External Quality Review

Fiscal Year 2021 – 2022

Obstetric Medical Home Record Review

Calendar Year 2020 Births
Final Report

Prepared for

Wisconsin Department of Health Services

Division of Medicaid Services

Prepared by

METASTAR

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External Quality Review Organization

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Introduction and Overview

Purpose of This Report

This report summarizes the results of the evaluation of medical records for all pregnant women enrolled in the Wisconsin Department of Health Services (DHS) Obstetric Medical Home (OBMH) through a participating managed care organization (MCO). MetaStar, Inc. conducted the review during fiscal year 2020-2021 for births occurring during calendar year 2020 (CY 2020). This is an optional external quality review activity requested and directed by DHS.

External Quality Review

MetaStar is the External Quality Review Organization (EQRO), contracted and authorized by the Wisconsin Department of Health Services (DHS) to provide independent evaluation of managed care organization (MCO) compliance with federal Medicaid managed care regulations and the DHS contract with MCOs. MetaStar conducts external quality review (EQR) for all MCOs operating Family Care (FC), Family Care Partnership (FCP), Program for All-inclusive Care of the Elderly (PACE), BadgerCarePlus (BC+), and Supplemental Security Income (SSI) or SSI-related Medicaid programs in the State of Wisconsin. MetaStar also conducts external quality review for two pre-paid inpatient health plans (PIHPs) who serve children with mental health needs. An additional MCO also provides comprehensive and coordinated health services for children and youth enrolled in the PIHP for the foster care medical home benefit.

MetaStar is contracted and authorized by DHS to conduct independent evaluations of Medicaid MCOs that provide health care services to pregnant women eligible for BadgerCare Plus (BC+) or Supplemental Security Income (SSI) Medicaid in the State of Wisconsin who are enrolled in the OB Medical Home. See the Appendix for more information about external quality review, the EQRO team, and a description of the methodology used to conduct the review activity.

Review Methodology and Scope of External Review Activities

MetaStar reviewed 837 enrollee records for this initiative. The purpose of the review was to:

- Assess the MCO's and clinics' levels of compliance with requirements contained in the MCO's contract with DHS;
- Collect data that supports potential future program refinements; and
- Collect data that supports program evaluation.

MetaStar's review is conducted using criteria and reviewer guidelines agreed upon with DHS, and based on the *Contract for BadgerCare Plus and/or Medicaid SSI HMO Services*, January 1, 2019 – December 31, 2021. Results from the review are documented in a system implemented and maintained by the DHS Medicaid Information System vendor, Gainwell Technologies (Gainwell); formerly DXC Technology.

Medical Home Profile

The Medical Home model is part of DHS' Healthy Birth Outcomes (HBO) initiative, focused on eliminating racial and ethnic disparities in birth outcomes and infant mortality for pregnant women eligible for BC+ or SSI Medicaid. Information about the initiative can be found on these DHS websites:

- http://www.dhs.wisconsin.gov/healthybirths/
- https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Managed_Care_Medical_Homes/Home.htm.spage
- https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/OBMH/OBMHome.htm.spage

During the time period associated with prenatal care for members who delivered infants in CY 2020, 12 MCOs contracted with clinics and established memoranda of agreements to implement the OBMH in Dane, Rock, Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties. Not all MCOs established agreements with all clinics in their networks that provide prenatal care to its members.

The MCOs, respective service areas and total number of records reviewed are documented in Table 1 below.

Table 1: MCOs and Service Areas

MCO	Total Records	Service Area		
		Dane County	Rock County	Southeastern WI
Anthem Blue Cross and Blue Shield (Anthem)	94			X
Children's Community Health Plan (CCHP)	195			X
Dean Health Plan (DHP)	215	X	X	
Group Health Cooperative of South Central Wisconsin (GHC-SCW)	34	X		
Independent Care Health Plan (*i*Care)	15			X
MHS Health Wisconsin (MHS)	24			X
MercyCare Health Plan (MCHP)	41		X	
Molina Healthcare of Wisconsin (MHWI)	80			X
Network Health Plan (NHP)	10			
Quartz	56	X		
Trilogy Health Plan (Trilogy)	12			X
United Health Care (UHC)	61		X	X
Total	837	3	3	7

The following table identifies each OBMH clinic, its MCO affiliations, and the number of records reviewed.

Table 2: OBMH Clinics and MCO Affiliation

Medical Home Clinic and Service Area	MCO	Total Records
Access Community Health Centers (Access) Dane County	DHP GHC-SCW Quartz	82
All Saints and All Saints Family Care Center (All Saints) SE WI	Anthem CCHP MHS MHWI NHP UHC	38
Aurora Midwifery & Wellness Center (Aurora) SE WI	Anthem CCHP MHWI	41
Beloit Clinic Rock County	UHC	0
Columbia St. Mary's Family Health Center (Columbia St. Mary's) SE WI	Anthem CCHP iCare MHS MHWI NHP	74

Medical Home Clinic and Service Area	MCO	Total Records
Dean Clinics (Dean) Dane and Rock Counties	DHP	207
Froedtert East OB/GYN Residency Clinic (Froedtert) SE WI	Anthem CCHP UHC	111
F&MCW CP OB/GYN (F&MCW) SE WI	Anthem CCHP NHP Trilogy UHC	40
GHC-SCW Clinics (GHC-SCW) Dane County	GHC-SCW	26
Lisbon Avenue Health Center (Lisbon) SE WI	Anthem CCHP iCare MHS MHWI UHC	79
Mercy Health Systems Clinics (Mercy) Rock County	MCHP	41
Sixteenth Street Community Health Center (Sixteenth St.) SE WI	Anthem CCHP MHWI NHP UHC	31
St. Joseph's Hospital Women's Health Center (St. Joseph's) SE WI	Anthem CCHP MHS MHWI NHP Trilogy UHC	61
UW Health Arboretum Clinic (UW Health) Dane County	Quartz	0
Wheaton Franciscan Glendale Family Care Center (Wheaton Franciscan) SE WI	Anthem CCHP Molina NHP Trilogy	6
Total Records		837

The most recent MCO enrollment data available at the time of the review and ongoing is posted to the following DHS website:

https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Enrollment_Information/Reports.htm.spage

CONTRACT REQUIREMENTS

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

The four core principles of the program include:

- Having a designated OB care provider who serves as the team leader and a point of entry for new problems;
- Ongoing care throughout the prenatal and postpartum periods;
- Comprehensive care that meets the member's health and psychosocial needs; and
- Coordinated care provision across the member's conditions, providers, and settings.

The specific contractual requirements for each element are outlined in the following results section.

RESULTS

The review evaluated the following categories: Record Submission, Verification of Enrollment, Verification of Care Coordination, Verification of Postpartum Care Coordination and Discharge Planning; and Identification of Birth Outcomes. Each section below describes the dataset for this report, the requirements verified, and the results of key review elements included for data abstraction. Results are reported by MCO and clinic. When reviewing and comparing results, the reader should consider the number of records reviewed may vary year-to-year with some MCOs and/or clinics having a small number of records reviewed.

The review period included the early days of the COVID-19 public health emergency (PHE), including the Wisconsin *Safer at Home* order. The requirements of the *Safer at Home* orders may be a contributing factor in the results.

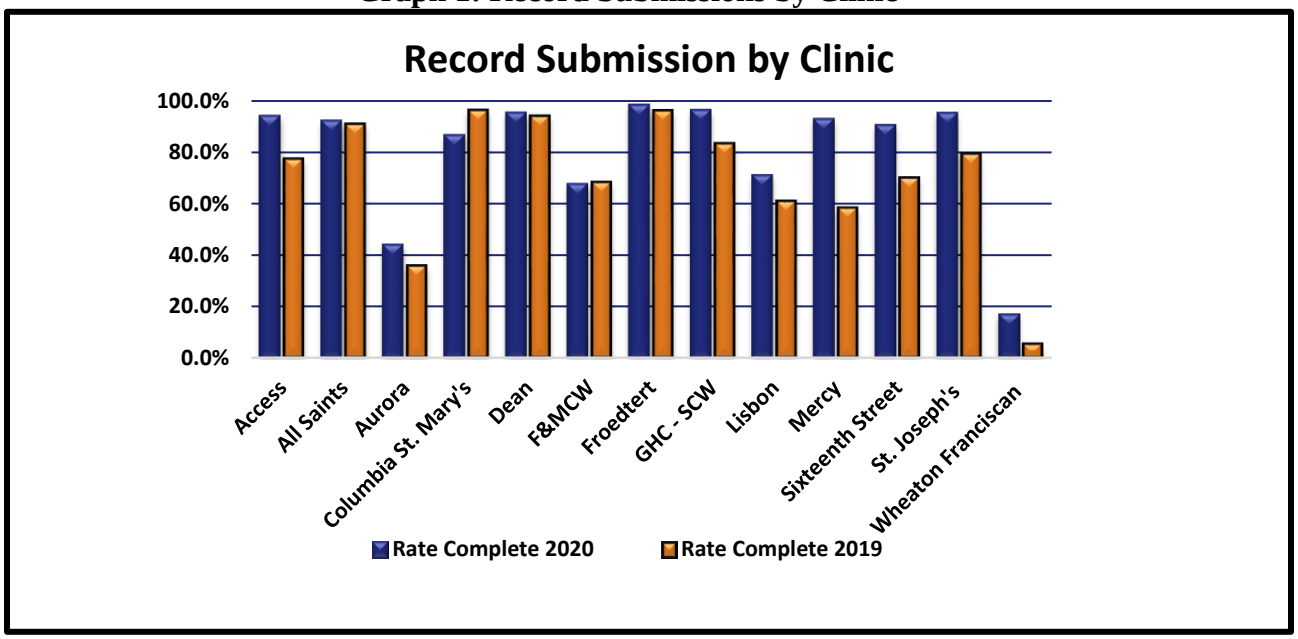
RECORD SUBMISSION

DHS delegated responsibility for dataset creation and MCO communications for medical record submissions to MetaStar. Following confirmation of the members in each dataset, DHS and/or MetaStar requested medical records for each member. The MCOs worked with the clinics to submit or provide access to the medical records.

The DHS information system used to store data for the OBMH includes documentation of whether a full or partial medical record was submitted for review. The medical record is considered complete when clinic, care coordination, and infant delivery documentation are submitted, or are accessible to reviewers through an electronic medical record (EMR).

The following graph documents the percentage of complete medical record submissions by clinic compared to the 2019 results.

Graph 1: Record Submissions by Clinic



Almost 88 percent (87.6) of all records reviewed were complete during CY 2020, an increase from 81.4 percent during CY 2019. Analysis indicated the year-to-year difference in the complete record submission rates is likely attributable to actions of the clinics, and is unlikely to be the result of normal variation or chance.

Review Findings

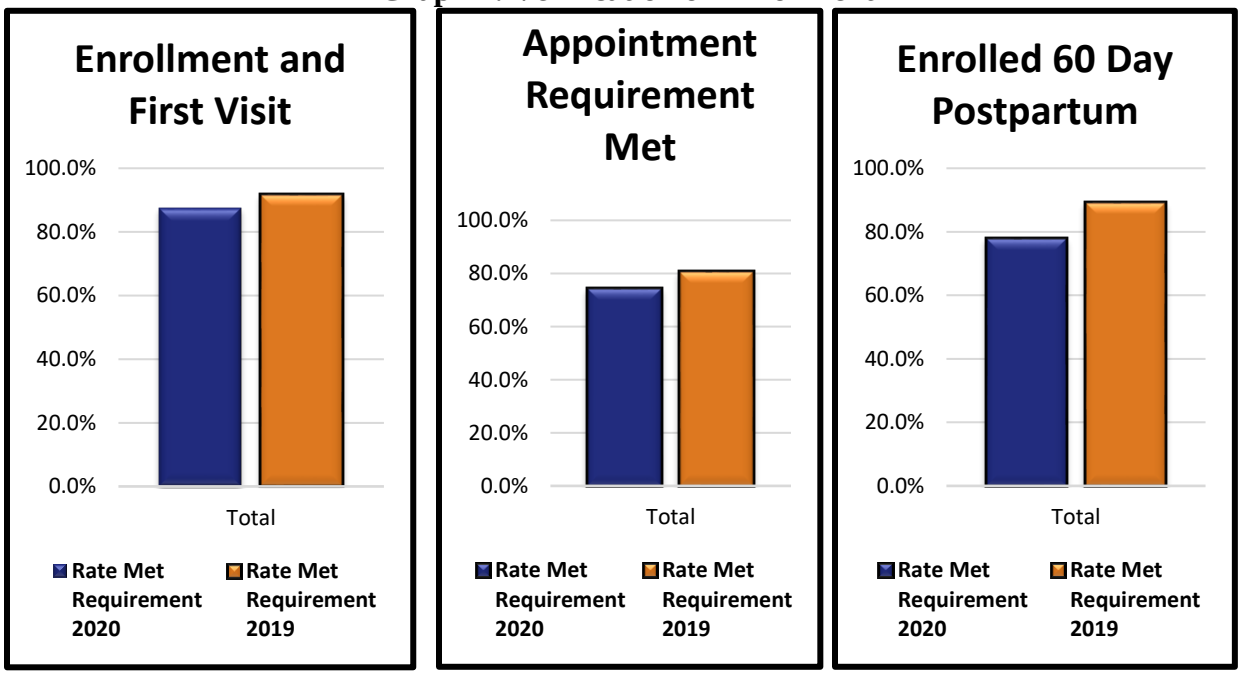
Verification of Enrollment

Requirement: The DHS-MCO contract outlines that members must:

- Make the first medical home visit within the first 16 weeks of pregnancy;
- Attend a minimum of 10 appointments with the OB care provider; and
- Remain enrolled through 60 days postpartum.

Results: The aggregate review findings for the above requirements by MCO and clinic are documented in the graphs below.

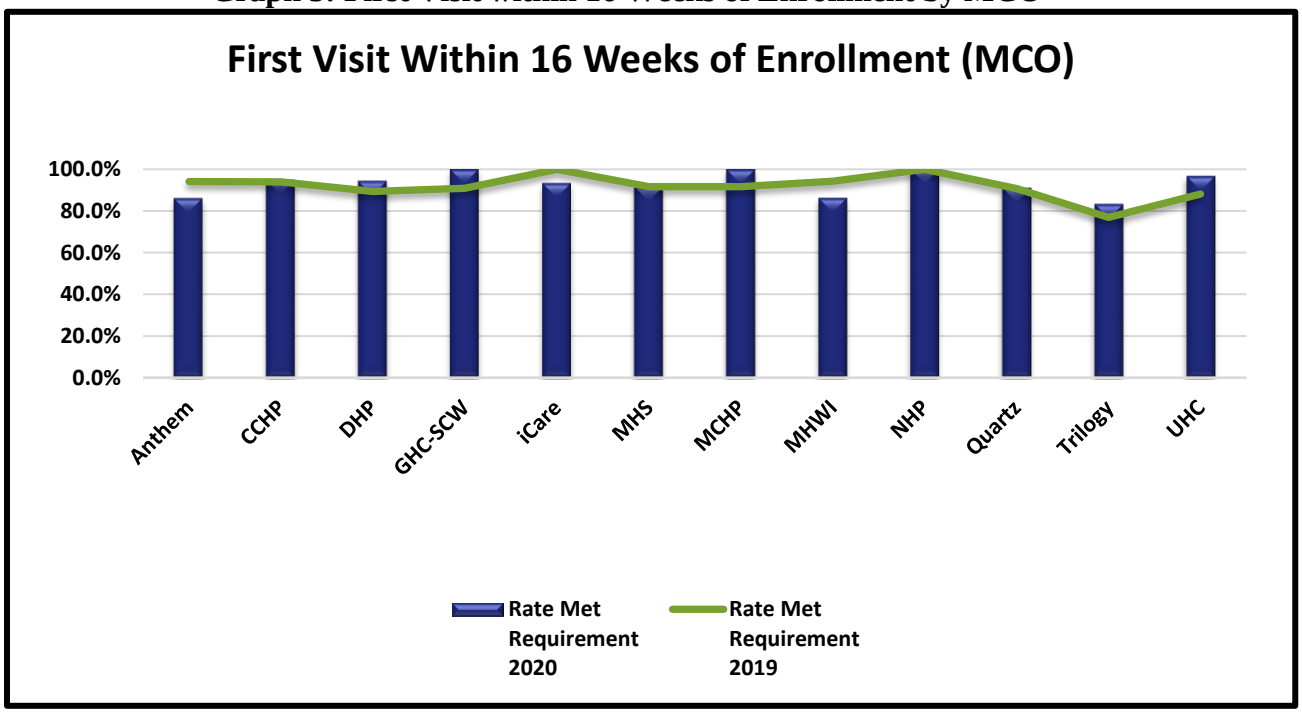
Graph 2: Verification of Enrollment



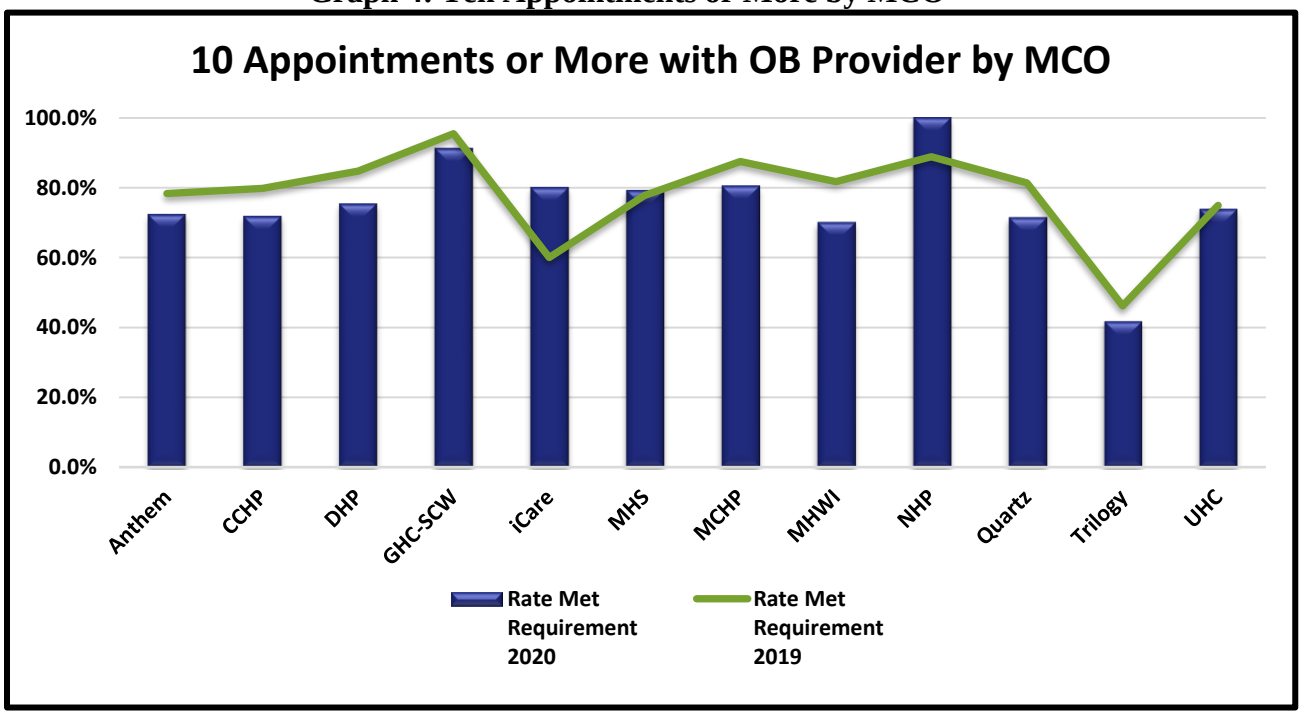
Analysis indicated the year-to-year difference in the 10 appointments with OB provider and enrollment through 60 days postpartum rates are unlikely to be the result of normal variation or chance. The year-to-year difference in the enrollment by 16 weeks rates is likely due to normal variation or chance.

