

disclosure required if the PIP does not cover services not furnished by physician/group.

- The HMO must report type of incentive arrangement, e.g. withhold, bonus, capitation.
- The HMO must report percent of withhold or bonus (if applicable).
- The HMO must report panel size, and if patients are pooled, the approved method used.

If the physician/group is at substantial financial risk, the HMO must report proof the physician/group has adequate stop loss coverage, including amount and type of stop-loss.

Q. Abortions, Hysterectomies and Sterilization Requirements

The HMO shall comply with the following state and federal compliance requirements for the services listed below:

1. Abortions must comply with the requirements of [Wis. Stats., Ch. 20.927](#), and with [42 CFR 441 Subpart E](#)--Abortions.
2. Hysterectomies and sterilizations must comply with [42 CFR 441 Subpart F](#)—Sterilizations.

Sanctions in the amount of \$10,000.00 may be imposed for non-compliance with the above compliance requirements.

The HMO must abide by [Wis. Stats., s. 609.30](#).

R. Medical Home Initiative for High-Risk Pregnant Women

Improving birth outcomes has been a high priority for the Department for several years for HMO members in Dane and Rock counties and Southeast Wisconsin. Continuing and expanding the medical home initiative for high-risk pregnant women is an important part of this effort.

The medical home for high-risk pregnant women is a care delivery model that is patient-centered, comprehensive, team-based, coordinated, accessible and focused on quality. The obstetric provider serves as the team leader and works in partnership with patients, other care providers, staff within the clinic and a care coordinator. The care team is responsible for meeting the patient's physical, behavioral health and psychosocial needs.

HMOs serving Dane and Rock counties and HMOs new to the Southeast Region in calendar year 2014 must implement medical homes in at least three (3) unique locations for high-risk pregnant women, as described in this Contract, by July 1, 2014. The HMO, in partnership with the medical homes, must be guided by four core principles:

- Having a designated obstetric (OB) care provider who serves as the team leader and a point of entry for new problems. The OB care provider is defined as a physician, nurse midwife, nurse practitioner or physician assistant with specialty in obstetrics, who provides prenatal care and performs deliveries;
- Providing ongoing care over the duration of the pregnancy and postpartum period;
- Providing comprehensive care (e.g., care that meets the member's range of health and psychosocial needs); and
- Coordination of care across a person's conditions, providers and settings.

1. Target Population

The target population for this medical home initiative is pregnant [BadgerCare Plus and Medicaid SSI](#) members who are at high-risk for a poor birth outcome.

Poor Birth Outcome

For this initiative, the Department has defined a poor birth outcome as:

- Preterm birth – gestational age less than 37 weeks
- Low birth weight – birth weight less than 2500 grams (5.5 pounds)
- Neonatal/early neonatal death – death of a live-born infant within the first 28 days of life
- Stillbirth – a fetal demise after 20 weeks gestation.

Eligible Members

Members must be within the first 16 weeks of pregnancy to be enrolled in the medical home and must meet one or more of the following criteria:

- Listed on the Department's BORN registry (Birth Outcome Registry Network) of high-risk women
- Less than 18 years of age
- African American

- Homeless – defined as an individual who lacks a fixed and regular nighttime residence or an individual whose primary nighttime residence is: a supervised shelter designed to provide temporary accommodations; a halfway house or similar institution that provides temporary residence for individuals; or a place not designed for, or ordinarily used as a regular sleeping accommodation for human beings (e.g., a hallway, bus station, or a lobby)
- Have a chronic medical or behavioral health condition which the obstetric care provider determines would negatively impact the outcome of the pregnancy

The reason(s) for the member's medical home eligibility must be documented in the medical record. The documentation must indicate that the member is within the first 16 weeks of her pregnancy.

Early Identification and Outreach

Early identification of women who may be eligible for medical home enrollment is important for several reasons. First, the medical home is targeting a population that is at the highest risk for a poor birth outcome. The population includes women who may not have been engaged in preventive health care or may have had a previous poor birth outcome. In addition, many pregnancies are unplanned, which often leads to delays in obtaining prenatal care.

In addition to identifying women as early as possible in their pregnancy, providing coordinated, high quality care, throughout her pregnancy may significantly improve the outcome.

The HMO's role is to work with their OB provider network to coordinate outreach and enrollment efforts with those of other programs in the community targeting high-risk pregnant women. The Department also encourages the HMO and medical homes to work with community-based organizations and local health departments to maximize on-going support services and reduce duplication, e.g., PNCC and home visiting programs, for members enrolled in the medical home.

