

**OBSTETRIC MEDICAL HOMES FOR HIGH RISK
MEDICAID MEMBERS**

USER'S GUIDE –

OB MEDICAL HOME REGISTRY UPDATES

Published: April 2016

**DIVISION OF HEALTH CARE ACCESS AND ACCOUNTABILITY
DIVISION OF PUBLIC HEALTH
OFFICE OF POLICY INITIATIVES AND BUDGET**

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Document Scope and Purpose

Scope

This document provides basic information and updates about the Wisconsin Department of Health Services' (Department) medical home initiative for high-risk pregnant women. This medical home is commonly referred to as the "OB Medical Home." The OB Medical Home is a joint effort of three divisions within the Department – the Division of Health Care Access and Accountability (DHCAA), the Division of Public Health (DPH) and the Office of Policy Initiatives and Budget (OPIB).

The simplified language in this document shall not be construed to replace or supersede the existing official Contract language.

Purpose

The purpose of this document is to serve as a user's guide for BadgerCare Plus and Medicaid SSI HMOs sponsoring obstetric clinics designated as OB Medical Homes. It is designed to provide a quick on-line reference for operationalizing OB Medical Home Contract requirements. The guide also consolidates a variety of information regarding implementation and operations, including a current list of questions about the OB Medical Home and Department responses.

The Department reviews the guide on a regular basis. When new information is available, the guide is updated and published. **OB Medical Home HMOs and clinic sites should refer to each publication for helpful information as each guide enhances published information and does not necessarily replace previous guide versions.**

Participating HMOs may find the guides useful in recruiting and working with clinics and community-based organizations.

The April 2016 iteration of the OB Medical Home User Guide is focused on OB Medical Home Registry updates.

Wisconsin's OB Medical Home Registry

The OB Medical Home Registry is a web-based tool to track Medicaid members who are enrolled in the OBMH. The Registry is used by the HMOs and the Department to determine clinic eligibility for the bonus payments – \$1,000 or \$2,000 – above the Department standard payment for prenatal and postpartum care and delivery.

The Registry is accessible to all clinics serving as OB Medical Homes, participating HMOs and the Department. Participating clinics and HMOs only have access to their patients and members. Under direction of the Department, with input from HMOs and clinic sites, registry enhancements were completed in June 2015.

On June 10, 2015, the Department hosted training via webinar on the registry updates. A recording of that training has been uploaded to the [registry homepage](#) (click to go to the webpage).

Registry Enhancements

Upon its development in 2011, the registry was used by OB Medical Home clinic sites to 1) inform HMOs that a woman had been enrolled in the OB Medical Home initiative; 2) inform the Department of women enrolled in the OB Medical Home initiative for chart review purposes; and 3) for a small number of clinics, utilize the registry in place of an electronic medical record. As such, the registry allowed more information than the criteria needed for the initiative, including ultrasound dates and results, for example.

After the 2014 expansion of the initiative, the HMOs and medical home sites commented that the registry was burdensome, as all clinics were now using their own electronic medical records and entering all of the data became duplicative.

The following registry enhancements were completed in July 2015:

1. Collect only data fields related to the contract requirements:
 - a. Medical Home Clinic Site
 - b. Member's Health Plan/HMO
 - c. Date member enrolled in OB Medical Home initiative
 - d. Date member first seen at the clinic (if different from enrollment)
 - e. Number of weeks of gestation at enrollment
 - f. Was the patient transferred from another provider
 - g. Date terminated from OB Medical Home initiative, if prior to completion
 - i. Reason for termination
 - h. Mothers demographic information
 - i. High Risk Category(ies)
 - j. Delivery information
 - k. Attestation: Did the mother attend a minimum of 10 prenatal visits
 - l. Attestation: Were home visits offered throughout enrollment
 - m. Did any home visits occur
 - n. Date of post-partum visit/or scheduled date of visit (optional checkbox for no post-partum visit due to patient refusal or patient no show)

2. Allow clinics to close a record prior to a woman completing program requirements, including a reason (i.e. woman dis-enrolled by choice, stopped attending appointments, unable to contact, etc.).
3. Automatically generate a time stamp for when the record was created.
4. Allow future pregnancy episodes of care and the ability to distinguish the different records.
5. Add a validation function so that clinics have an extra “check” to ensure all needed information has been entered.