The following graphs provide results by MCO and clinic respectively.

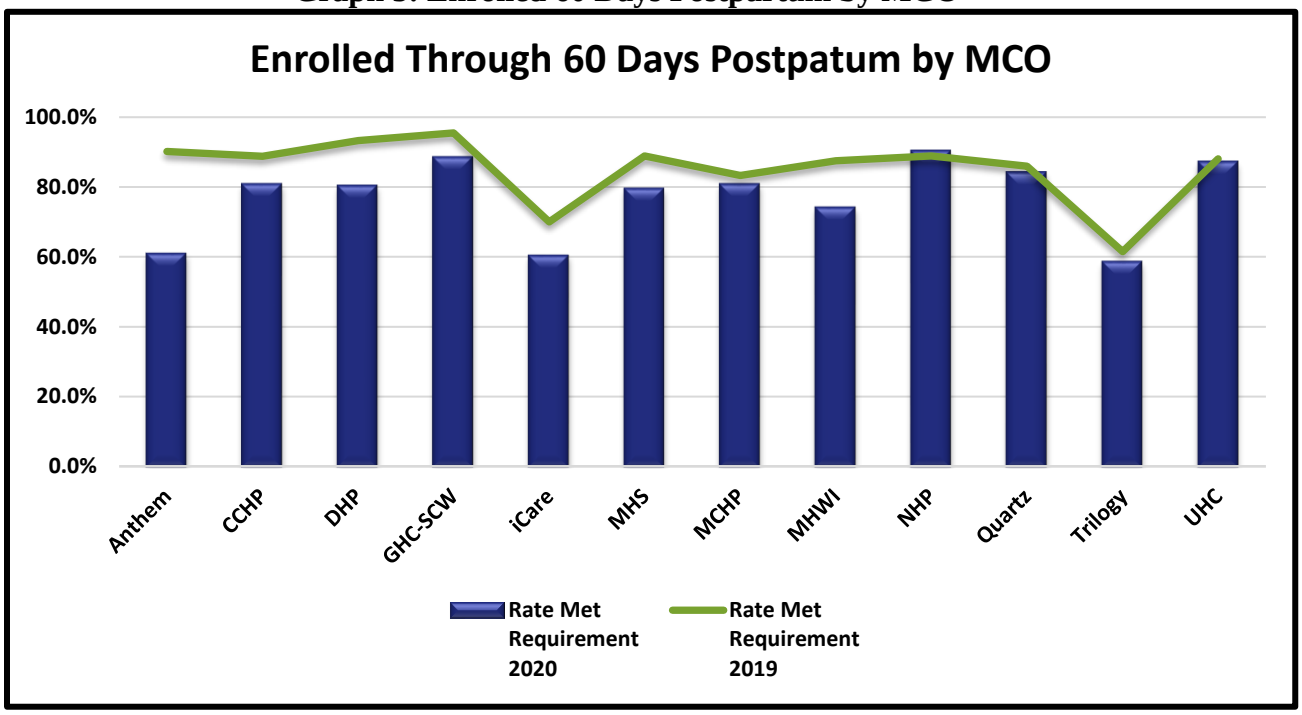
Graph 3: First Visit within 16 Weeks of Enrollment by MCO



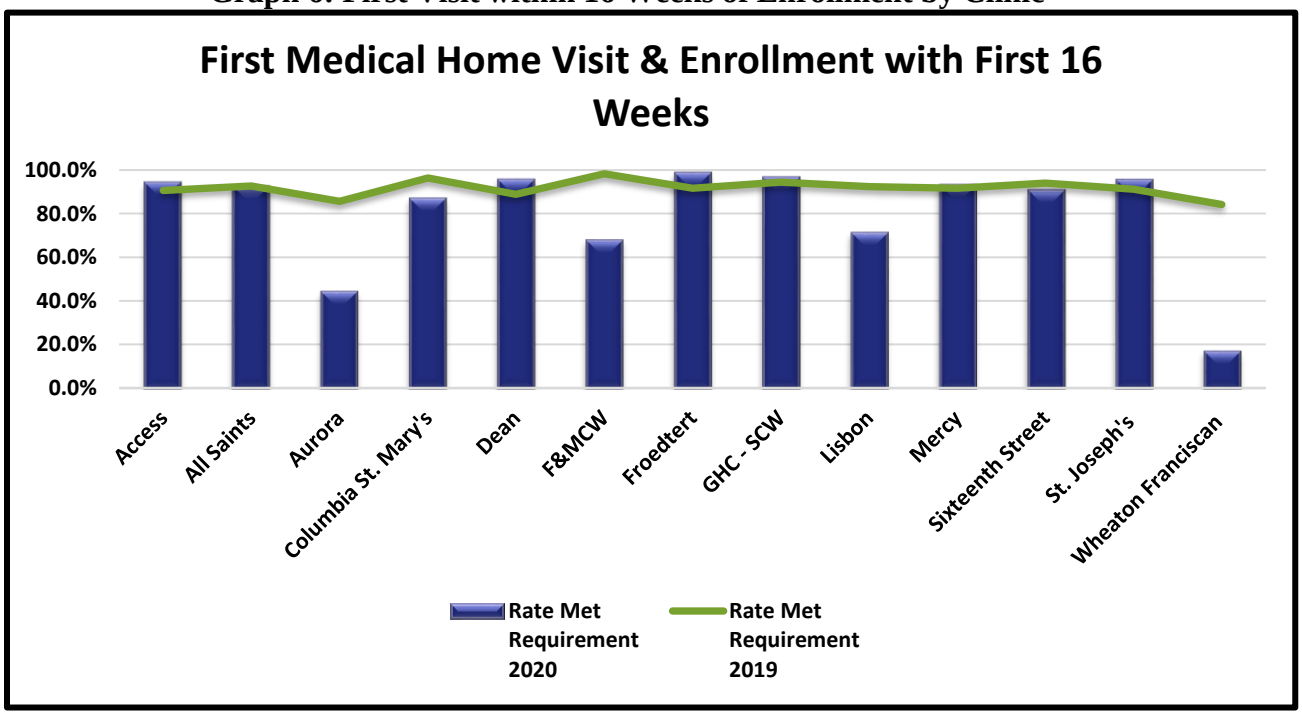
Graph 4: Ten Appointments or More by MCO



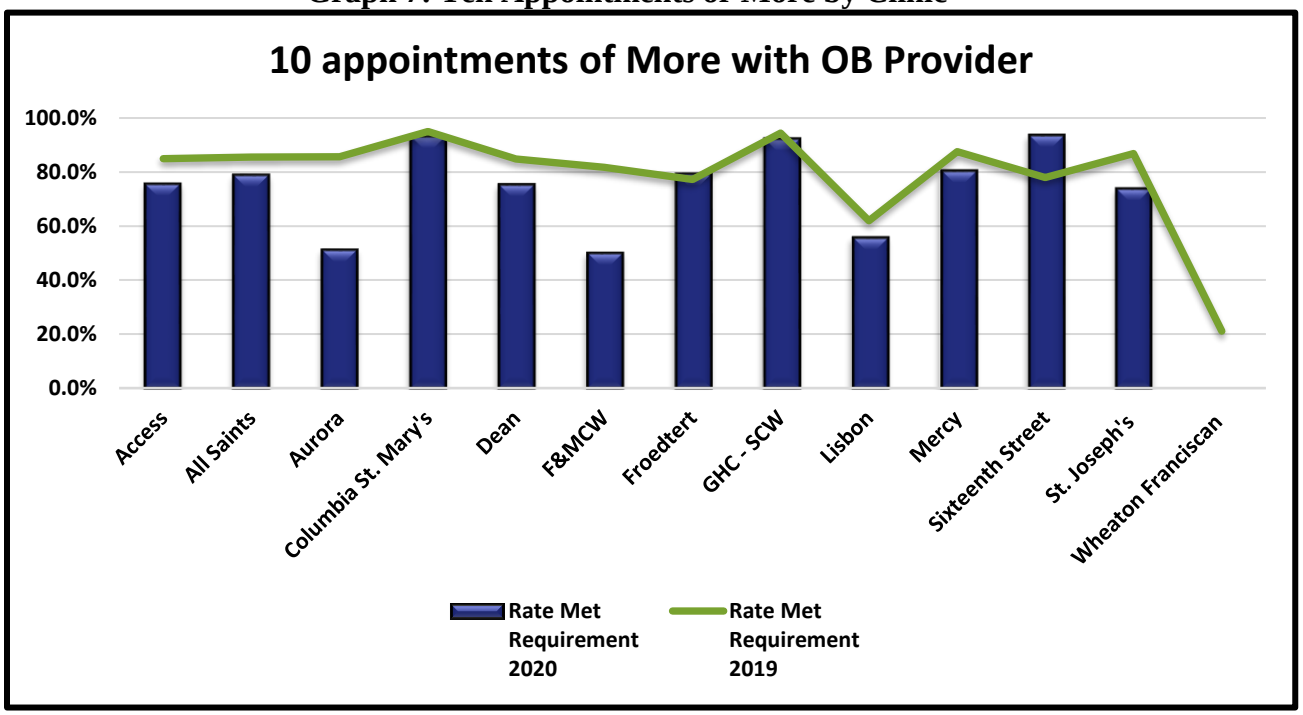
Graph 5: Enrolled 60 Days Postpartum by MCO



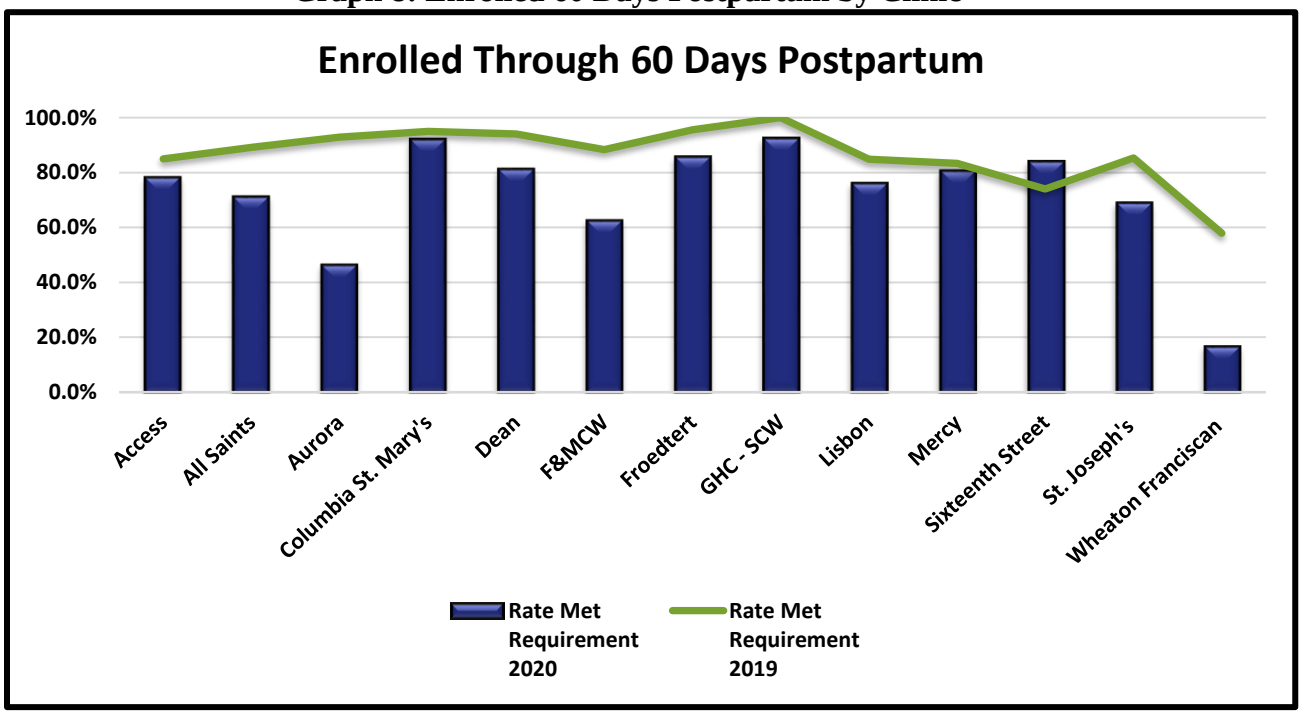
Graph 6: First Visit within 16 Weeks of Enrollment by Clinic



Graph 7: Ten Appointments or More by Clinic



Graph 8: Enrolled 60 Days Postpartum by Clinic



The individual clinics year-to-year rates of compliance varied in CY 2020 when compared to CY 2019. Of the 13 clinics that were included in both calendar years, 46.2 percent showed an

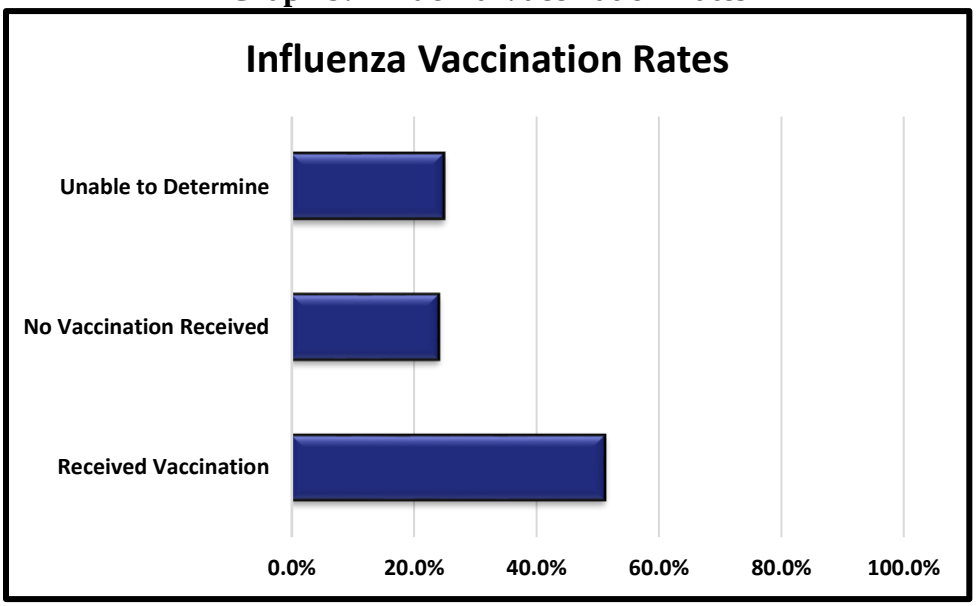
increase in CY 2020 from CY 2019 for the first visit within 16 weeks; while 15.4 percent showed a year-to-year increase in the requirement of a minimum of 10 appointments. Over 92 percent of clinics included in both calendar years showed decline in the postpartum enrollment requirement in CY 2020 compared to CY 2019.