2. Basic Requirements

The Medical Home must be a single clinic or network of clinics that is accountable for the total care of the member and must:

- a. Include an OB care provider that serves as the care team leader and a point of entry for new problems during the member's pregnancy. The OB care provider, the care coordinator, and the member's primary care physician (who may or may not be the

OB care provider) will work together to identify the medical needs of the member to ensure that she will have a healthy birth outcome.

- b. Adopt written standards for patient access and communication to the member as determined by the HMO and approved by the Department. These written standards must, at a minimum, meet appointment and waiting times according to Art. III, H of the contract. In addition, treatment and/or medical advice must be available 24 hours a day, seven days a week.

- c. Use an electronic health record system or registry to manage patient data in order to:
 - Document medical home enrollment date,
 - Organize clinical information,
 - Identify diagnoses and conditions among the provider's patients that have a chronic condition that will impact the pregnancy,
 - Track patient test results,
 - Identify abnormal patient test results,
 - Systematically track referrals and follow up, and
 - Document birth outcomes.

- d. Adopt and implement evidence-based guidelines that are based on, but not limited to, treatment and management of the following chronic medical conditions:
 - Asthma
 - HIV/AIDS
 - Cardiac disease
 - Diabetes mellitus
 - Hypertension
 - Pulmonary disease
 - Behavioral health/mental health

The HMO and medical homes must have in place clear procedures for addressing the complex needs of women with these conditions, including, but not limited to, referrals to appropriate specialists.

- e. Actively support and promote patient self-management.
- f. Demonstrate cultural competency among provider and office staff.

3. Care Coordinator

A key component of the medical home initiative is the coordination of care for the member. Each medical home must have a designated care coordinator on-site (located where the member's OB care provider is located) that performs the following tasks:

- a. Communicates with the member and other care providers to identify needs and assist in developing a care plan and keeping the plan up-to-date;
- b. Makes referrals to appropriate services (e.g., health, behavioral health and psychosocial) and provides follow up. Referrals are not complete without timely follow up with the member and/or with the provider to track the results of the referral. For example, to ensure the member received the service or to obtain laboratory results.
- c. Provides member education and assists the member in managing her own care, and
- d. Assists in removing barriers to care.

The care coordinator may be an employee of the HMO or of the medical home. All care coordinators must be easily accessible on a regular established schedule by members participating in the medical home.

To ensure continuity of care, the care coordinator shall contact the office of any PCP that the participating member had/has an ongoing relationship with, to gather information about the member's medical history, current health conditions and any concerns that the PCP may have regarding the member.

4. Care Plan

The OB care provider must develop a care management plan for the member in conjunction with the care coordinator and the PCP (if not the OB care provider). To the extent possible, the member must be included in the development of the care plan.

The care management plan must be based on the initial assessment, including the initial prenatal clinic visit, where all needs of the member are identified to ensure that the medical home will provide comprehensive care.

The care management plan must include a patient self-care component and at least one home visit by the care coordinator within the first 30 days of enrollment in the medical home. If the member declines the home visit, the refusal is documented in the medical record. The care coordinator must offer the member on-going visits at her home or at a community location.

The care coordinator must establish regular communication with the member, OB care provider and PCP, if any, to track progress on the care management plan.

The care plan must be signed by the OB care provider and dated. The plan must be reviewed and updated as the member's health and circumstances change.

5. Discharge Plan

All members shall remain enrolled and receiving services as needed within the medical home for 60 days postpartum.

If the member had a healthy birth outcome, the following activities shall take place within the member's 60 days postpartum period:

- a. The member shall have at least one postpartum follow-up appointment with the OB care provider that shall meet all ACOG and other postpartum guidelines that apply.
- b. Ensure that the member is connected to/has an appointment with a PCP and/or pediatrician.
- c. The care coordinator shall contact the member's PCP to inform her or him of the birth outcome and any concerns that the OB care provider has regarding the member's and/or child's health postpartum.
- d. The care coordinator shall educate the member on interconception care specific to her needs.

In addition to the above, for members who have a poor birth outcome, as defined by the Department (e.g., low birth weight, preterm infant or infant death within 28 days), the HMO is responsible for the following:

- a. Working with the medical home care coordinator to develop a care management plan for the infant and the mother with input from the mother, the OB care provider, and the PCP and/or pediatrician. The plan shall include the coordination of care with other providers (which may be within the medical home) who are appropriate to provide ongoing services for the mother's and infant's specific needs.
- b. Maintaining contact with the mother to ensure that the initial referral appointments with other providers are kept and providing follow up, as needed.
- c. To the extent feasible, maintain contact with the mother at least twice a year for two years following the birth to ensure the mother and child are receiving appropriate care. HMO responsibility for follow up ends if the member is no longer enrolled in the HMO.