Use of Registry – Chart Reviews and Payment Reconciliation

Chart reviews are completed quarterly by the Department’s external quality review organization (EQRO). The Department uses a list pulled from the registry, and verified by the HMO, to inform the EQRO which records require review. If a woman enrolled in the initiative has not been entered in to the registry in a timely manner, a chart review will not be conducted by the EQRO and the clinic may be required to return any bonus payments received for those women.

Prior to third quarter 2015, the Department pulled a list from the registry based upon births that occurred within the quarter for review. After the close of each quarter, the Department waited 60-days, to allow for the 60-day postpartum timeframe, before querying the registry to populate the chart review report. This process created an extended lag between the end of a quarter and the completion of chart reviews.

Beginning in quarters 3 and 4 of calendar year (CY) 2015, the Department queried the postpartum date to populate the chart review report. The new process shortens the timeframe between the end of the quarter and the completion of chart reviews, and allow for a quicker payment reconciliation process.

It is imperative that clinics list the date of the scheduled postpartum visit in the registry for each woman. If date of the postpartum visit changes, the clinic may update the postpartum field in the registry. If the postpartum visit does not occur due to a no-show, the clinic should not remove the original visit date, but instead utilize the checkbox for “No postpartum visit.” If the postpartum visit date is not entered in to the registry, the woman will not be included in the chart review report and the EQRO will not conduct a chart review. No enhanced payments will be made for women whom there was no chart review completed by the EQRO.

On February 01, 2015, the Department approved the “Prospective Payment Reconciliation Process” for the OB Medical Home initiative. This document, created with feedback from participating HMOs, lays out the prospective payment procedure to be used beginning for CY 2015 and beyond. The following requirements are defined in the policy document and were agreed upon by the Department and participating HMOs:

- All clinics must enter enrolled women into the registry within 30 days of enrollment into the OB Medical Home Initiative.
- Clinics that fail to enter women into the registry within the timeframes noted above will not receive the OB Medical Home initiative bonus payment (\$1,000 or \$2,000) for those women not entered.
 - The HMOs are responsible for informing clinics of this requirement.

- The HMO will ensure that all clinics are well informed of the requirements and initiative criteria to ensure invoicing is completed only for those women who complete all program requirements.

Please refer to Appendix B and Appendix C of this document for further details regarding the EQRO chart reviews and prospective payment and reconciliation process.

Appendix A – Frequently Asked Questions

Ref #	Question/Comment	Department Response
1	<p>If a woman is enrolled in an HMO and enrolled in an OB Medical Home, then transitions to fee-for-service for a portion of her pregnancy, then is re-enrolled into an HMO (the same one or different), may the clinic still invoice the HMO for the bonus payment?</p>	<p>As long as the woman continues to remain enrolled in the OBMH (OB Medical Home) program and receives the required OBMH services (care coordination, home visits, etc.) during her time in fee-for-service, then yes, the clinic may invoice for the enrolled woman.</p> <p>It is important to note that the clinic will invoice the woman's HMO at the time of delivery/postpartum care completion. If the woman re-enrolls into a different HMO, the clinic must be considered an OBMH site partnering with that HMO, and provide documentation of care provided throughout the entire pregnancy with the HMO, in order to receive the bonus payment. For example, if the woman is enrolled with HMO1 and being seen at Clinic A, but enrolls into HMO 2 mid-way through her pregnancy, Clinic A must have an agreement with HMO 2 as an OBMH site in order to collect the bonus payment from HMO 2. If no agreement between Clinic A and HMO 2 exists, the clinic would <u>not</u> be eligible to invoice HMO 2 or HMO 1.</p>
2	<p>In reference to Q&A #17, FAQ document published on 11/14/2014:</p> <p>1. If we do not have an MOU with the other clinic site, but we have a BAA is that acceptable?</p> <p>2. Do we actually need to scan records from the other clinic/care facility when they are available to us on the same EMR and we have a patient's release of information?</p>	<p>1. A BAA (Business Associate Agreement) and the patient's agreement to release her information are acceptable.</p> <p>2. If the OBMH clinic plans to count visits with another provider as part of the required 10 prenatal visits, then the OBMH needs to ensure that documentation is available for chart review by the Department's EQRO (External Quality Review Organization). The clinic may determine the best process for completing this, whether it is scanning records, or importing records, etc. If the OBMH clinic does not plan to use the visits as part of the required 10 prenatal visits, simple documentation in the record of the care coordination between the OBMH clinic and the referral/specialty clinic is sufficient.</p>

