify the EDD.

This approach is a deviation from the HEDIS specifications, which use diagnoses codes to identify deliveries. OHA uses the diagnoses codes identified in the HEDIS specifications to validate information included in the Natural Mother table and in hospital claims.

Service Dates

In some cases, a woman had multiple service dates that were far apart. Claims showing services provided more than 180 days apart could be evidence of two different deliveries. For claims showing services provided more than 180 days apart, the earliest date was used as the first delivery date, and the latest date was used as the second delivery date.

Other Deviations from HEDIS

OHA did not limit the services to certain types of providers, such as services provided only by an OB or midwife. OHA includes all of the codes listed in the specifications, regardless of provider type, to produce this measure.

Limitations

In addition to the challenges outlined above, it is also difficult to clearly distinguish the onset of prenatal care within the first 12 weeks of pregnancy. CCOs may not be aware women are pregnant until after the first trimester. One CCO found that only 72 percent of women who are known to be pregnant had a pregnancy rate code.

Eligibility

Prenatal care services are a benefit available to all Medicaid enrolled women with a suspected or confirmed pregnancy.

Billing and Reimbursement

It is the responsibility of each provider to select the most appropriate diagnosis and procedure codes when billing for services. It is the providers' responsibility to comply with the CCO's prior authorization requirements or other policies necessary for reimbursement, before providing services to any Medicaid client enrolled in a CCO. It is the providers' responsibility to be compliant with federal and state laws (see OAR 410-120-1160).

Global Billing Codes

The codes listed in the HEDIS specifications for the numerator are followed for this measure in 2013. Bundled payments for prenatal, delivery, and postpartum services have been allowed since July 2009. OHA's 2013 measure specifications include several global OB care CPT codes (59400, 59425, 59426, 59510, 59610, and 59618).

These claims do not include specific information dating the initiation of prenatal care services and are usually submitted after pregnancy ends. OHA verifies the service dates on these claims and count only those with service dates in first trimester or within 42 days of last enrollment towards numerator compliance, as the HEDIS outlines in steps under 'Administrative Specification'. The codes are used to calculate the numerator, and are counted when the service dates fall into first trimester or within 42 days of last enrollment.

Maternity Case Management

Maternity Case Management billing guides are available online from the Public Health Division:

- Maternity Case Management Billing Guide (non-FQHC, non-RHC) https://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/ORCHIDS/Documents/MCMBillingGuide_NonFQHC.pdf
- Maternity Case Management Billing Guide (for FQHCs and RHCs) https://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/ORCHIDS/Documents/MCMBillingGuide_FQHC.pdf

Coding Resources

The National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services and NCCI edits have been developed for application to services billed by a single provider for a single patient on the same date of service. The edits were developed for the purpose of encouraging consistent and correct coding and reducing inappropriate payment. The NCCI is maintained for CMS by Correct Coding Solutions, LLC.[25]

Inquiries may be submitted to:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907
Fax number: (317) 571-1745

CMS makes all decisions about the contents of NCCI and the manual. Correspondence from Correct Coding Solutions, LLC reflects CMS' policies on coding and NCCI.

Additional resources include:

- AMA's Current Procedural Terminology (CPT) Manual
- CMS' HCPCS Level II code descriptors and Pub 100 References

[25] National Correct Coding Initiative Policy Manual for Medicare Services – INTRODUCTION_FINAL10312012.doc, Revision Date: 1/1/2013

Resources

Additional information is also available on the Transformation Center website:
http://transformationcenter.org/

Preconception and Interconception Care

- Recommendations to Improve Preconception Health and Health Care — United States: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. MMWR: Recommendations and Reports. April 21, 2006 / 55(RR06);1-23

- The National Preconception Curriculum and Resources Guide for Clinicians: Before, Between, and Beyond Pregnancy. http://www.beforeandbeyond.org/index.php

- Cheng TL, Kotelchuck M, Guyer B. Preconception women's health and pediatrics: An opportunity to address infant mortality and family health. Academic Pediatrics 2012;12:357-359.