IMMUNIZATIONS

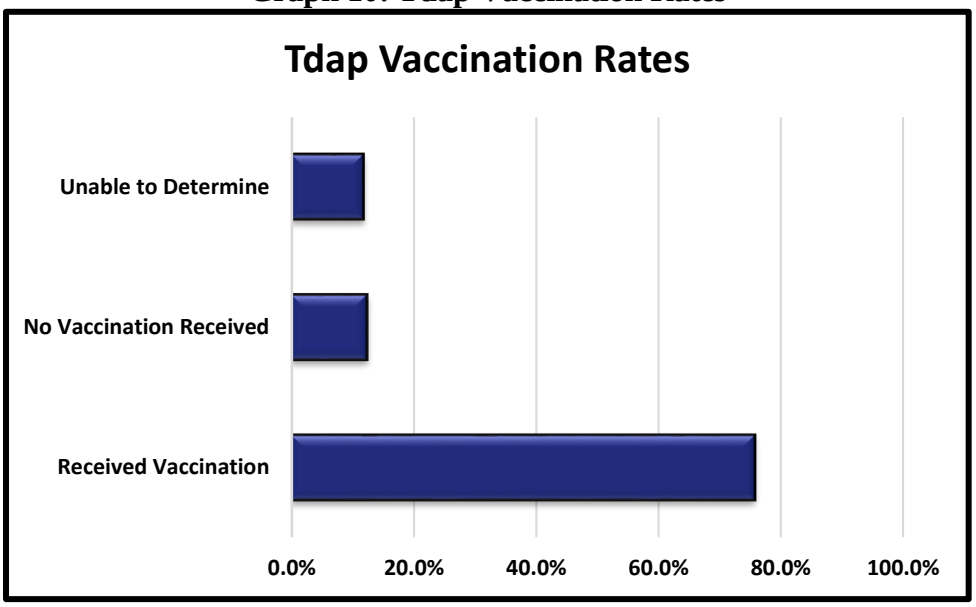
The American College of Obstetricians and Gynecologists (ACOG) recommends an annual influenza vaccine during each pregnancy. The ACOG also recommends a Tetanus, Diphtheria, Pertussis (Tdap) vaccination given during the third trimester of each pregnancy. MetaStar has collected immunization data for both influenza and Tdap given during pregnancy for each record reviewed; however, the data collected does not factor into the OBMH incentive payment determinations.

The aggregate review findings for the influenza and Tdap immunizations are documented in the graphs below.

Graph 9: Influenza Vaccination Rates



Graph 10: Tdap Vaccination Rates

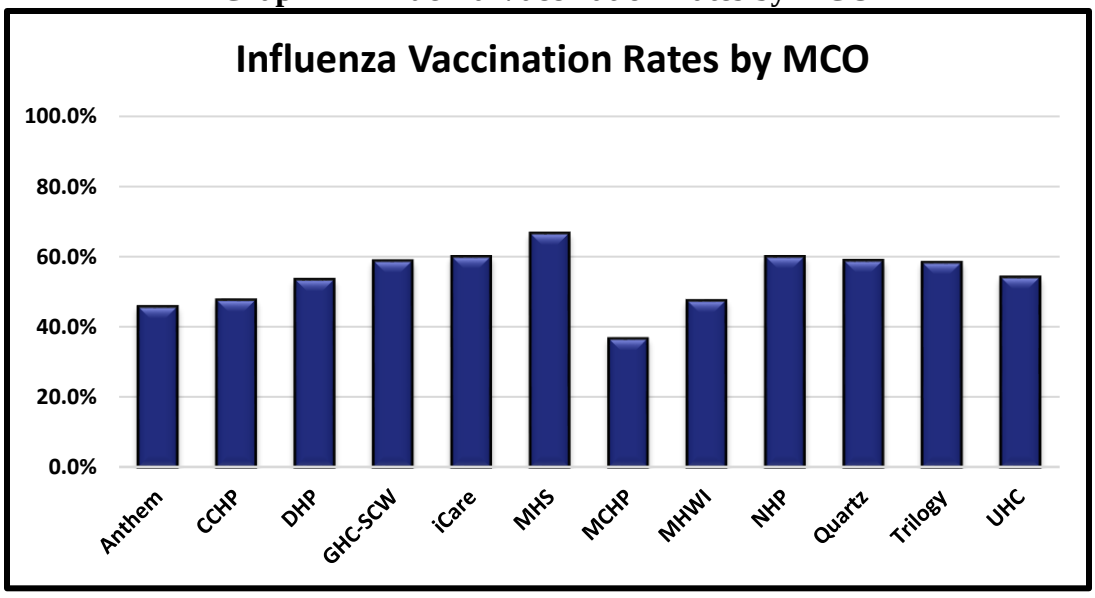


Documentation indicated 22.2 percent of members declined an influenza vaccine during pregnancy. Almost 25 percent of records reviewed did not contain enough information to determine if the member received the influenza vaccine.

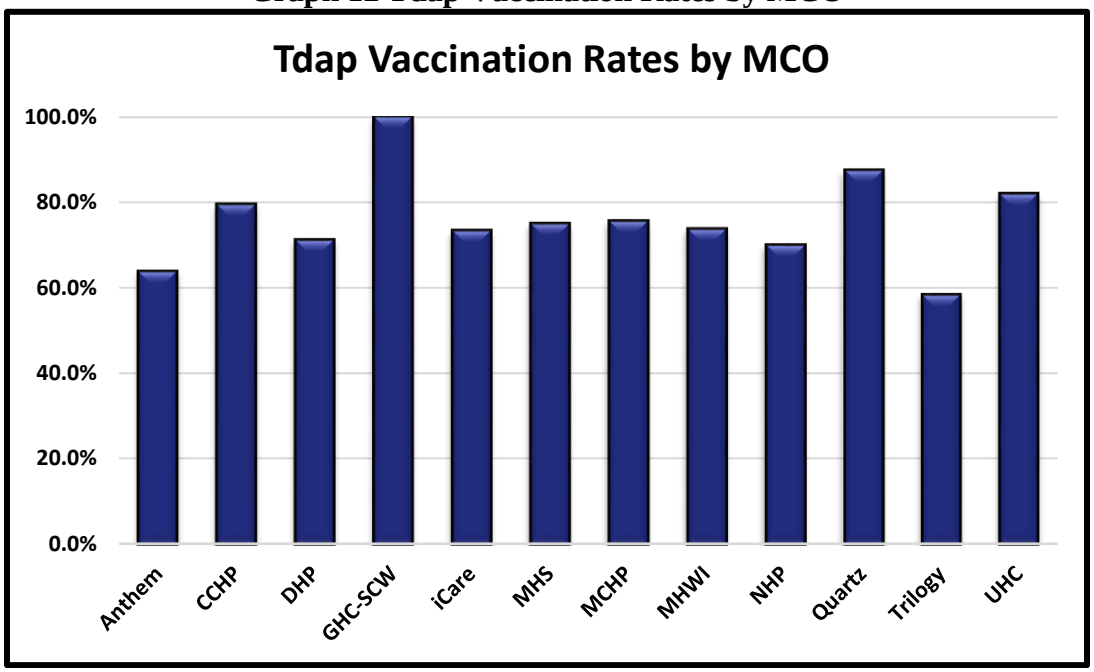
Of the 634 women who received a Tdap vaccine, 97 percent occurred during the third trimester as recommended. Fourteen (2.2 percent) received the vaccine during the second trimester. Just over 10 percent of records included documentation that the member refused the vaccine.

The following graphs provide results by MCO and clinic respectively.

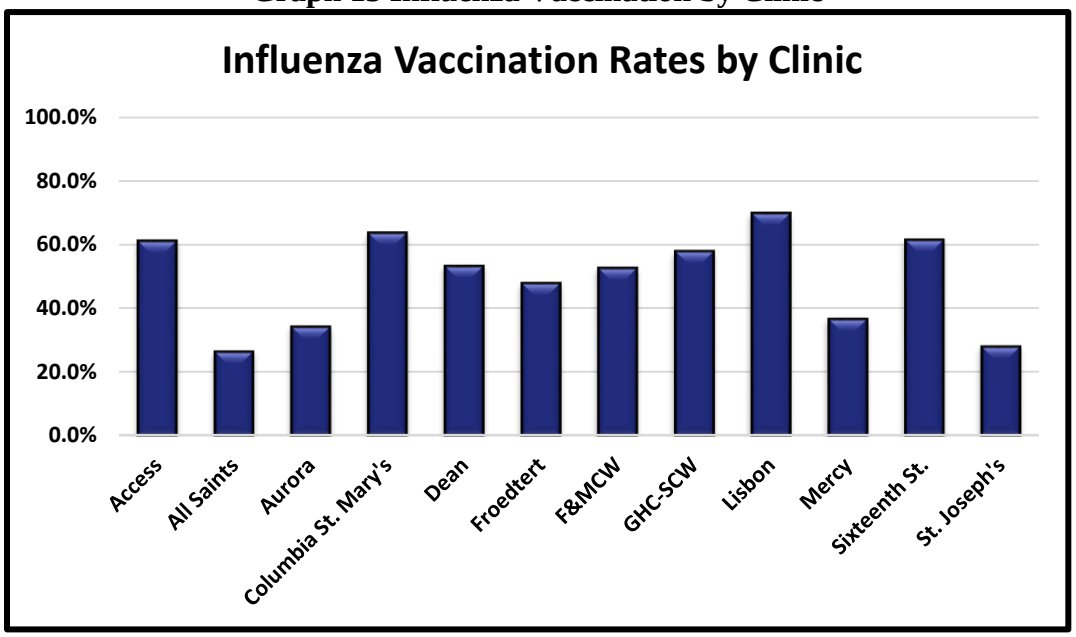
Graph 11 Influenza Vaccination Rates by MCO



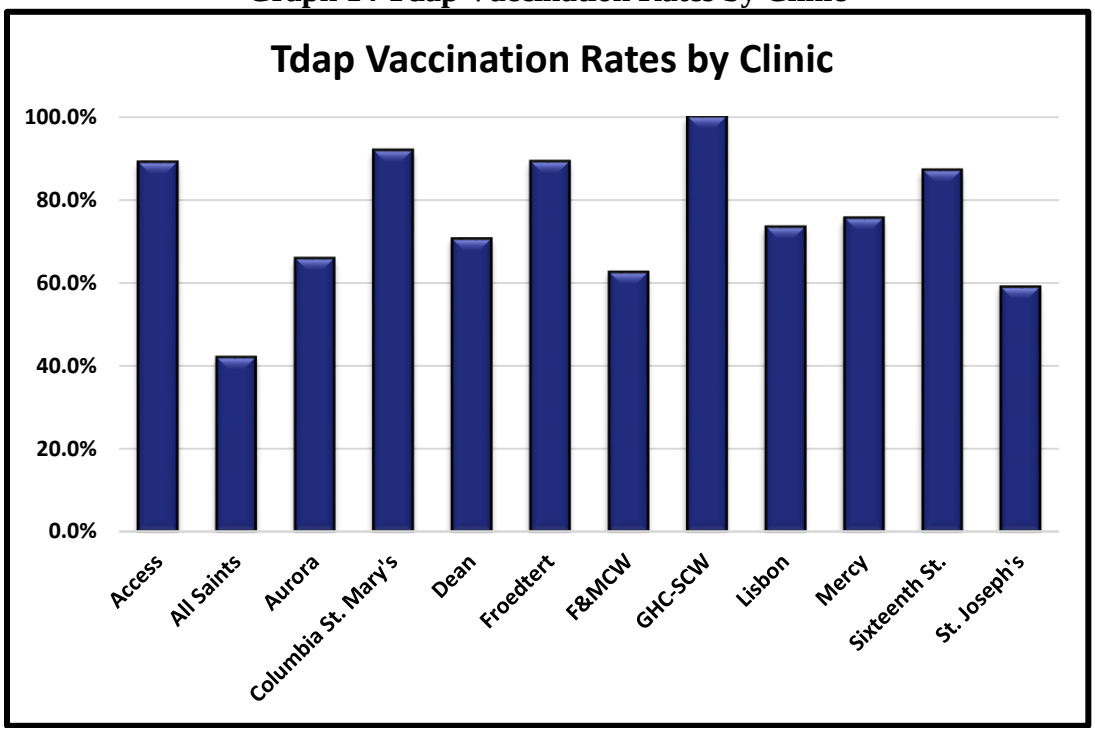
Graph 12 Tdap Vaccination Rates by MCO



Graph 13 Influenza Vaccination by Clinic



Graph 14 Tdap Vaccination Rates by Clinic



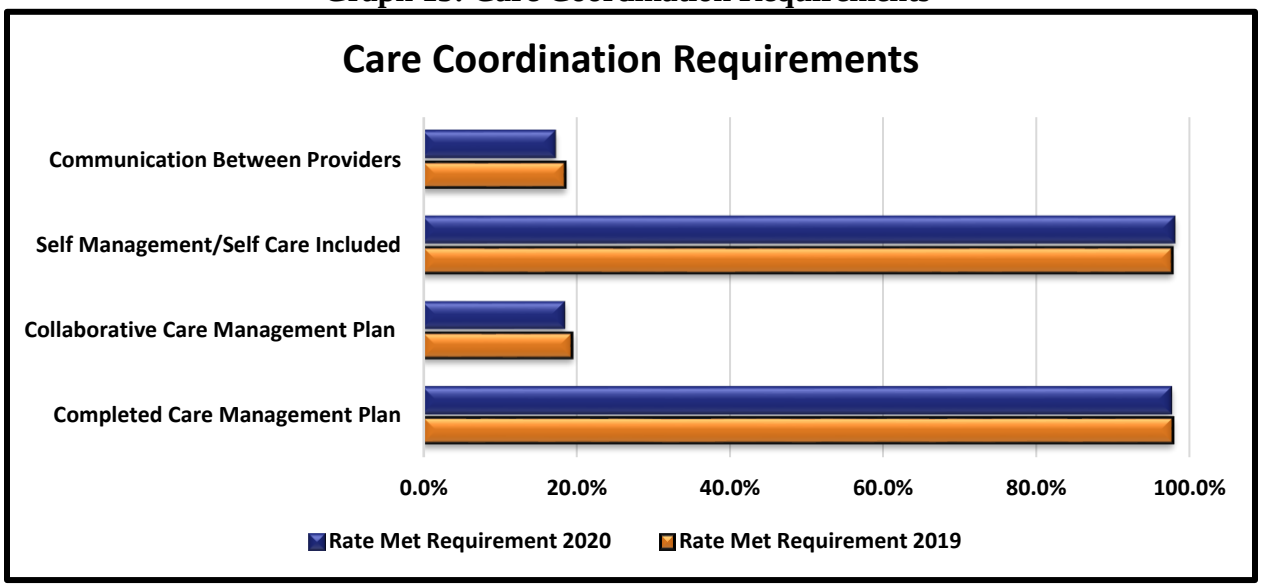
VERIFICATION OF CARE COORDINATION

Requirement: The DHS-MCO contract also describes the following requirements related to documentation of care coordination:

- A care management plan developed as a result of an initial intake process where all needs are identified;
- The OB care provider developed the care management plan in conjunction with the care coordinator, the primary care provider (PCP), and the member;
- A care management plan that includes a self-management/self-care component;
- Regular care coordination communications between the OB care provider, the PCP, and the care coordinator; and
- Information regarding an offer of home visits by nurse/social worker/care coordinator.

Results: The aggregate review findings for the first four requirements are documented in the graph below.

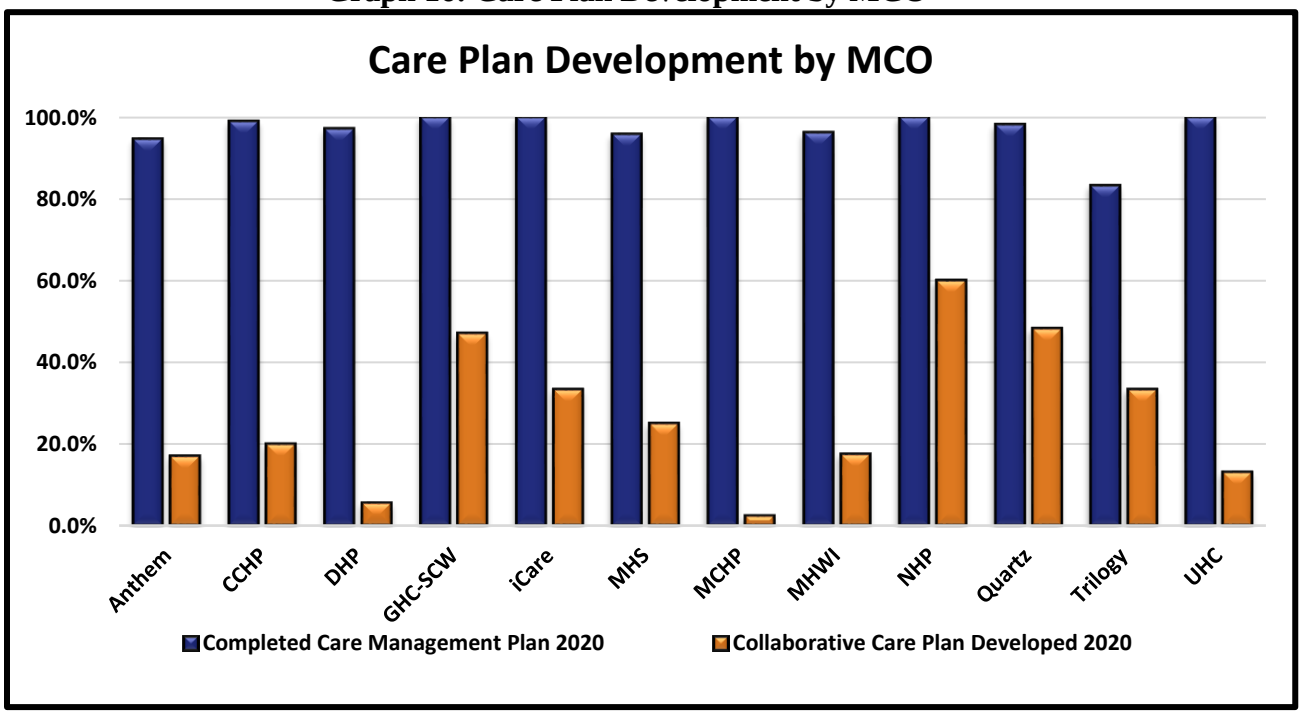
Graph 15: Care Coordination Requirements