3	Will chart reviews be used to recoup money from clinics?	The Department hopes that recoupments will not be necessary, however, they are possible. During payment reconciliation, the HMO will have time to work with the clinic to supply the Department additional information that may not have been found during the EQRO chart review. If the HMO (and clinic) are unable to verify that a woman met all criteria as defined in the Contract, a clinic may be asked to repay any prospective bonus payments made for the specific member that is unverified. Additionally, if a clinic billed the HMO for a good birth outcome and the EQRO chart review determined that the birth outcome was poor, the clinic may be required to repay \$1,000 of the \$2,000 payment, assuming all other criteria were met.
4	Would you clarify FAQ #2, published in the December 2014 User Guide? If the woman is transferred from a provider that is not a FQHC or CHC, may she still be included in the program?	This would apply to any provider, not just FQHC (Federally Qualified Health Center) or CHC (Community Health Center) providers. Please ensure that if a woman is transferred that she meets all criteria listed under FAQ #2.
5	How often must a home visit be offered?	There is no requirement that a specific number of home visits must be offered, but the care coordinator(s) or person offering the home visits should work to build rapport with the member that has refused a home visit so that the member may eventually accept the offer. As stated in the Contract, home visits should be continually offered throughout the program.
6	If a member “declines” the care coordination activities as they pertain to enrollment in PNCC, for example, yet a care plan is established with the care providers and is covered with the patient during every visit – will this still count toward the care plan and care coordination component?	At minimum, the record must include documentation of regular conversations between care coordinator and member, evidence of regular communication between the OB provider and the care coordinator, document evidence of any referrals and communication with other providers, and any home visits or off-site visits. The requirement is for the member to receive care coordination services; there is no requirement that the member be enrolled in PNCC (prenatal care coordination).
7	Does a postpartum appointment have to be scheduled prior to discharge from the delivery facility as is stated in the December 2014 User Guide?	The guide uses the word “should” in discussion of the postpartum visit being scheduled prior to discharge, as scheduling the appointment prior to hospital discharge is not a requirement. Best practice shows that scheduling the appointment before discharge, or even before delivery, may increase the rate of postpartum visit occurrences.

8	The December 2014 User Guide states the baby should be seen by a healthcare professional within 2 days following discharge. Again, there are times when this simply doesn't make sense for the clinics nor does it fit within their scheduling practice. Many schedule within 3 or 5 days.	The guide uses the word "should" as this is not a requirement. Two days is best practice, however, it is not a requirement of the program. The Department OB Medical Home Project team has spent much time reviewing data and best practices and working with our partners in Public Health to place best practice guidelines in the guide for clinic and HMO reference. If the information provided is required of the program, it is clearly noted in the OB Medical Home Guide.
9	Can HMOs and/or clinics offer incentives to women to participate in the OB Medical Home program?	Yes, HMOs and/or clinics may offer incentives as part of the OB Medical Home program to encourage women to complete their participation. The HMO must communicate the proposed incentive program to the Department in advance for review and approval.
10	Can the EQRO travel onsite to the clinic or HMO to complete record reviews?	As stated in the contract, the Department will not reimburse for the cost of submitting the required documentation. If the HMO or clinic prefers the EQRO perform the record review onsite, the HMO or clinic will be responsible for any costs/fees charged by the EQRO to do the review onsite.
11	Does an ultrasound appointment count towards one of the prenatal visits?	The visit must occur with the OB care provider to count as one of the prenatal visits. An appointment with the OB care provider would need to occur along with the ultrasound appointment to be counted as one of the prenatal visits.
12	If a patient has a BC+ HMO as secondary coverage, is she still eligible for the OBMH initiative?	Yes, the patient is still eligible for the OBMH even with BC+ HMO as secondary coverage.