- Bright Futures for Women's Health and Wellness
http://mchb.hrsa.gov/womenshealth/resources.html#bright

Quality Improvement

- Health Resources and Services Administration, Clinical Quality Measures, Prenatal – First Trimester Care Access Toolkit
http://www.hrsa.gov/quality/toolbox/measures/prenatalfirsttrimester/

- Milbank Report: Evidence-Based Maternity Care
http://www.childbirthconnection.org/article.asp?ck=10575

National Recommendations

- Association of Maternal and Child Health Programs (AMCHP) Compendium
http://www.amchp.org/programsandtopics/data-assessment/projects/Documents/AMCHP%20Birth%20Outcomes%20Compendium%202012.pdf

- Report of the Secretary's Advisory Committee on Infant Mortality (SACIM): Recommendations for Department of Health and Human Services (HHS) Action and Framework for a National Strategy
http://www.hrsa.gov/advisorycommittees/mchbadvisory/InfantMortality/About/natlstrategyrecommendations.pdf

- The Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality
http://mchb.hrsa.gov/infantmortality/coiin/

For More Information

For questions related to the CCO incentive measure, please contact:
Sarah Bartelmann at sarah.e.bartelmann@state.or.us

For questions related to public health research and programs, please contact:
Anna Stiefvater, RN, MPH at anna.k.stiefvater@state.or.us

For questions related to Medicaid billing, please contact:
Provider Services at 1.800.336.6016

Appendix A: Frequently Asked Questions

Is the CCO Incentive Measure for "Timeliness of Prenatal Care" only, or for "Timeliness of Prenatal Care" plus "Postpartum Care"?

The CCO incentive measure is for Timeliness of Prenatal Care only. This is one of the two rates associated with the HEDIS® measure "Prenatal and Postpartum Care" (NQF 1517). OHA is reporting on the postpartum care rate as one of the 33 state performance measures, but CCO performance on postpartum care is not tied to the quality pool.

For 2014, OHA will ask CCOs to conduct chart review for both prenatal and postpartum care information, to fully report hybrid data for both rates associated with the measure. However, only the prenatal care rate is tied to the quality pool.

How will a CCO receive credit toward the incentive measure for the providers that code prenatal care as a non-billable item? Will non-claims based data be included in the CCO incentive metric, or will OHA accept reports from a provider electronic medical record showing this activity?

Only claims data will be included in the CCO incentive metric for the first measurement year (CY 2013). If a provider is not using the codes listed in the 2013 incentive measure specifications, the CCO will not receive credit for prenatal care services that are provided.

In 2014, HEDIS® hybrid methodology will be used, incorporating chart review to identify prenatal care. OHA will publish additional guidance on the chart review, including sampling frame and timeline later in 2014.

Why focus on preconception and interconception care?

Preconception health care is critical because several risk behaviors and exposures prior to pregnancy affect fetal development and subsequent outcomes. The greatest effect occurs early in pregnancy, often before women enter prenatal care or even know that they are pregnant. For example, for optimal effect on reducing the risk for neural tube defects, folic acid supplementation should start at least three months before conception.

In Oregon, 49 percent of pregnant women reported that they did not take a folic acid supplement before pregnancy.[26] An easy intervention to improve birth outcomes would be to encourage young women to increase their folic acid intake.

The preconception period is also an optimal time to remind women to enroll in prenatal care as soon as they know that they are pregnant.

[26] Oregon PRAMS, 2011.

Appendix B: CAWEM Plus

Since 2008, CAWEM Plus, also known as Oregon's Prenatal Expansion Program, has expanded the coverage from just labor and delivery to include prenatal care and other OHP services for pregnant women covered by CAWEM in participating counties.

As of October 1, 2013, CAWEM Plus services are available to all pregnant CAWEM-eligible women statewide (fee for service) until the day after childbirth. While CCOs are not accountable for prenatal care for CAWEM-eligible women, their American-born children will be eligible for OHP, and automatically enrolled in a CCO at birth. Many of the strategies outlined in this guidance document could also apply to CAWEM-eligible women to improve their prenatal care and birth outcomes overall.

For more information on CAWEM requirements, see the DMAP Provider Letter, September 17, 2013. http://www.oregon.gov/oha/healthplan/Announcements/CAWEM%20Plus%20prenatal%20benefit%20expands%20to%20all%20Oregon%20counties%20effective%20October%201,%202013.pdf

Appendix C: Alternate Models of Prenatal Care

Three new approaches to prenatal care are being tested as part of the CMS Strong Start initiative.[27] The goal of the initiative is to determine if these models can reduce the rate of preterm births, improve the health outcomes of pregnant women and newborns, and decrease the anticipated total cost of medical care during pregnancy, delivery and over the first year of life for children born to mothers in Medicaid.