6. Reporting

HMOs serving Dane and Rock counties and HMOs new to the Southeast Region in calendar year 2014, must submit to the Department by March 15, 2014, a detailed plan on how the HMO will implement the medical home initiative in their service areas by July 1, 2014. The plan must include projected enrollment targets for each year. The Department shall supply a format for the plan that addresses all of the requirements. HMOs currently supporting medical homes for high-risk pregnant women are exempt from this requirement.

The HMO must submit the following information to the Department on a quarterly basis for each member enrolled in the medical home initiative:

- a. Medical home clinic name
- b. Mother's Medicaid ID
- c. Mother's Name
- d. Mother's birthdate
- e. Mother's address, including county of residence
- f. Mother's enrollment date in the medical home
- g. Mother's anticipated delivery date
- h. Date of termination from the medical home if prior to delivery date and reason for termination

The HMO must submit a report to the Department semi-annually evaluating its medical home initiative – one December 1 and one due June

1. The report shall include:

- a. A list of participating clinics and primary contact information;
- b. A narrative describing how the medical home satisfies criteria in Article III, R, 2 (a) through (f);
- c. A narrative that includes specific examples of processes and outcomes detailing how the medical home, in conjunction with the care coordinator, provides comprehensive and patient-centered care, and correctly identifies the needs of the member;
- d. ~~Quality data findings from Article III, R, 2 (f);~~
- e. Status report on patient access standards from Article III, R, 2 (b); and
- f. Any corrective action that is being taken to meet the requirements of the medical home initiative.

7. External Quality Review

The Department will work with its External Quality Review Organization to establish a process to verify that members enrolled in the medical home meet the requirements specified in Article III, R.1. The review will also verify that the provision of prenatal and postpartum services met the requirements specified in Article III, R.

The HMO is responsible for working with the medical homes to submit required documentation in a timely manner as requested by the Department. DHS does not provide additional reimbursement to HMOs or clinics for submission of medical records. HMOs are encouraged to define responsibilities of each party, which may include reimbursement policies and reporting requirements, in their subcontracts or agreements with medical home providers.

8. Evaluation

The HMO must assure that appropriate members of the organizations participating in the medical home initiative will work with the Department and authorized representative of the Department to evaluate the initiative. This may include, but is not limited to, the following:

- a. Assuring the clinic staff will complete pre/post surveys to identify process changes within the clinic;
- b. Assuring that staff will be available to participate in meetings related to the evaluation.

- c. Collecting and reporting needed data, as identified by the evaluator.
- d. Reviewing findings and offering comments/suggestions.
- e. Sharing information with relevant stakeholders and distributing reports following approval by the Department.

9. Payment Structure

Participating clinics will receive enhanced payments for pregnant women that meet the eligibility criteria in Article III, R, 1-2 and:

- a. Are enrolled in the medical home within the first 16 weeks of her pregnancy,
- b. Have attended/had a minimum of 10 medical prenatal care appointments with the OB care provider,
- c. Have been continuously enrolled during her pregnancy, and
- d. Have continued enrollment through 60 days postpartum.

For each pregnant member meeting these criteria:

- a. The Department will pay \$1,000 in addition to the kick payment to the HMO upon a delivery for every birth to an eligible member enrolled in the medical home initiative. The amount will increase to \$2,000 if the birth has a good outcome as defined by the Department.
- b. These payments will be paid to the HMOs and the HMOs will be required to pass the payments on to the medical home.

10. HMO representative

The HMO must designate a staff person to oversee the execution of the medical home initiative. The HMO representative will be responsible for representing the HMO regarding inquiries pertaining to the medical home initiative and will be available during normal business hours. The HMO representative will be responsible for ensuring the medical home initiative is implemented in accordance with the contract.

S. Enhanced Physician Reimbursement for Medical Home Practice Design

The HMO may provide enhanced reimbursement to primary care provider practices that function as a medical home. If the HMO plans to implement enhanced physician reimbursement, please submit the following strategies:

- Whether the HMO provides such a reimbursement and if so which practices are recipients.
- The criteria the HMO uses to identify practices that function as a medical home and are eligible for this reimbursement.
- The HMO's process for evaluating practices annually as to whether they meet the criteria.
- How this reimbursement process is implemented.
- Evidence that they are supplying their in-network providers with materials that explain in detail what their medical home criteria are, and how a clinic would be reimbursed for functioning as a medical home.

T. Participation in Department Health IT Workgroup

The HMO must participate in a Health IT Workgroup established by the Department to coordinate activities and develop cohesive systems strategies among the Department and the HMOs. The Health IT Workgroup will meet on a designated schedule as agreed to by the Department and the HMOs.