Appendix B – Prospective Payment Reconciliation Process for OB Medical Home

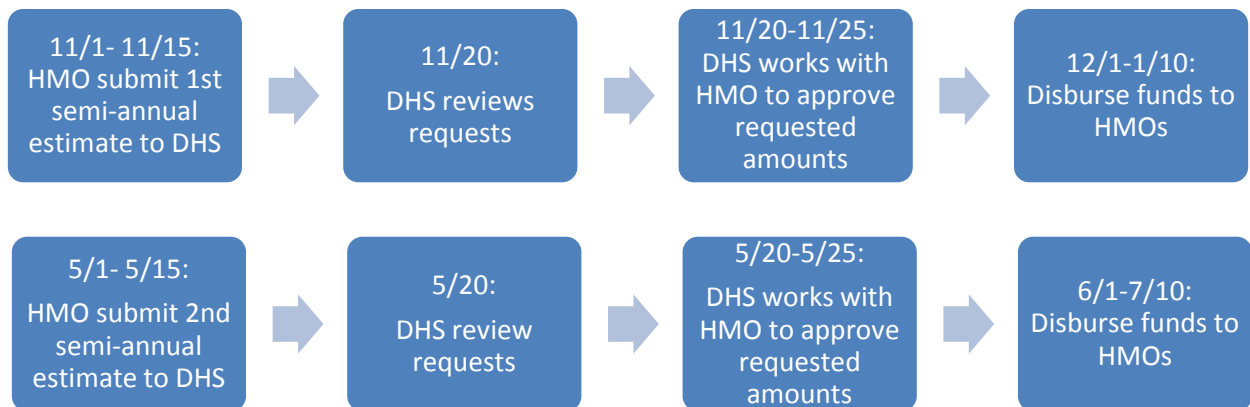
Purpose

The purpose of this document is to highlight the prospective payment and payment reconciliation process for the OB Medical Home Initiative. As defined in Article IV, Section D of the 2016 – 2017 BadgerCare Plus and Medicaid SSI HMO Contract, the Department of Health Services (Department) will provide an enhanced payment to HMOs for pass-through to OB Medical Home clinics.

The prospective payments will be made from the Department to the HMOs semi-annually. The following assumptions are agreed upon by the Department and the HMOs participating in the OB Medical Home initiative:

- Participating clinics must enter enrolled women into the Department’s OB Medical Home Registry (Registry) within 30 days of enrollment into the OB Medical Home. This element will be enforced starting with women enrolled in the OB Medical Home on January 1, 2016.
- Clinics that fail to enter women into the Registry within the timeframes noted above will not receive the OB Medical Home Initiative payments (\$1,000 or \$2,000).
 - The HMOs are responsible for informing participating clinics of this requirement.
 - The HMOs will ensure that all clinics are well informed of the requirements and initiative criteria to ensure HMOs are invoicing only for those women who complete all program requirements.
- The Department, in collaboration with the HMOs, will work to ensure that the Registry data fields are updated, as needed. This included adding a timestamp of when an entry was created to allow HMOs to ensure clinics are entering women into the Registry within the required timeframe.
- HMOs will use data entered into the Registry, in combination with other data sources, to estimate the number of OB Medical Home participants for prospective payment requests.
- HMOs will submit the first semi-annual payment request no later than November 15th of each year for January – June of the following CY to DHSOBMH@wisconsin.gov.
- HMOs will submit the second semi-annual payment request no later than May 15th of each year for July – December of the current year to DHSOBMH@wisconsin.gov.
 - Requests should include the estimated number of women who will complete the program, through the 60 day post-partum visit within the semi-annual period and assume a good birth outcome.
 - Requests should include a brief explanation of the estimate, i.e., how the estimate was calculated.