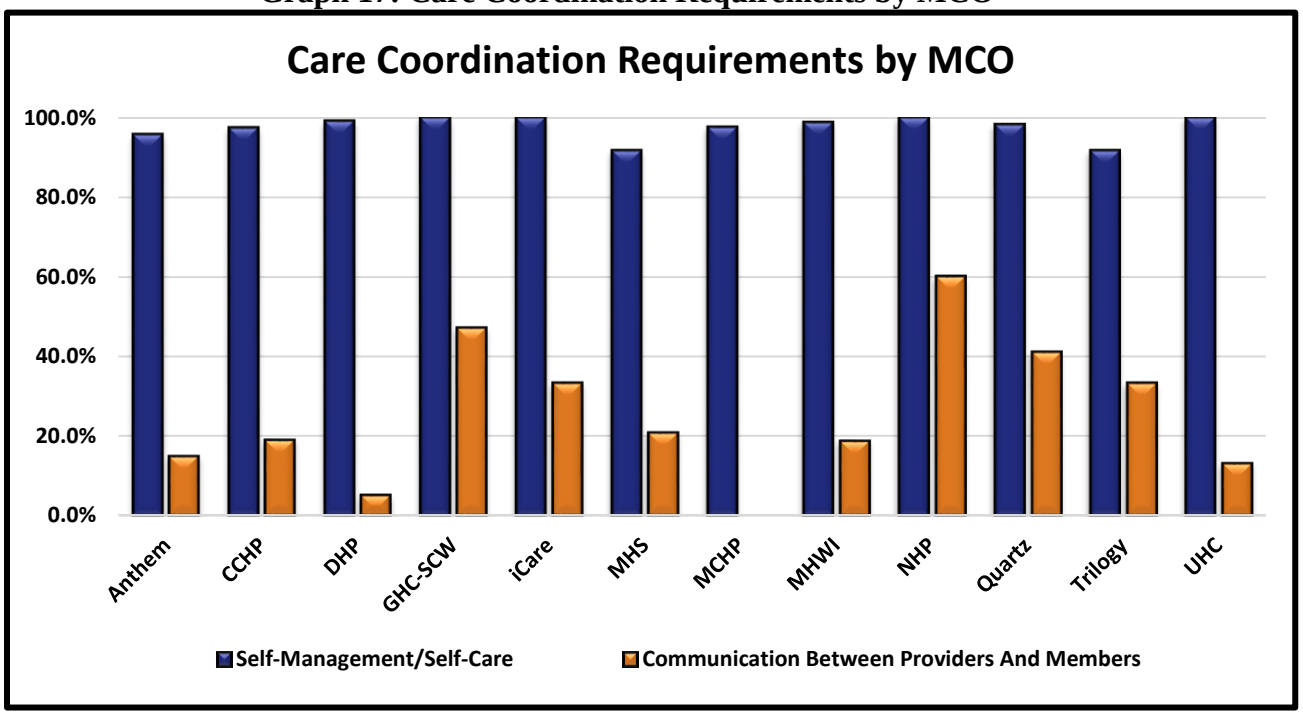
Analysis indicated the year-to-year difference in the completed care management plan, self-management/self-care included, collaborative plans and communication rates are likely due to normal variation or chance.

The following graphs provide results by MCO and clinic respectively.

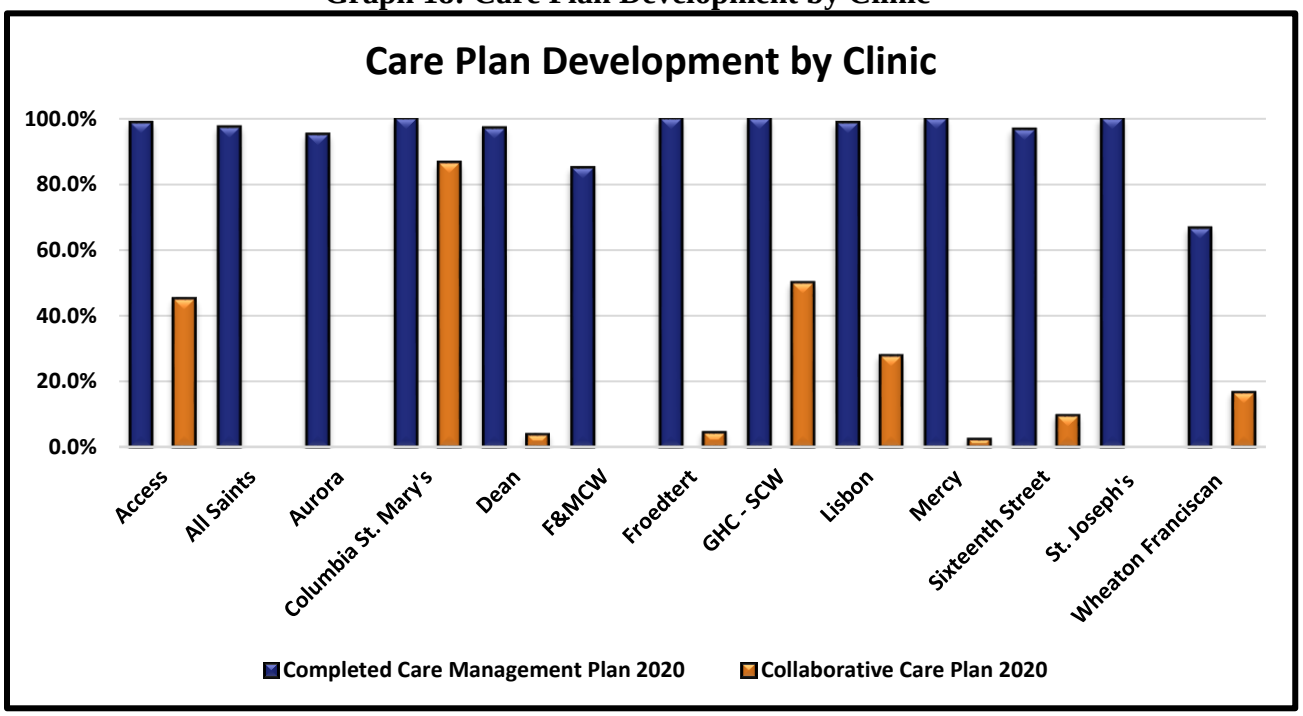
Graph 16: Care Plan Development by MCO



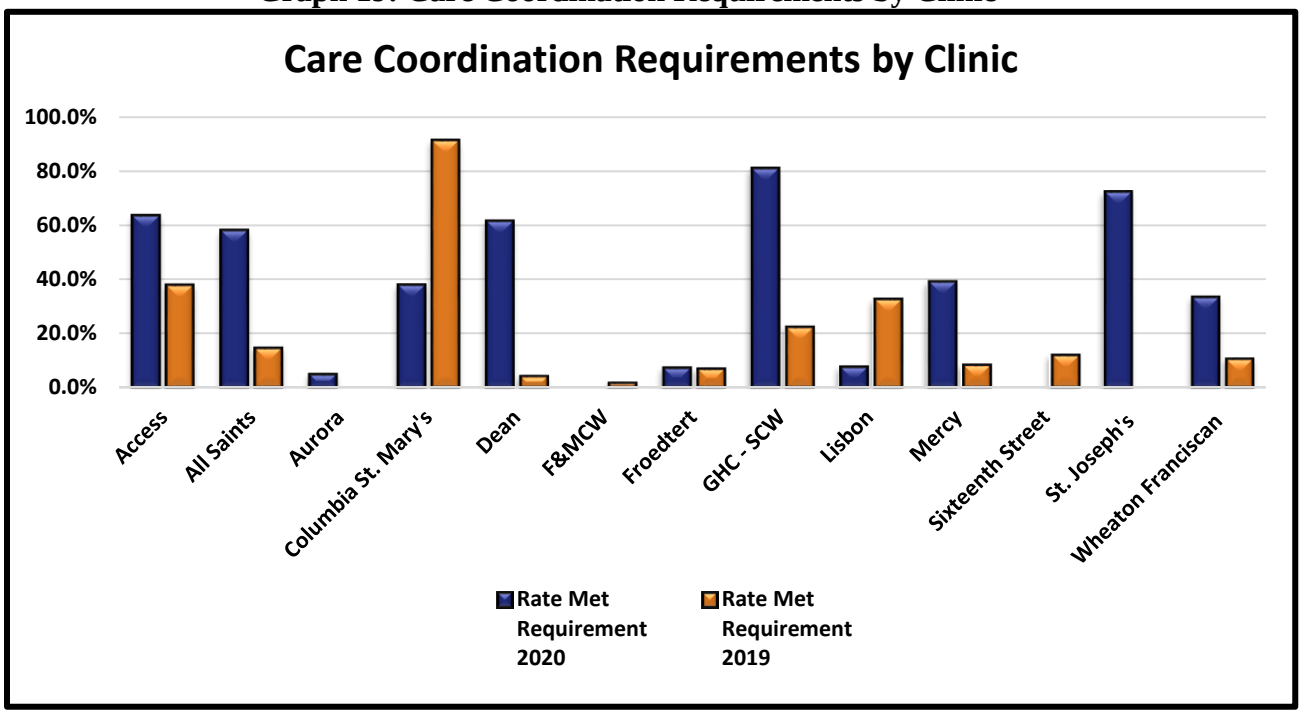
Graph 17: Care Coordination Requirements by MCO



Graph 18: Care Plan Development by Clinic

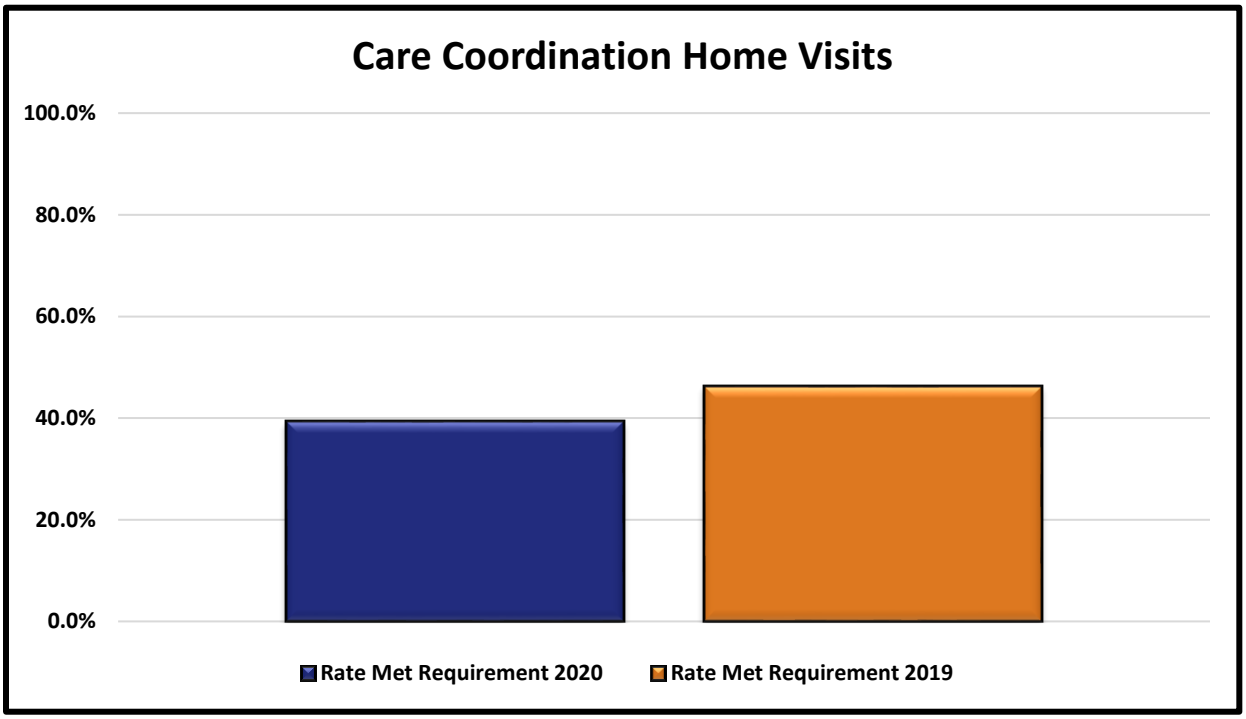


Graph 19: Care Coordination Requirements by Clinic



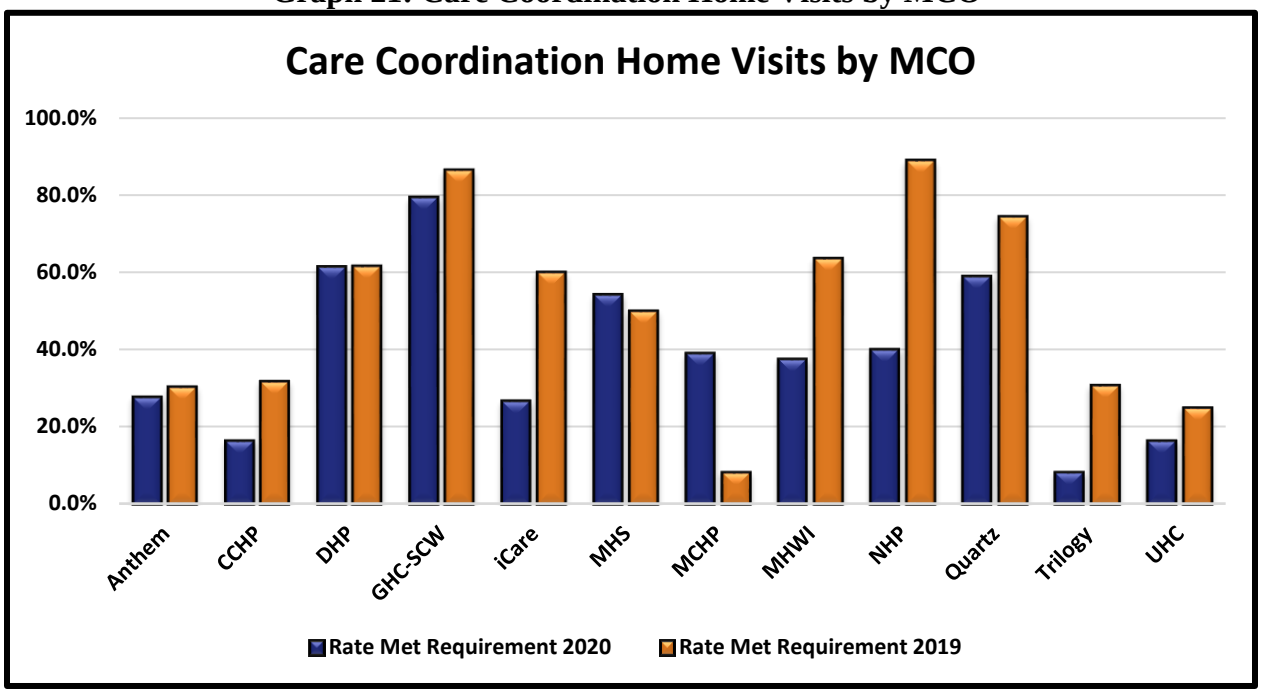
The graph below documents the aggregate rate that records documented members were offered home visits.

Graph 20: Care Coordination Home Visits

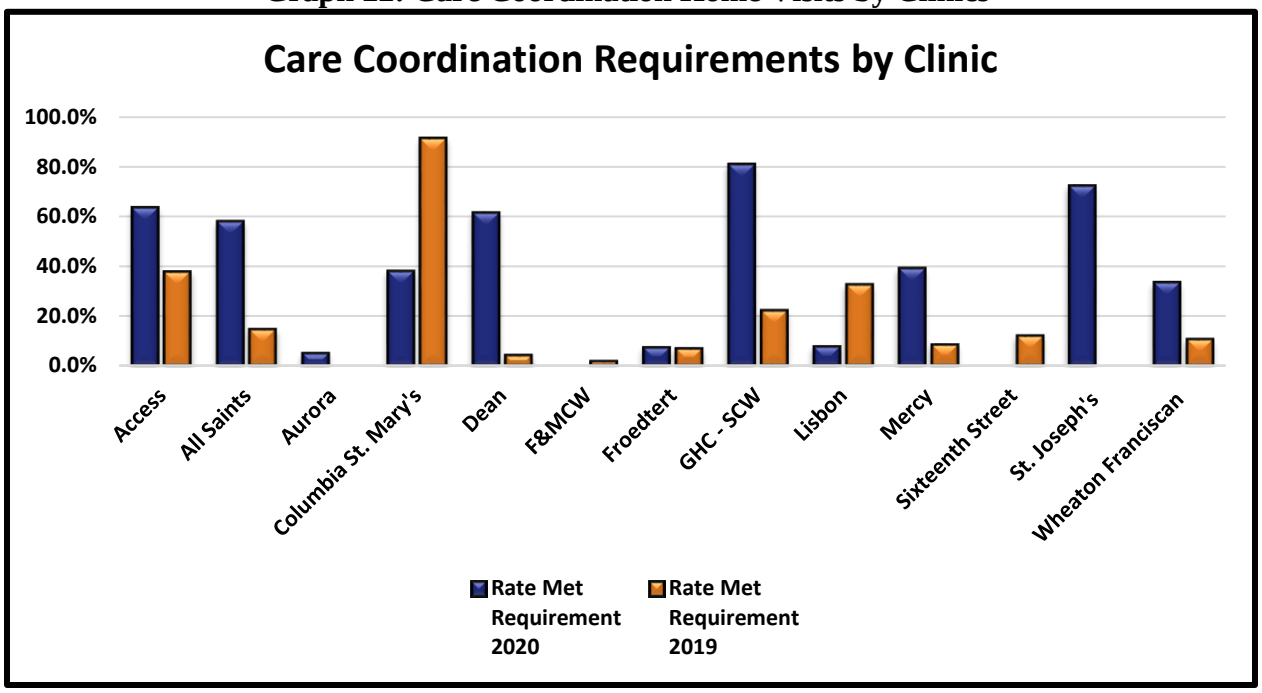


The following graphs provide the offer of home visit results by MCO and clinic respectively.