(1) **CenteringPregnancy** is a model of group care that integrates health assessment, education, and support into a unified program within a group setting. Eight to twelve women with similar gestational ages meet to learn care skills, participate in a facilitated discussion, and develop a support network with other group members.

There is strong evidence that women in CenteringPregnancy programs are more likely to receive adequate prenatal care than non-participating women.[28] CenteringPregnancy has also been shown to improve birth outcomes.[29]

More information available online at: https://www.centeringhealthcare.org/pages/centering-model/pregnancy-overview.php

(2) **Maternity CareHomes** offer psychosocial support, education and health promotion in addition to traditional prenatal care. Services attempt to expand access to care, improve care coordination and provide a broader array of health services.

More information available online at: http://transform.childbirthconnection.org/2012/03/what-is-a-maternity-care-home/

(3) Birth Centers provide family-centered care for healthy women before, during, and after normal pregnancy, labor, and birth."[30] Birth centers are a model for high-quality, low-cost maternity care. They address the complications that arise during delivery, and they profoundly reduce costs.

The American Association of Birth Centers (AABC) defines the birth center as "a homelike facility existing within the health care system with a program of care designed in the wellness model of

[27] http://innovation.cms.gov/initiatives/strong-start/

[28] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2276878/pdf/nihms-42174.pdf

[29] Ickovics, Jeannette R.; Kershaw, Trace S.; Westdahl, Claire; Rising, Sharon Schindler; Klima, Carrie; Reynolds, Heather; Magriples, Urania. Group Prenatal Care and Preterm Birth Weight: Results From a Matched Cohort Study at Public Clinics. Obstetrics & Gynecology: November 2003 - Volume 102 - Issue 5, Part 1 - p 1051–1057.

[30] http://www.birthcenters.org/about-aabc/position-statements/definition-of-birth-center

pregnancy and birth. A recent AABC study demonstrates the safety of birth centers and consistency in outcomes over time.[31]

(4) Quality Improvement Models for Health Care Organizations have been developed by the Health Resources Services Administration (HRSA). They include the *Care Model Approach,* which is an organization framework for change that is implemented to improve care by working across six domains of care. The model has been proven to improve care delivery and transform the way care is delivered.

The *Critical Pathway Approach* allows organizations to assess the complexities of their processes, and identify workflow inefficiencies. This approach allows an organization to target improvements that have an impact on how care is delivered and the changes that a care team can make.

HRSA identifies specific changes that work for care teams and health systems on their website: http://www.hrsa.gov/quality/toolbox/measures/prenatalfirsttrimester/part4.html

[31] Stapleton, S. R., Osborne, C. and Illuzzi, J. (2013), Outcomes of Care in Birth Centers: Demonstration of a Durable Model. Journal of Midwifery & Women's Health, 58: 3–14.

Appendix D: Oregon MothersCare Contacts

County	Address	Phone
Baker	Baker County Health Dept. 3330 Pocahontas Rd. Baker City, OR 97814	541-523-8211
Benton	Benton County Health Dept. 530 NW 27th St. Corvallis, OR 97339-0579	541-766-6835
Clackamas	Clackamas County Health Dept. 1425 Beavercreek Rd. Oregon City, OR 97045	503-655-8336
Columbia	Columbia County Health Dept. 2370 Gable Road St. Helens, OR 97051	503-397-4651
Coos	Coos County Health Dept. 1975 McPherson #1 North Bend, OR 97459	541-756-2020
Crook	Crook County Health Dept. 375 NW Beaver St., Ste.100 Prineville, OR 97754	541-447-5165
Curry	Curry County Health Dept. PO Box 746 Gold Beach, OR 97444	541-247-3300
Deschutes	Deschutes County Health Dept. 2577 NE Courtney Bend, OR 97701	541-322-7400
Douglas	Douglas County Health & Social Services 621 W. Madrone, Room 223 Roseburg, OR 97470	541-440-3521
Grant	Grant County Health Center 528 E. Main St. Ste. E John Day, OR 97845	541-575-0429
Hood River	Hood River County Health 1109 June Street Hood River, OR 97031	541-386-1115