- The Department will review, and approve or deny, prospective payment requests no later than 10 business days after receipt.
- The Department will issue prospective payments within 45 calendar days of approval.
- Prospective payment funds should be used to pay for services rendered in the calendar year for which they are requested.
- The Department will reconcile payment annually using data obtained from chart reviews completed by the external quality review organization (EQRO). Reconciliation will be for payments made in a calendar year.
- The Department will complete payment reconciliations no earlier than March of the subsequent calendar year, to allow participating clinics time to invoice for women who completed the program in December.
- The timelines for the semi-annual prospective payment requests for 2015 and beyond are highlighted below:



Appendix C – Record Request Process for OB Medical Home

1. Process

The purpose of this document is to highlight the record request process for the Obstetrical Medical Home (OBMH) Initiative. As defined in the BadgerCare Plus and Medicaid SSI HMO Contract, the Department of Health Services (Department) has developed a process with their External Quality Review Organization (EQRO), currently MetaStar Inc., to conduct medical chart reviews that: 1) verify members enrolled in the OB Medical Home initiative meet the defined contract requirements; 2) collect data to support potential future program refinements; and 3) collect data to support program evaluation.

2. Responsibilities

The HMO is responsible for working with OB medical homes, care coordination providers, hospitals or any other care provider that may or should have documentation of OB Medical Home services, to ensure required documentation is submitted in a timely manner, as requested by the Department. Medical home site participation in the OB Medical Home Initiative mandates the submission of all patient charts related to the pregnancy and OB Medical Home requirements. The Department does not provide additional reimbursement to HMOs or medical home sites for submission of medical records. The cost for submission of medical records is included in the incentive funding.

3. Process

The Department will make periodic requests for medical records (typically quarterly). MetaStar, on the behalf of the Department, will send these requests to the HMO's OB Medical Home liaison and Contract Administrator via Secure File Transfer.

a. File Creation and Transfer

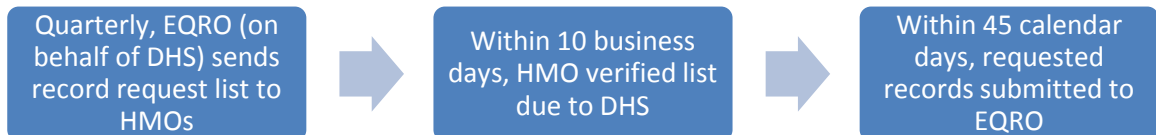
The Department uses a list pulled from the registry based on women who have completed or should have completed her 60 day postpartum visit within the quarter for review. The Department will generate the list by using either the date of the postpartum visit or the originally scheduled postpartum appointment entered by the clinic or HMO.

MetaStar, on the behalf of the Department, will send a cover memo (as shown in the sample memo under #6), along with an Excel file containing the list of queried records, to the HMO OB Medical Home liaison and Contract Administrator, via Secure File Transfer. The HMO must work with the medical home sites to verify the list includes all women who completed or should have completed her 60 day postpartum visit in the quarter for review.

b. Timeframe for Response – HMO

Within 10 business days of receiving the record request, the HMO shall verify the list is complete and accurate, or identify any discrepancies between the Department’s list and medical home site records via secure email to DHSOBMH@wisconsin.gov and dsersch@metastar.com.

Within 45 calendar days of receiving the record request, the HMO and/or the medical home site must provide the EQRO with all requested materials. HMOs should provide an explanation for any missing documentation in the Excel file. Use the column titled “Complete records submitted?” to explain any missing documentation. The EQRO accepts any documentation from the medical records that verify eligibility and program requirements are met.



c. Record Submission Options – HMO

Options for submission of records for the EQRO chart review include (in order of preference):

- Grant remote access to the EQRO to the medical home site’s electronic health system,
- Submit electronic documents, or
- Submit paper copies, if that is the only option.