Graph 21: Care Coordination Home Visits by MCO



Graph 22: Care Coordination Home Visits by Clinics



DHS exempted clinics from the home visit requirement for the duration of the PHE. Documentation of the exemption was identified in many records, with many records reflecting explanations provided to members. However, incomplete record submission, lack of detailed documentation and contracting prenatal care coordination (PNCC) to external entities continue to impact the home visit compliance rates. Additionally, the PHE precautions shifted the PNCC appointments to telephonic or video sessions only.

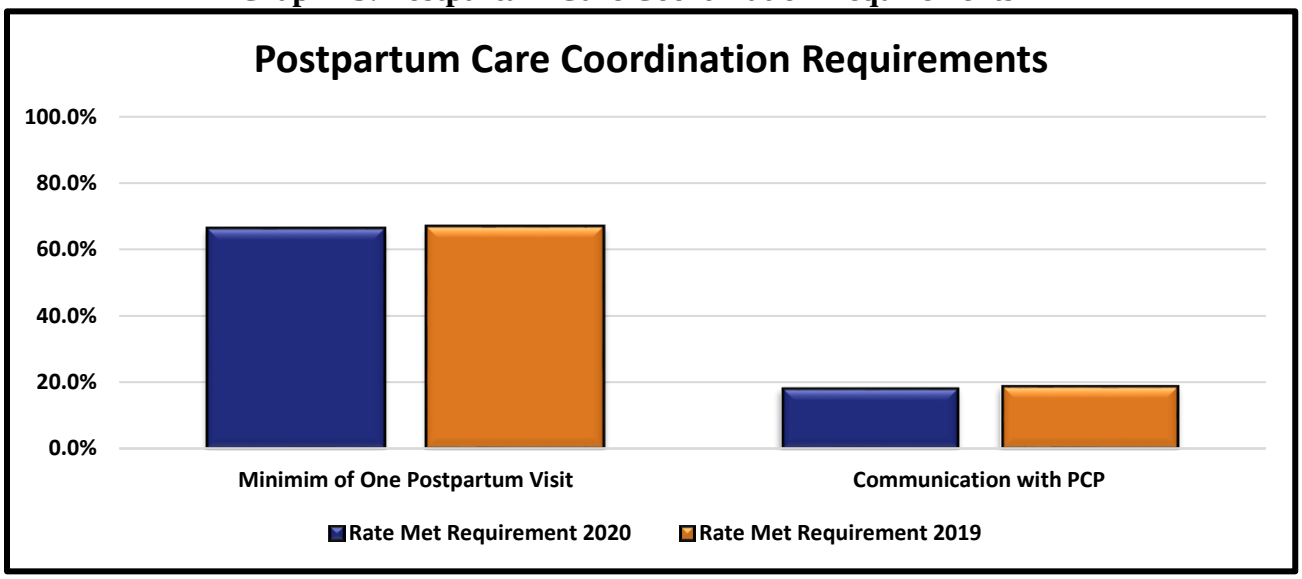
Verification of Postpartum Care Coordination and Discharge Planning

Requirement: The DHS-MCO contract includes the following requirements related to documentation of discharge planning and postpartum care. MetaStar evaluated records to determine whether members received satisfactory care, which includes:

- At least one postpartum visit (PPV) within 84 days post-delivery;
- Communication with the PCP post-delivery if the PCP is other than the OB provider;
- Member education on inter-conception care specific to the member's needs related to family planning preferences;
- Depression screening;
- Member education regarding breastfeeding;
- Member education regarding newborn care; and
- Follow-up care for any member with a chronic condition.

Results: The graphs below document the aggregate results of the record review for the requirements noted above; followed by additional graphs that provide results by MCO and clinic respectively. The postpartum visit element specifically looks for a confirmed PPV appointment within the required 84-day timeframe, and does not reflect missed appointments or efforts to support members in making appointments. Graph 17 shows the aggregate rates for this postpartum review element

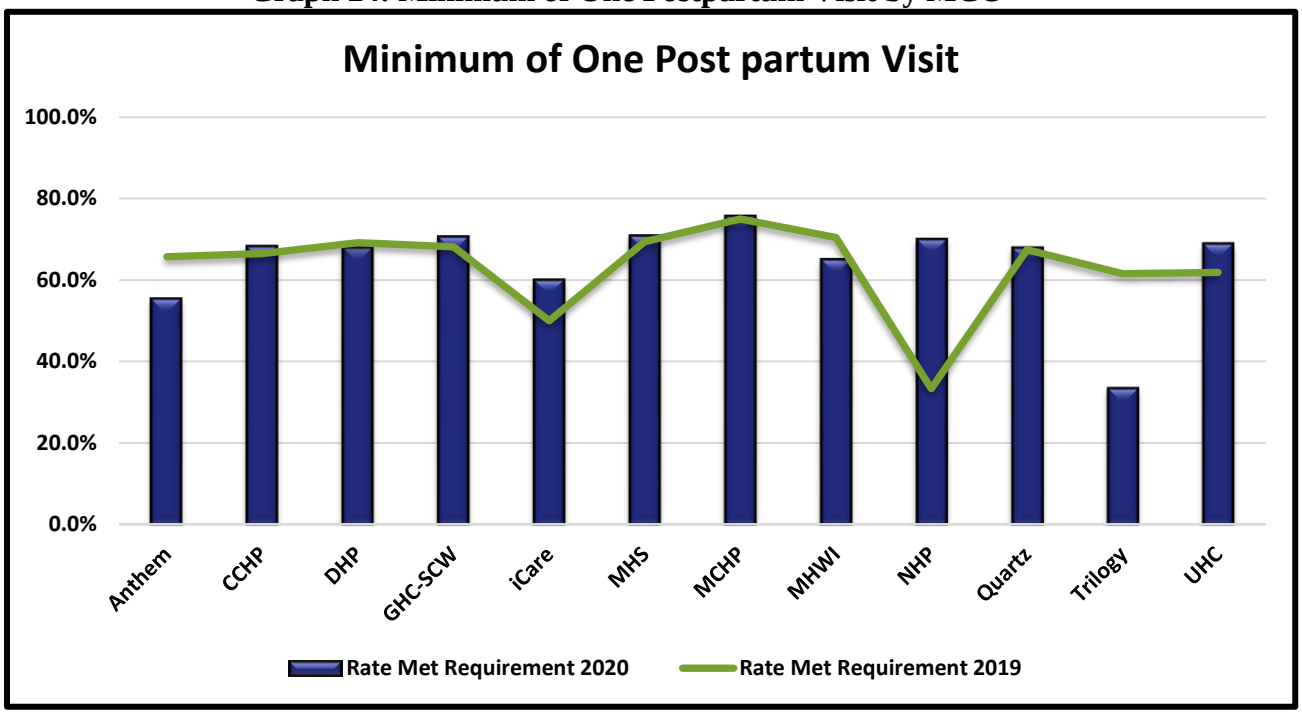
Graph 23: Postpartum Care Coordination Requirements



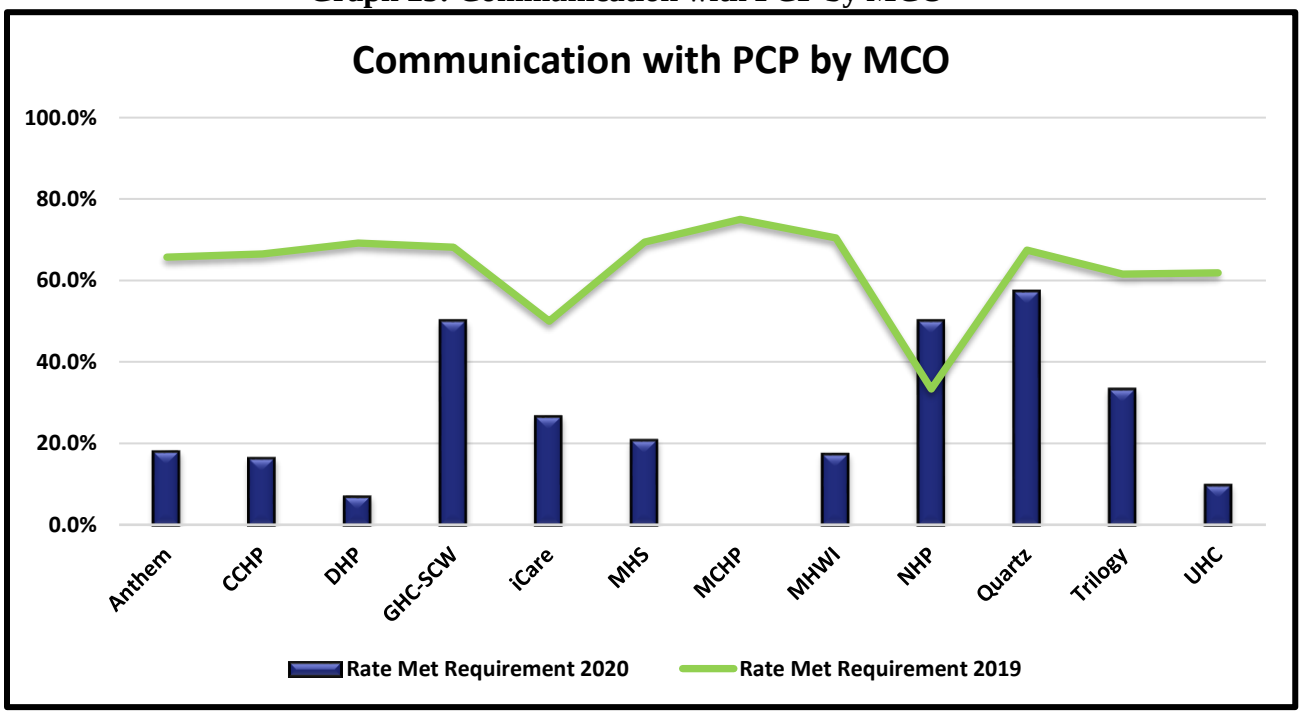
Analysis indicated the year-to-year difference in the postpartum visit rates is likely due to normal variation or chance.

Graphs 18 and 19 following provide results by MCO and clinic respectively.

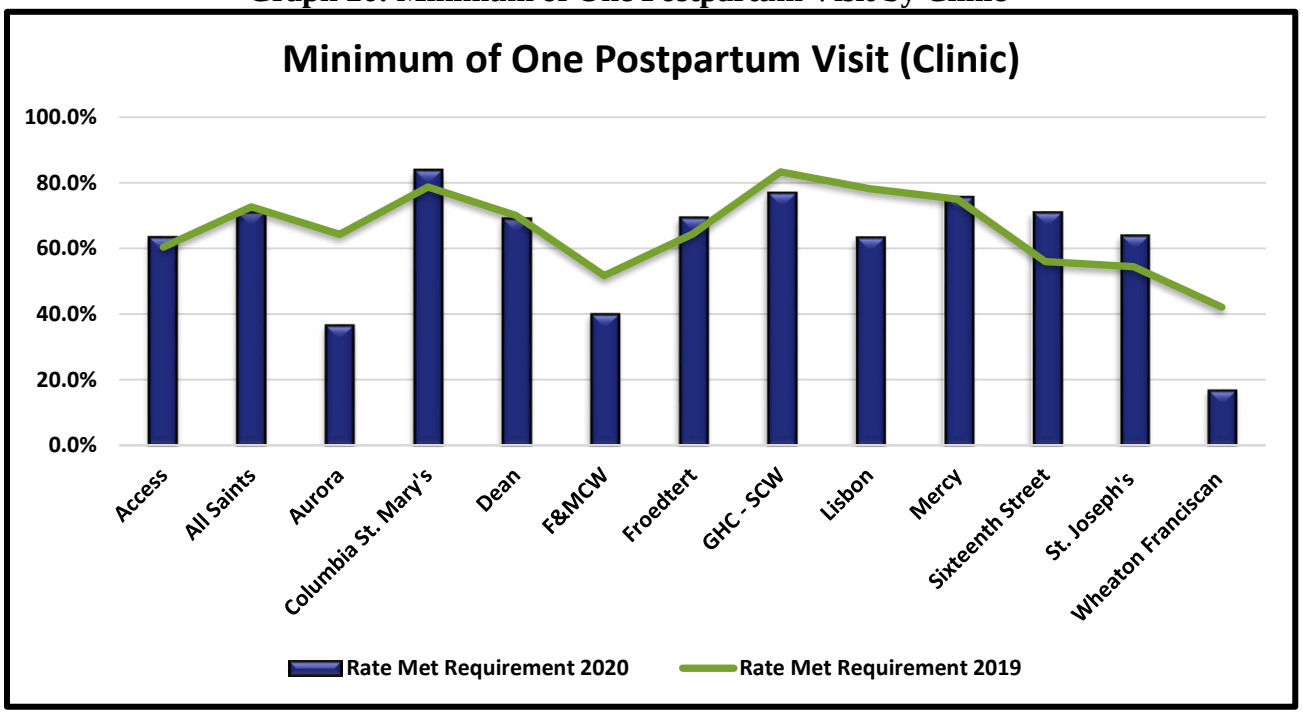
Graph 24: Minimum of One Postpartum Visit by MCO



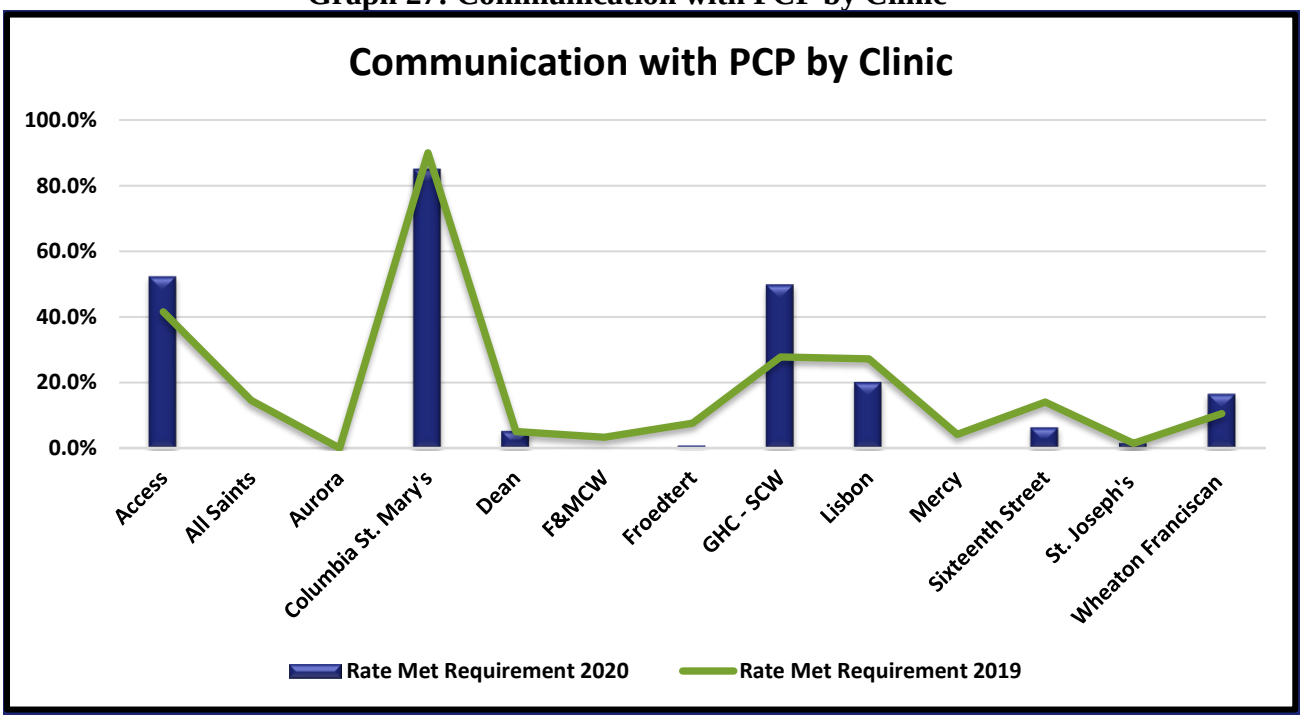
Graph 25: Communication with PCP by MCO



Graph 26: Minimum of One Postpartum Visit by Clinic



Graph 27: Communication with PCP by Clinic

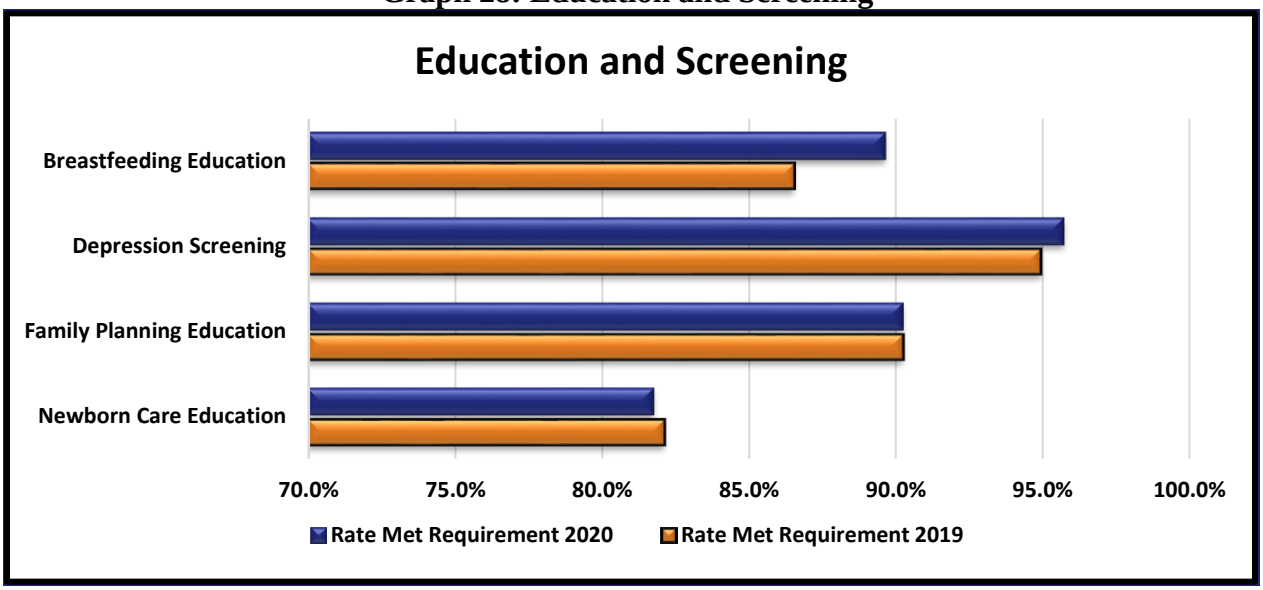


A PCP was not documented in 56.6 percent of the records reviewed. This is an increase from CY 2019 when 53 percent of records did not include documentation of the members' PCP. Similar to

previous years, the rate of compliance for post-delivery communication may be impacted by internal messaging systems within the MCO or clinic systems that are unavailable to reviewers.