County	Address	Phone
Jackson	Jackson County Health & Human Services 1005 E. Main St., Building A Medford, OR 97504	541-774-8209
Jefferson	Jefferson County Health Dept. 715 SW 4th St. Ste. C Madras OR 97741	541-475-4456
Josephine	Josephine County Public Health 715 NW Dimmick Grants Pass, OR 97526	541-474-5325
Klamath	Klamath Open Door Family Practice 2074 S. 6th St. Klamath Falls, OR 97603	541-851-8110
Lane	Lane County Health Dept. 151 W. 7th Avenue Room 210 Eugene OR 97401	541-682-3926
Lincoln	Lincoln County Health Dept. of Health & Human Services 1010 SW Coast Hwy Ste. 203 Newport, OR 97365	541-265-4947
	Lincoln Community Health Center 4422 NE Devils Lake Blvd., Ste. 2 Lincoln City, OR 97367	541-265-4947
Linn	Linn County Dept. of Health Services PO Box 100 315 4th Ave. SW Albany OR 97321	541-967-3888
	Samaritan Mid Valley Clinic 325 Industrial Way Lebanon, OR 97355	541-451-7872
Malheur	Treasure Valley Women's Clinic 1219 SW 4th Ave., Ste. 2 Ontario, OR 97914	541-889-2229
	Malheur County Health Dept. 1108 SW 4th St. Ontario, OR 97914	541-889-7279

County	Address	Phone
Marion	Marion County Health Dept. 3180 Center Rd. NE Salem, OR 97301	503-588-5355
	Santiam Memorial Hospital 1401 N 10th Ave. Stayton, OR 97383	503-769-2175
	Silverton Hospital DBA Community Outreach Clinic 208 South Water St. Silverton, OR 97381	503-873-0815
Morrow	Morrow County Health Dept. PO Box 799 120 S. Main St. Heppner OR 97836	541-676-5421 Mon. & Tues. Boardman Office: 541-481-4200
Wallowa	Wallowa County Health Dept. 758 NW 1st Enterprise OR 97828-1527	541-426-4848
Wasco/Sherman/Gilliam North Central Public Health Region	North Central Public Health Dept. 419 East 7th The Dalles, OR 97058	541-506-2600
Washington	Opening Doors Washington Co. 1001 SW Baseline St. Hillsboro, OR 97123 (Community Action Organization) 9340 SW Barnes Rd., Ste. 100A Portland OR 97225	503-517-3198

FOR PREGNANCY REFERRALS IN OTHER COUNTY HEALTH DEPARTMENTS

http://public.health.oregon.gov/ProviderPartnerResources/LocalHealthDepartmentResources/Pages/lhd.aspx

Clatsop
Clatsop County Public Health
820 Exchange, Suite 100
Astoria, OR 97103
(503) 325-8500, Fax (503) 325-8678

Harney
Harney County Health Department
420 N Fairview
Burns, OR 97720
(541) 573-2271, Fax (541) 573-8388

Lake
Lake County Public Health Office
100 North D Street Suite 100
Lakeview, OR 97630
(541) 947-6045, Fax (541) 947-4563

Multnomah
Multnomah County Health Department
426 SW Stark Street 8th Floor
Portland OR 97204
503-988-3674, Fax 503-988-3676

Pregnancy Clinic Referrals: 503-988-5558

Polk
Polk County Health Department
182 SW Academy, Suite 302
Dallas, OR 97338
(503) 623-8175 Fax (503) 831-3499

Tillamook
Tillamook County Central Health Center
PO Box 489
801 Pacific Avenue
Tillamook, OR 97141
(503) 842-3900, Fax (503) 842-3903
http://www.co.tillamook.or.us/gov/health

Umatilla
Umatilla County Public Health Division
200 SE 3rd Street
Pendleton, OR 97801
(541) 278-5432 Fax (541) 278-5433

Union
Union County Center for Human Development, Inc.
2301 Cove Avenue
La Grande, OR 97850
(541) 962-8800, Fax (541) 963-5272

Wheeler
Wheeler County Health Office
Asher Community Health Center
712 Jay Street, PO Box 307
Fossil, OR 97830
(541) 763-2725, Fax (541) 763-2850

Yamhill
Yamhill County Public Health
412 NE Ford Street
McMinnville, OR 97128
(503) 434-7525, Fax (503) 472-9731