Due to travel time/cost constraints, onsite reviews by the EQRO is not a viable option for the OB Medical Home Initiative.

In all instances, protocols related to maintaining security and confidentiality of records must and will be met.

The EQRO will work with the HMO OB Medical Home liaison, and other HMO and medical home site staff, to review the record delivery options and make arrangements for system access and records delivery.

4. Record Review Findings – Payment Reconciliation and Follow-up

The Department will use the findings from the EQRO record review to reconcile prospective medical home payments made to the HMOs. Refer to the Obstetric Medical Home – Prospective Payment and Reconciliation Process for additional information on this process (Appendix B).

a. Annual Reconciliation – Department

On an annual basis, the Department will use the findings from the EQRO record reviews to determine which women were eligible for payment and whether the participating medical home site met the defined Contract requirements for receiving medical home payments. The prospective payment process allows HMOs to pass through payments to clinics prior to the final annual report

from the EQRO. HMOs have flexibility to determine disbursement of funds to clinics. HMOs are encouraged to work with each clinic to determine how payments are distributed.

HMOs that pay medical home sites in advance of the EQRO record reviews shall provide the Department with a list of all payments made for the calendar year upon request. The Department will complete payment reconciliation by comparing the record review findings to the HMO paid invoices list.

b. Review and Rebut – HMO

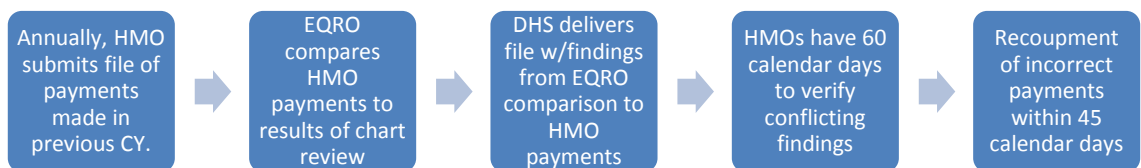
The Department will communicate the findings of the comparison of the payment reconciliation review to the HMO and provide 60 calendars for the HMO to verify any conflicting findings.

It is the responsibility of the HMO to work with individual medical home sites to reconcile any discrepancies between the results of the EQRO record review findings and medical home site paid invoices/reports or other available data. If the HMO is unable to attest to missing information within 60 calendar days, the Department may recoup from the HMO money paid for women that did not verifiably meet all program criteria defined in the contract. It is the responsibility of the HMO to recoup from the medical home site. The Department does not prevent the HMO from choosing to pay the medical home site for ineligible women using HMO funds, should they choose to do so.

c. No Chart Review, No Medical Home Payment

Chart reviews are a mandatory component of the OB Medical Home payment process. The Department will not make a medical home payment in cases where no chart review occurred, even if the HMO and clinic met all other contract requirements.

HMOs are required to ensure that all members enrolled in the medical home are documented in the OB Medical Home Registry. Thus, no chart reviews will be completed retrospectively if the HMO finds that the medical home site has not complied with the registry entry requirement (registry entry within 30 days of enrollment into the OBMH). Per section 3.b above, HMOs and clinics have an opportunity to ensure the record list is complete for the requested timeframe. If the EQRO does not receive the medical records to complete a chart review during the appropriate review period, the medical home site will be ineligible for the medical home payment from the Department. The Department does not prevent the HMO from choosing to pay the medical home site for these women using HMO funds, should they choose to do so.



5. Documentation Criteria for Medical Home Record Reviews

The guidelines for documentation are based on chart review criteria set by the Department and used by the EQRO and should be used by OB Medical Home sites. The review and documentation criteria align with the Contract requirements and include other data elements requested by the Department for program planning and evaluation.