The graph below identifies the percentage of records that contained evidence of at least one depression screening and other required pregnancy-related education. Screening and education may have occurred prenatally, postpartum or both.

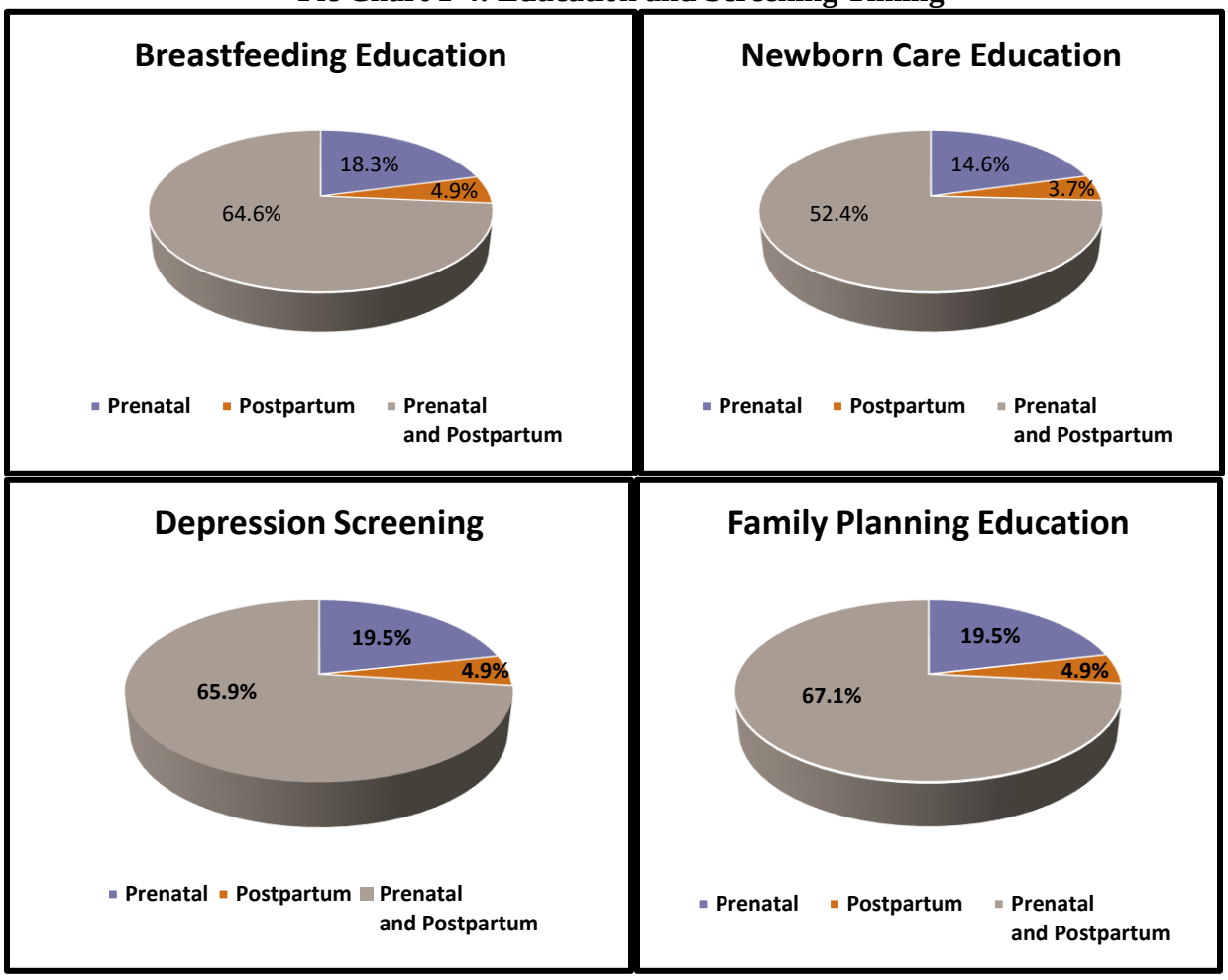
Graph 28: Education and Screening



Record review found members continue to consistently receive information about key topics associated with postpartum care. The review results show that education takes place periodically throughout the prenatal period. Breastfeeding education and depression screening rates of compliance were higher in CY 2020 while family planning remained the same and newborn care education declined slightly when compared to CY 2019.

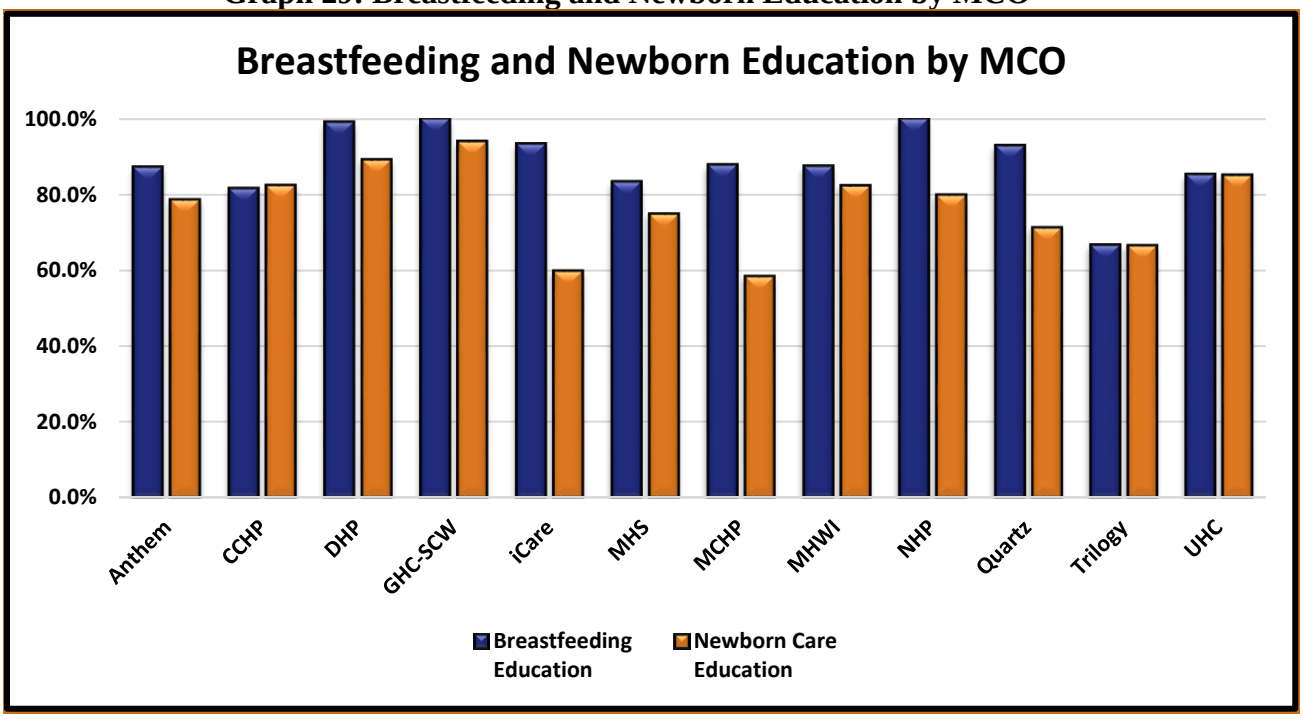
The following pie charts identify the percentage of members who received education or screening by the type received, and when it occurred during the pregnancy. The majority of screening and education was provided in both the prenatal and postpartum care periods.

Pie Chart 1-4: Education and Screening Timing

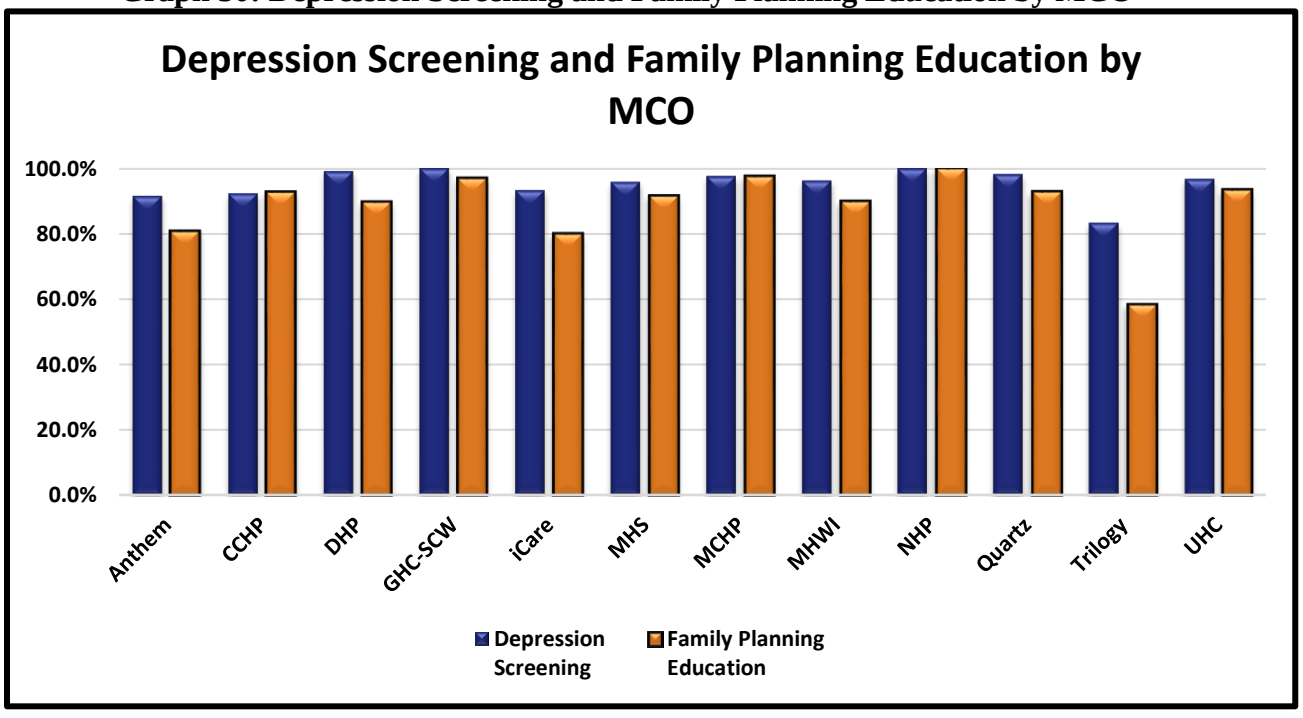


The following graphs identify the percentage of records that contained evidence of at least one depression screening and other required pregnancy-related education per MCO and clinic respectively.

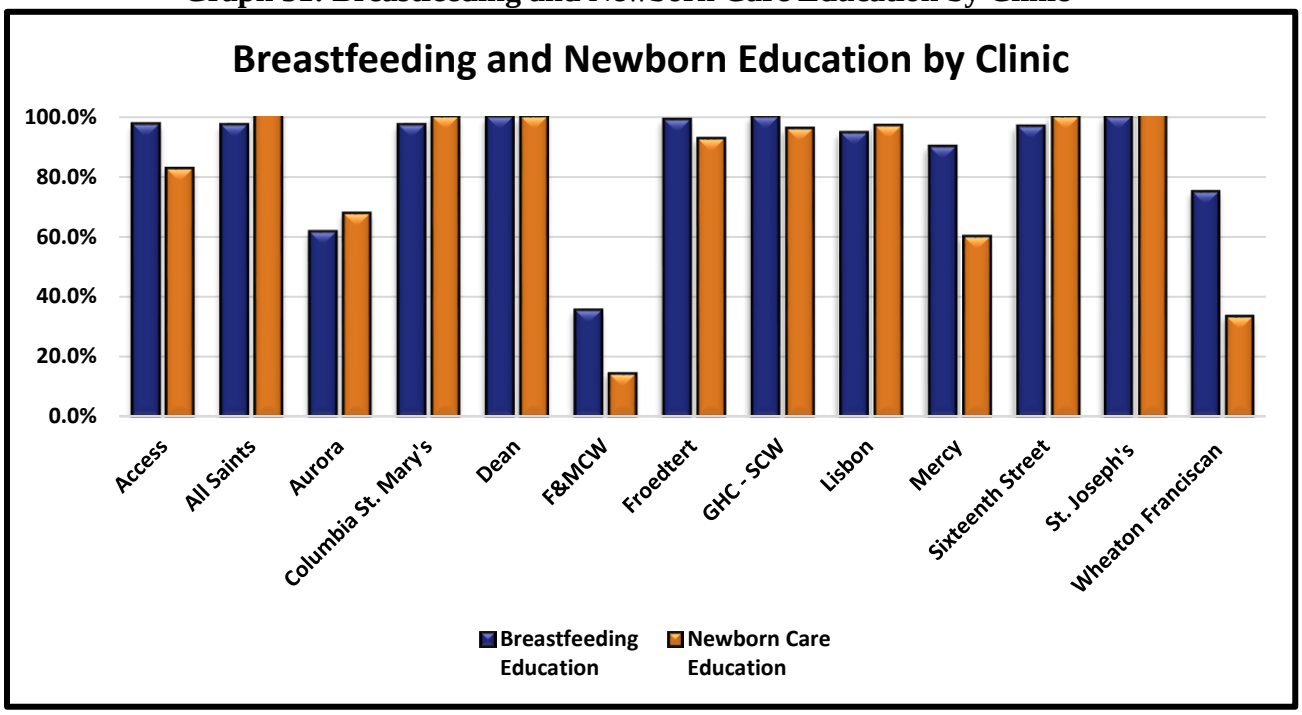
Graph 29: Breastfeeding and Newborn Education by MCO



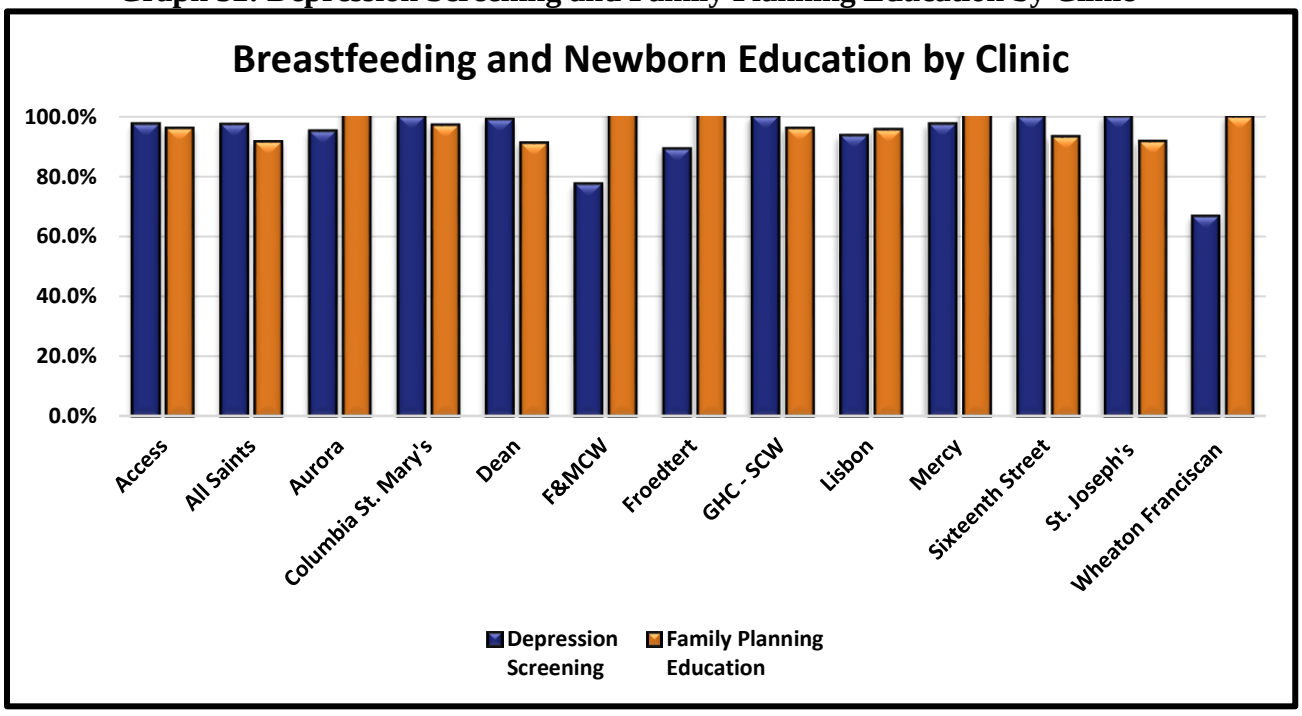
Graph 30: Depression Screening and Family Planning Education by MCO



Graph 31: Breastfeeding and Newborn Care Education by Clinic



Graph 32: Depression Screening and Family Planning Education by Clinic

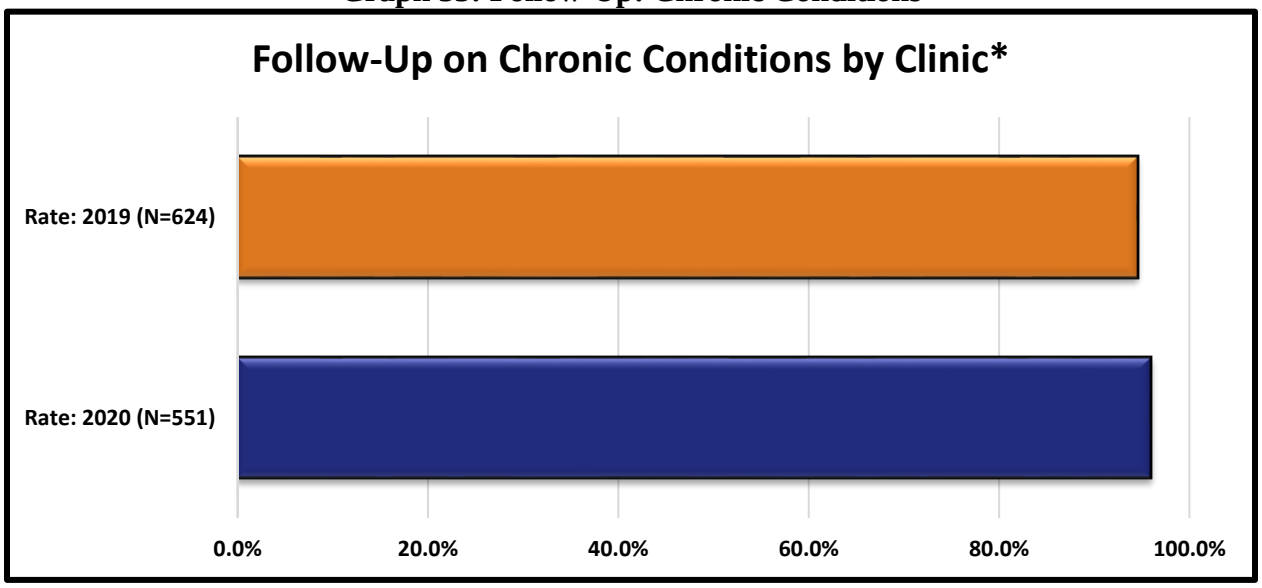


The following chronic conditions continued as a focus in the OBMH for this reporting period:

- Asthma;
- Cardiac disease;
- Diabetes mellitus;
- HIV/AIDS;
- Hypertension,
- Pulmonary disease;
- Behavioral health (including depression, smoking and substance abuse); and
- Morbid obesity.