Demographics
Member Medicaid Identification Number (MCI)
Member Last Name
Member First Name
Member Middle Initial
Member Date of Birth
HMO Name
Medical Home Clinic Name
Name and credentials of primary care provider
Name and credentials of OB provider
Name and credentials of designated care coordinator
Name and credentials of other care providers
Enrollment Requirements
Document the date of the first visit with a health care professional.
Document the date of the first visit with the care coordinator.
Documentation of HMO enrollment date may be needed if the enrolled member was fee-for-service upon enrolling in the OBMH initiative.
Document the date of the member's last menstrual period (LMP).
Prenatal Visits
Document the date of each prenatal visit with the OB provider that the member attended prior to delivery.
Document the number of Centering Pregnancy visits attended, if applicable.
Document any reason for delayed, missed or rescheduled appointments and the follow-up conducted, e.g., telephone calls to patients and/or collateral contacts, letters sent, home visits attempted, etc.
Postpartum Visit
Document the date of the postpartum visit with the OB provider.
Document the reason for any delayed, missed or rescheduled appointments.
The Care Plan
Document the needs identified at intake and following the initial, comprehensive assessment. Needs should include medical and non-medical issues. Care plans are dynamic, but the documentation should reflect that the plan was initiated within the first three (3) prenatal visits (these visits may include at least one visit with the care coordinator).
Document the individuals involved in the development of the care plan by signature or by reference (e.g., a listing of participants).
Engaging the member in her own care is a core aspect of the OB Medical Home. Document evidence of the following self-management skills – problem solving, decision making, appropriate use of available resources, formation of a patient/provider partnership, action planning and/or self-tailoring. Other examples of self-care/self-management include medical management, role management and emotional management, and/or participation in a Centering Pregnancy program.
Care Coordination

At a minimum, the record must include documentation of regular conversations between the care coordinator and the member.
Document evidence of regular communication between the OB provider and the care coordinator.
Document evidence of any referrals and communication with other providers, e.g., the primary care provider, if any, or any specialists.
Document home visits by the care coordinator or other designated clinic staff. Regular visits at locations other than the clinic (non-medical sites) may be considered in place of a home visit. If no home visit occurred, documentation must reflect one or more offers of a visit to the home or other convenient location and that the member refused such offer(s).
Delivery Information
Document the delivery date, delivery type, gestational age at delivery, infant weight and hospital where delivery occurred.
Document any information about a fetal demise within 28 days of delivery, if such an event occurred, or if a still-birth occurred.
Postpartum Visit and Services
Document the date of the postpartum visit.
Document any information related to the reasons for no postpartum visit, delayed or rescheduled postpartum visits (including the number of these events) and information about efforts that encouraged the member to attend the postpartum visit.
<u>Communication with the PCP.</u> Document evidence of post-delivery communication with the member's PCP, if identified (the OB provider may also be the member's PCP). A letter, phone call or other form of communication informing the PCP (if any) of delivery and any concerns meets the requirement.
<u>Communication and/or Referral to a Pediatrician.</u> Document evidence that the member received a referral to a pediatrician (if the PCP is not providing infant care).
<u>Member/Patient Education.</u> Document evidence that information was shared by the care coordinator or other member of the care team about the following: interconception care, family planning, depression, including a screening and the results, breastfeeding and who to call for assistance, and newborn care.
Enrolled members with Poor Birth Outcomes or Chronic Conditions
In the event of a poor birth outcome, document the date this information was shared with the member's HMO and any follow-up that should be done.
In the event of chronic conditions, document the date that this information was shared with the member's HMO and any follow-up that should be done.
The following conditions are specifically identified in the current Contract for OB Medical Home participants – asthma, HIV/AIDS, morbid obesity, cardiac disease, diabetes mellitus, hypertension, pulmonary disease, behavioral health/mental health.

6. Sample: Request of Records Memo to the HMO

Date: XXXXXX

To: HMO Contract Administrator
HMO OB Medical Home Liaison

From: MetaStar, on behalf and under the direction of the Department of Health Services
Division of Health Care Access and Accountability

Subject: Reviews and Request for Records
OB Medical Home Initiative for High Risk Pregnant Women

The purpose of this memo is to continue the record submission process for the OB Medical Home Initiative for High Risk Pregnant Women for calendar year 20XX.

Attached is a request for records for OB Medical Home enrollees who **had a postpartum visit originally scheduled** between *[Enter Date]* and *[Enter Date]*, according to information available in the Department's OB Medical Home registry.

Within 10 business days (XX-XX-XXXX) of receiving the records list, the HMO shall agree the list is complete and accurate, or identify any discrepancies between the Department's list and medical home site records. Please notify, via secure email, the Department at DHSOBMH@wisconsin.gov and MetaStar at dsersch@metastar.com.

Any records that meet the above criteria but are not included as part of this record review will not be reviewed at a later date. Please work with your OB Medical Home clinics to ensure that all women for whom they will seek/or have sought payment for are included in this review. The Department will not issue payment for any record that was not reviewed.

Please submit or provide electronic access to these women's records to MetaStar no later than close of business *[45 calendar days from date of DHS request]*.

HMO liaisons please email the OB Medical Home inbox, DHSOBMH@wisconsin.gov, and Danielle Sersch, dsersch@metastar.com, if you believe you will be unable to meet the deadline.

The timeframe associated with this request for medical records begins with the first date of service related to the pre-natal care and includes services provided during the 60 day postpartum period. MetaStar will accept any documentation from the medical records that verifies the following:

- The member met the eligibility criteria for enrollment in the medical home initiative, that is:

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- Enrollment was within the first 16 weeks of pregnancy.
- The member met the stated criteria (e.g., <18 and is diabetic)
- The basic requirements of the program were met. At a minimum, the documentation must show that the member:
 - Received care coordination services from a designated individual, e.g., regular communication with the patient, other care providers and other service providers was initiated and maintained throughout the pregnancy and included home visits or alternative if home visits were refused. *Note: DHS is not responsible for accessing PNCC records. Care coordination should be an active component of the medical home with patient information shared among providers. The medical home or the HMO is responsible for providing documentation that this on-going communication is occurring.*
 - Had a care management plan developed by the care team that met the stated criteria (e.g., includes a patient self-care component and monthly home visits; if no home visits occurred, there must be a documented reason or alternative).
 - Had a minimum of 10 appointments with her OB care provider.
 - Remained enrolled in the medical home through the 60th day postpartum and had at least one postpartum visit.
 - Had a discharge plan that addressed:
 - Member education: family planning, breast feeding, newborn care, interconception care.
 - Post-delivery transition back to her PCP, including communication with the PCP, as appropriate.
 - If her birth outcome was poor, had a treatment plan that documents referrals to ongoing services and that there was follow-up to ensure the initial appointment(s) were kept and needed services were offered.

Please provide an explanation for any missing documentation.

Instructions for Submitting Documents

Three options (in order of preference) are available for submitting documents for MetaStar.

1. Grant remote access to MetaStar to review requested documents by contacting Danielle Sersch at dsersch@metastar.com or 800-362-2320, extension 8224.
2. Submit electronic documents. See below for instructions on submitting electronic documents to MetaStar.
3. Paper copies will be accepted, if that is the only option. See below for instructions on submitting paper/hard copy documents that are not available electronically to MetaStar.

<p>For electronic documents: Submit to Danielle Sersch via MetaStar's Secure File Transfer System (https://www.metastar.com/SFT/). If possible, please zip or compress all documents into one file.</p>	<p>For paper/hard copy documents that are not available electronically: Send via U.S. Mail to MetaStar, Inc. Attention: Danielle Sersch 2909 Landmark Place Madison, WI 53713</p>
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Please work with clinics to ensure that documents are not submitted via third party record handlers, such as IOD or HealthPort. If there are any questions about document requests and submissions, please contact Danielle Sersch, 800-362-2320, extension 8224. Thank you for your assistance and cooperation with the Medical Home Initiative Review process.

Enclosure (1)

CC: Sarah Orth, MetaStar
Ann Marie Ott, MetaStar
Danielle Sersch, MetaStar
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Appendix D – 2016-2017 BadgerCare Plus and Medicaid SSI HMO Contract

January 1, 2016 marked the start of a new contract period for BadgerCare Plus and Medicaid SSI HMOs. The entire 2016-2017 HMO contract can be found here:

<https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Providers/providerContracts.htm.spage>