The graph below reports aggregate results for the members who received follow-up related to their chronic conditions.

Graph 33: Follow-Up: Chronic Conditions



*Note: The review indicator *Follow-up: Chronic Conditions* applied to 551 records in CY 2020 and 624 records in CY 2019.

Analysis indicated the year-to-year difference in the follow-up on chronic conditions rates is likely due to normal variation or chance. As documented in the graph above, 34.2 percent of members (286 members) did not have a chronic condition. Of the 551 women who had a chronic condition, 212 (38.5 percent) had more than one condition. The most common chronic conditions included:

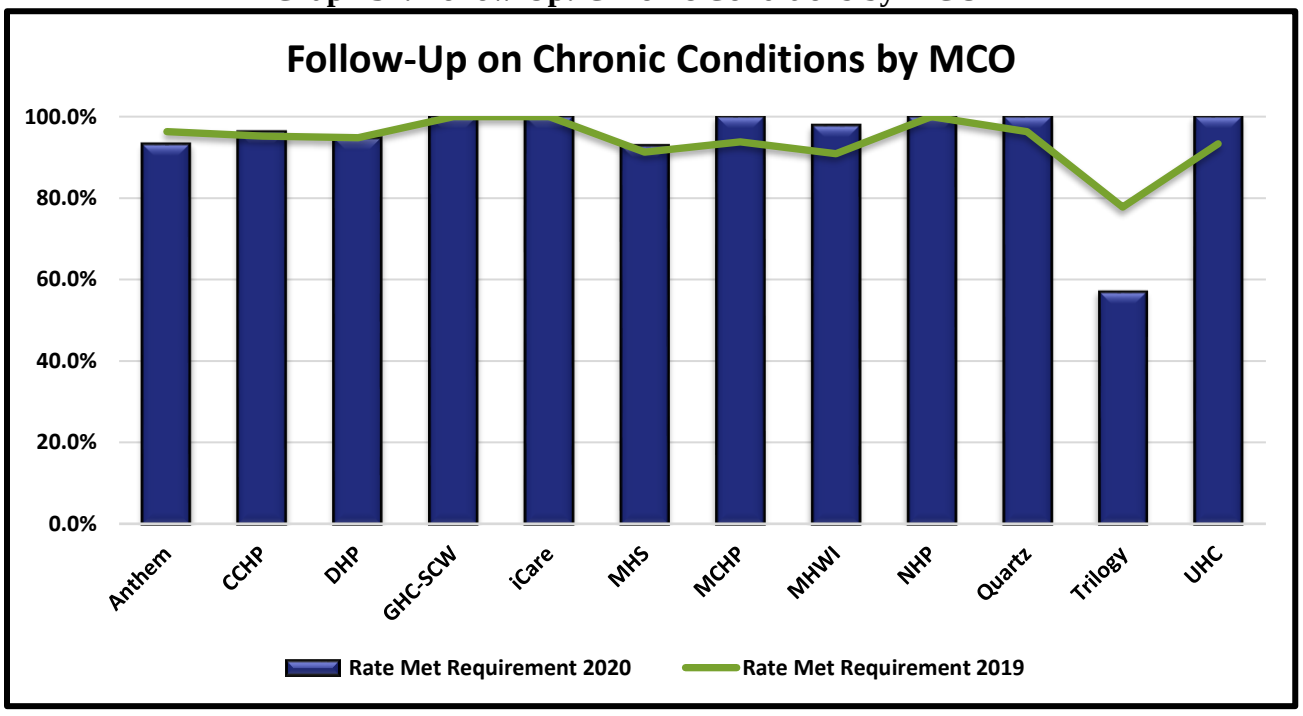
- Behavioral Health (291);
- Morbid Obesity/Obesity (147);
- Asthma (159);

- Hypertension (37);
- Substance Abuse (29);
- Diabetes (10);
- Genital Herpes (49); and
- Thyroid Conditions (nine).

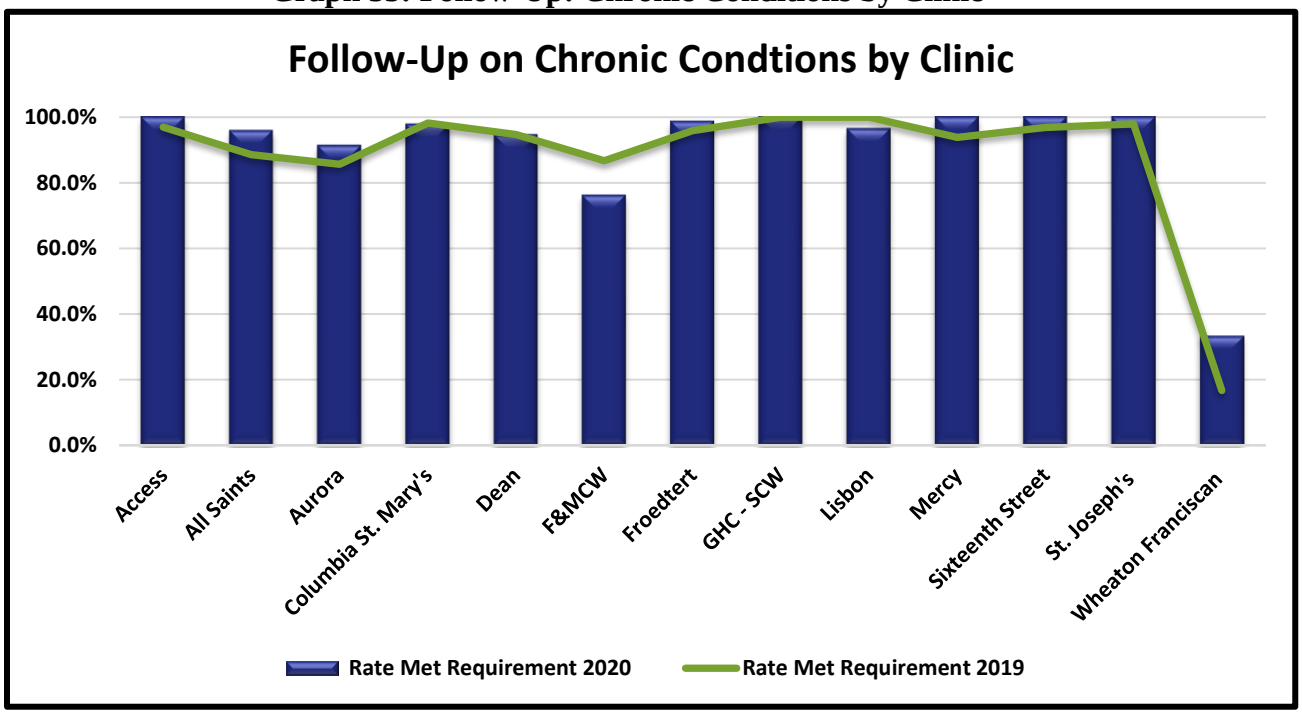
Some additional, but not all-inclusive, examples of chronic conditions diagnosed in members included: sickle cell trait, epilepsy, chronic pain (including migraines), diabetes, HIV/AIDS, pulmonary disease, Multiple Sclerosis, Wolff Parkinson White Syndrome, and Von Willebrand's disease. Seven records also included domestic violence or other abuse as a continuing concern.

The following graph provides follow-up results by MCO and clinic respectively.

Graph 34: Follow-Up: Chronic Conditions by MCO



Graph 35: Follow-Up: Chronic Conditions by Clinic



Of the 13 clinics that were included in both calendar years, 61.5 percent showed an increase in CY 2020 from CY 2019 while two clinics remained over 90 percent for follow-up on chronic conditions. Just over 23 percent (23.1) showed a decrease in CY 2020 from CY 2019.

Smoking Status

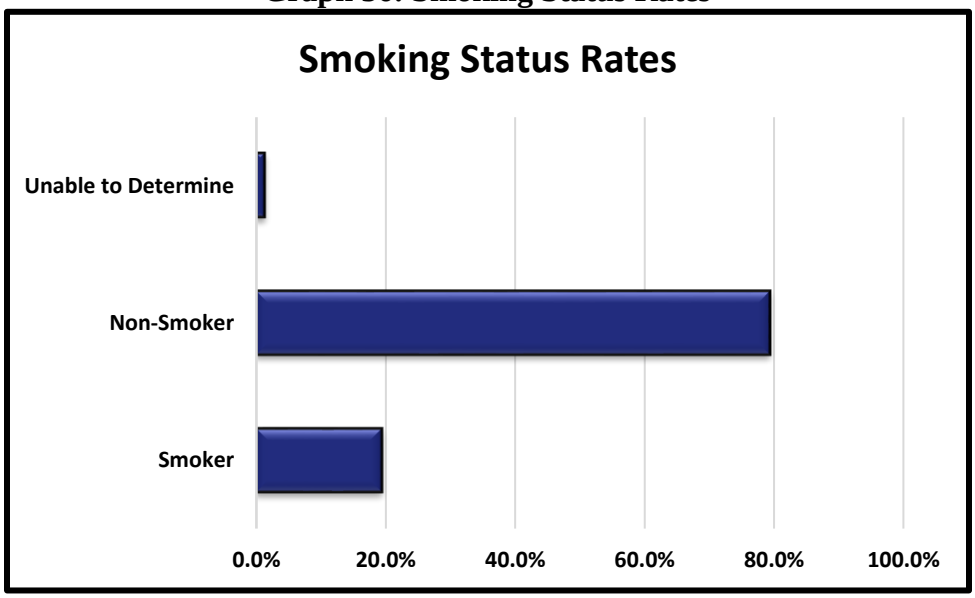
The ACOG identifies several smoking-related prenatal and postpartum risks including:

- Delayed fetal growth;
- Increased risk of premature birth;
- Risk of permanent brain and lung damage;
- Increased risk of stillbirth;
- Sudden Infant Death Syndrome;
- Colic;
- Low birth weight.

MetaStar has collected smoking status, counseling to quit, referral to a smoking cessation program and if follow-up occurred during the pregnancy. The data collected does not factor into the OBMH incentive payment determinations.

The aggregate review findings for the smoking data are documented in the graphs below.

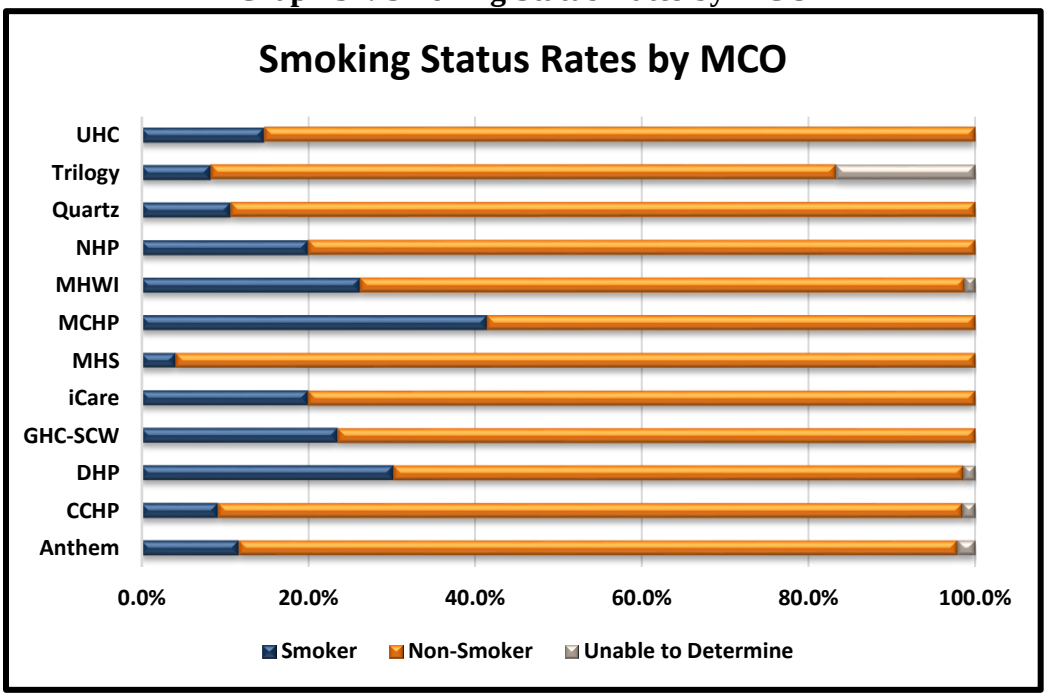
Graph 36: Smoking Status Rates



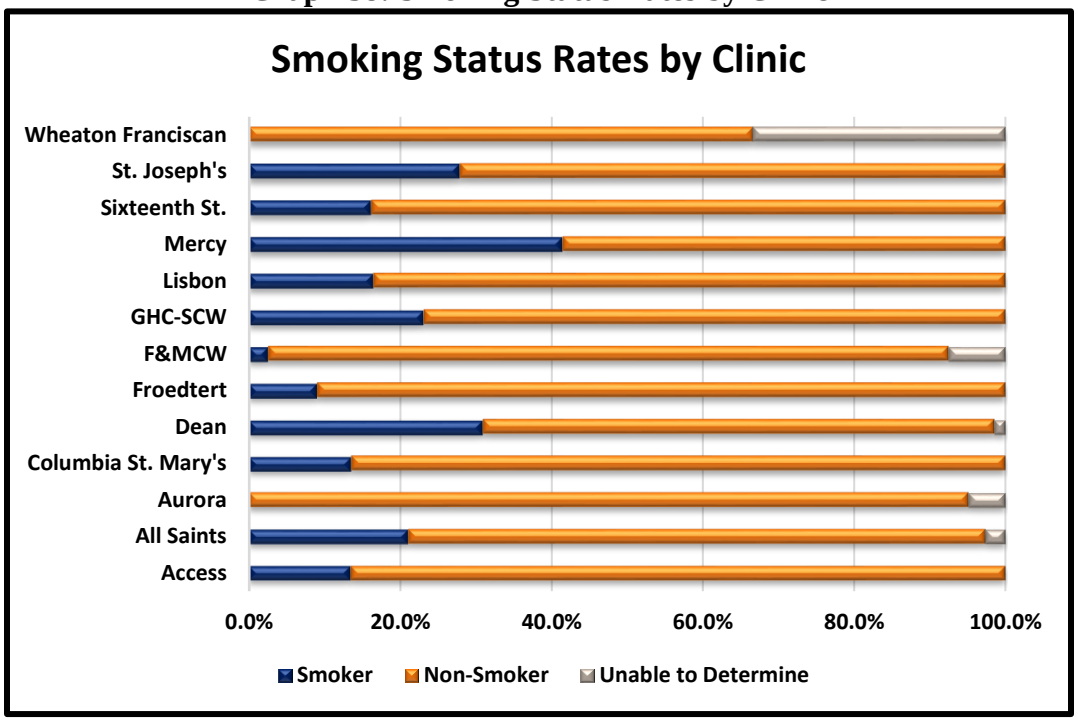
Of the 162 records that indicated smoking during pregnancy, 93.2 percent received counseling to quit. Documentation of follow-up regarding the member's smoking status was found in 84.6 percent. The follow-up indicated 50.4 percent decreased their tobacco use and 26.3 percent quit.

The following graphs provide results by MCO and clinic respectively.

Graph 37: Smoking Status Rates by MCO



Graph 38: Smoking Status Rates by Clinic



Identification of Birth Outcomes

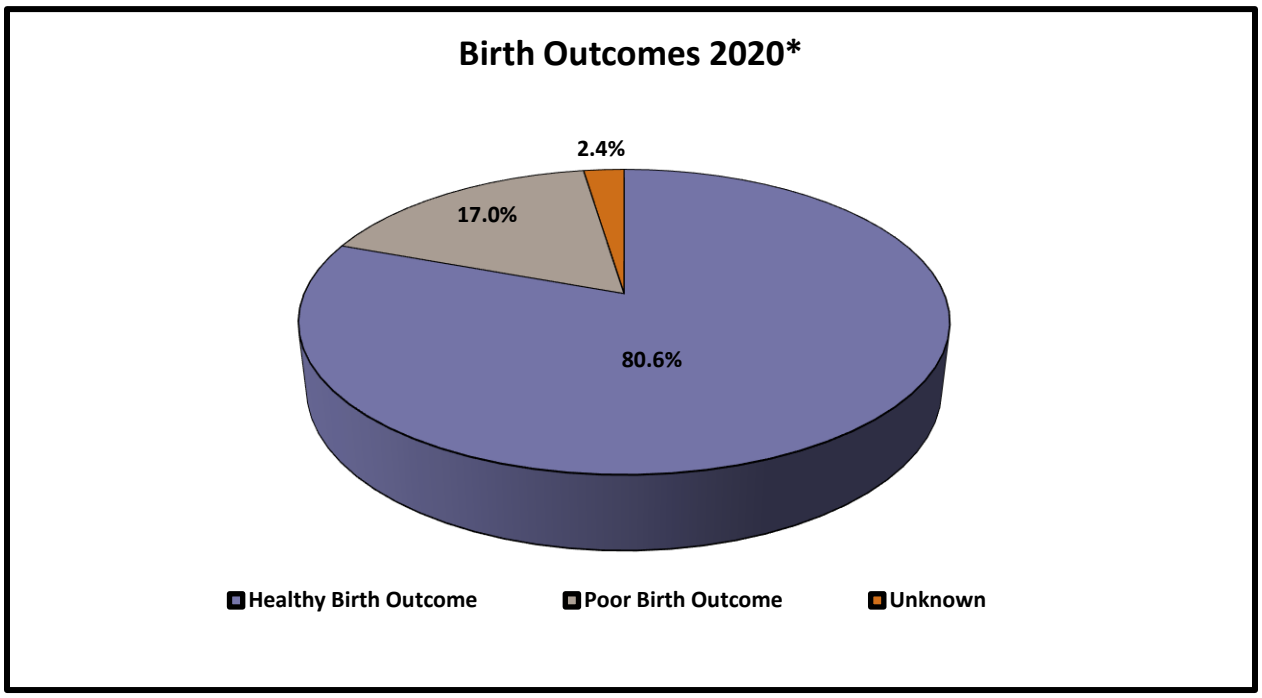
The DHS-MCO contract provides information about payments related to the OBMH initiative and indicates DHS will define poor birth outcomes. DHS defines poor birth outcomes as follows:

- A birth that took place prior to 37 weeks gestation, or "pre-term birth;"
- A baby that weighed less than 2500 grams at the time of birth, or "low birth weight;"
- A stillborn baby delivered after 20 weeks; and
- An infant death within 28 days of birth, or "neonatal death."

Insufficient information was available in the medical records to determine the birth outcomes for 50 members. In these instances, DHS directed MetaStar to review MCO self-declared information in the DHS registry to determine whether the woman experienced a poor birth outcome. MetaStar reviewers found sufficient information in the registry for 30 women, but did not find sufficient information in the registry for 20 of the women. Of the members without documentation of the outcome in the medical record, two were identified with poor birth outcomes by the clinics in the registry. MetaStar identified 140 poor birth outcomes in the medical records for the remaining members in this reporting group, for a total rate of 16.9 percent.

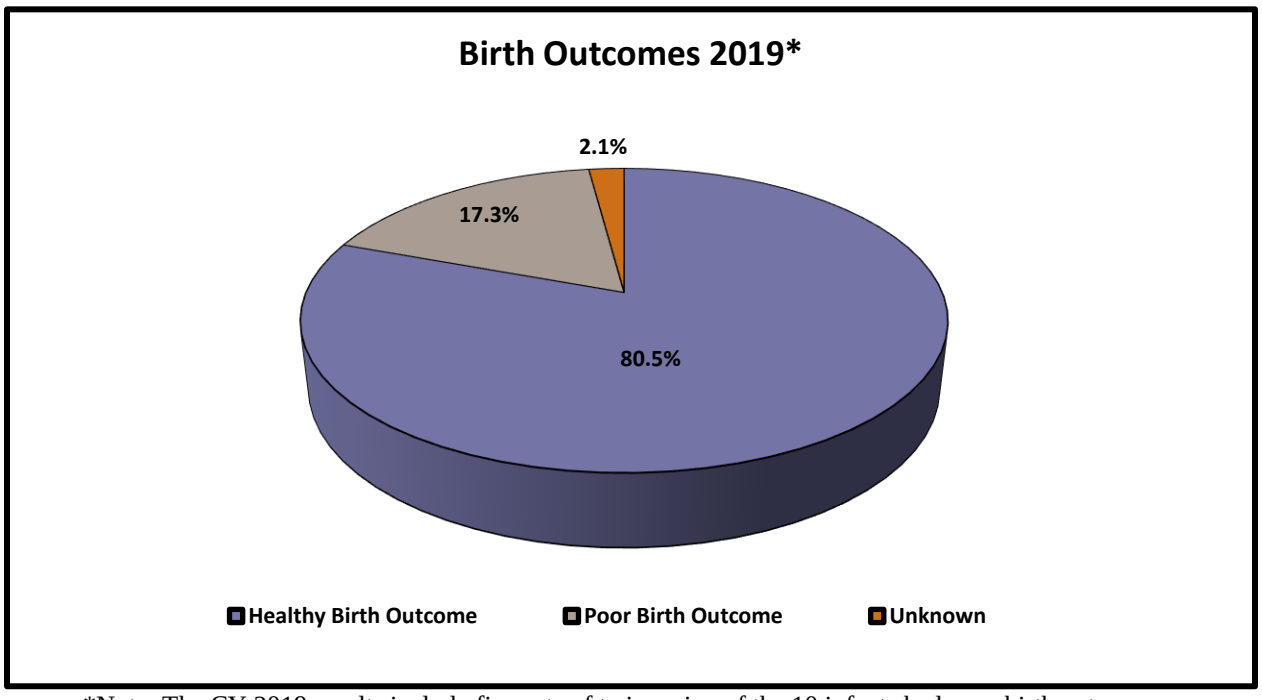
The graph below identifies the rates of healthy birth outcomes and poor birth outcomes verified in medical records and documented in the registry, as defined by DHS for this initiative.

Pie Chart 5: Birth Outcomes 2020



*Note: The CY 2020 results include five sets of twins; 11 of the 12 infants had poor birth outcomes.

Pie Chart 6: Birth Outcomes 2019

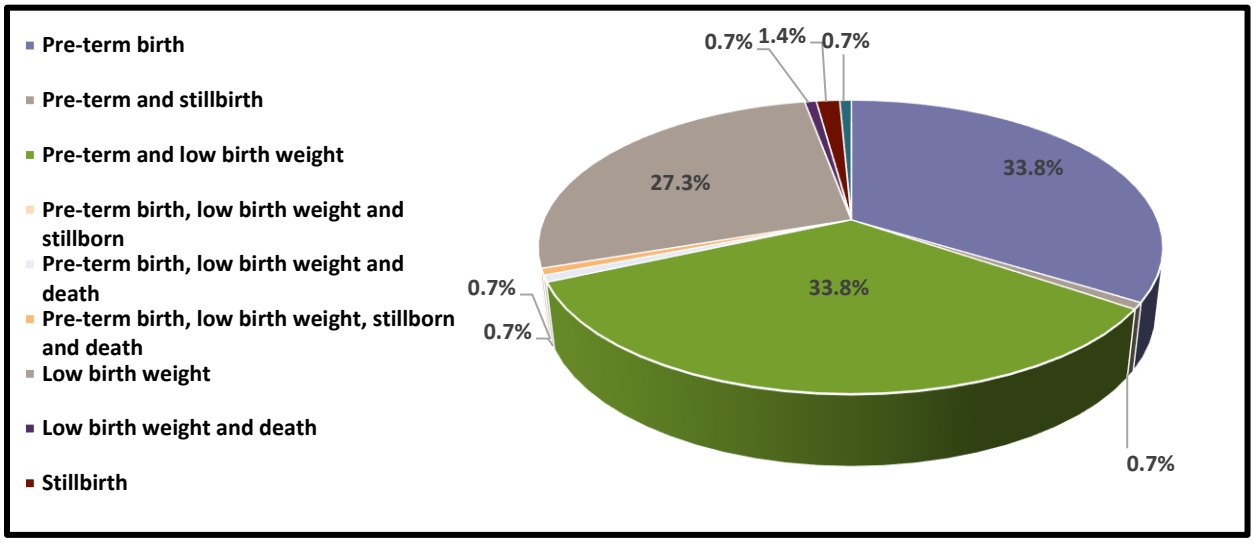


*Note: The CY 2019 results include five sets of twins; nine of the 10 infants had poor birth outcomes.

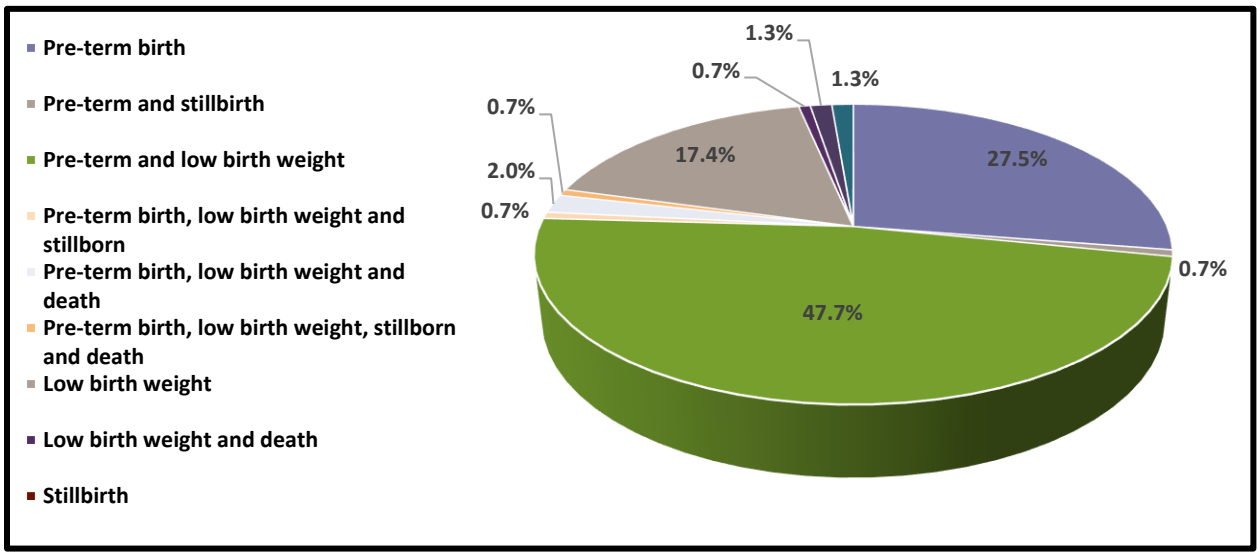
The healthy birth outcome rate increased in CY 2020 compared to CY 2019, and is less than the CY 2018 (84.3 percent) rate. Analysis indicated the year-to-year difference in the healthy birth outcomes rates is likely due to normal variation or chance.

The reasons associated with the poor birth outcomes in CY 2020 compared to CY 2019 are documented in the pie charts below.

Pie Chart 7: Poor Birth Outcomes 2020

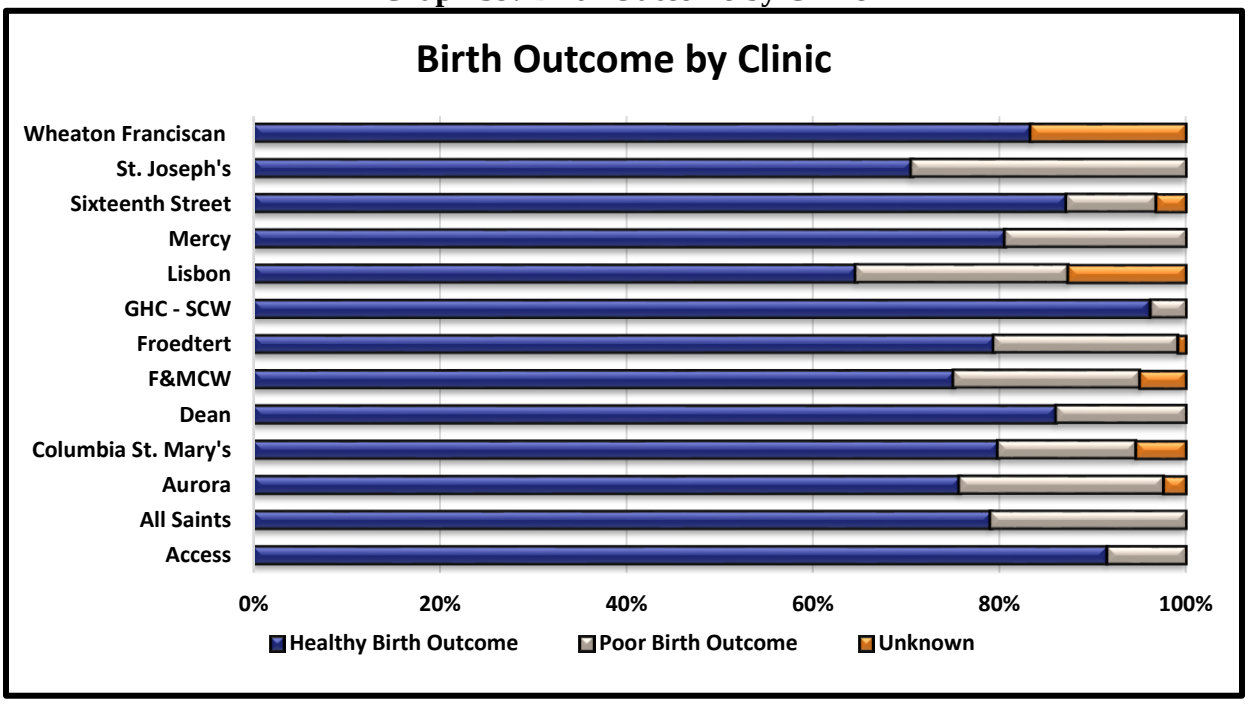


Pie Chart 8: Poor Birth Outcomes 2019



The following graph provides birth outcome results by clinic.

Graph 39: Birth Outcome by Clinic



CONCLUSIONS

GENERAL OBSERVATIONS

The review period included the declaration of the COVID-19 PHE and Wisconsin's *Safer at Home* order. Exemptions to some program requirements were granted by DHS due to the PHE. The home visit requirement was suspended, and a virtual (telehealth) format was permitted for both prenatal and postpartum visits beginning in March 2020. Some clinics closed during the *Safer at Home* order timeframe, limiting the ability to meet the 10 prenatal and one postpartum visit requirements. Additionally, not all providers or members felt that telehealth provided the same level of care as in-person prenatal or postpartum visits. MetaStar did not review impacts to clinics or providers during the PHE specific to hours or operation or closures.

STRENGTHS

Strengths were identified in the following areas:

- Clinics continue to complete a thorough intake assessment and incorporate the members' needs into the care plan.
- Almost all care plans include member self-care or self-management component.
- Depression screening and family planning education were documented in over 90 percent of the records reviewed.

Opportunities for Improvement and Recommendations

As a result of its review, MetaStar identified the following opportunities for improvement. For each area of opportunity, the review team has provided related recommendations to DHS and the MCOs to support improvements in the OBMH and align with the state's quality strategy.

- DHS should continue efforts to reduce health disparities related to prenatal and postpartum health care.

Each MCO and clinic should review their response to the PHE to address gaps in emergency or disaster plans to:

- Identify alternate methods for providing services and supports in the event of a PHE
- Ensure adaptation of the identified alternative methods for a rapid return to provision of the full range of services.

We recommend the agencies conduct a root cause analysis to identify the barriers to success in meeting the OBMH requirements. As interventions are identified, use Plan-Do-Study-Act (PDSA) cycles of improvement to measure the effectiveness of each intervention. Recommended focus areas for improvement include:

- Conducting and documenting collaborative care plans. The care plans indicate collaboration when documentation includes evidence the care plan was created in conjunction with the care coordinator, the primary care provider (PCP), and the member.
- Improving members' engagement in their postpartum care to increase the rate of postpartum visits.
- Increasing documentation of regular care coordination communications between the OB care provider, the PCP, and the care coordinator throughout the prenatal and postpartum periods.

APPENDIX – REQUIREMENT FOR EXTERNAL QUALITY REVIEW AND REVIEW METHODOLOGY

REQUIREMENT FOR EXTERNAL QUALITY REVIEW

The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate pre-paid inpatient health plans (PIHPs) and managed care organizations (MCOs) to provide for external quality reviews (EQRs). To meet these obligations, states contract with a qualified external quality review organization (EQRO).

MetaStar - Wisconsin's External Quality Review Organization

The State of Wisconsin contracts with MetaStar, Inc. to conduct EQR activities and produce reports of the results. Based in Madison, Wisconsin, MetaStar has been a leader in health care quality improvement, independent quality review services, and medical information management for more than 40 years, and represents Wisconsin in the Superior Health Quality Alliance, under the Centers for Medicare & Medicaid Services (CMS) Quality Improvement Organization Program.

MetaStar conducts EQR of MCOs operating Medicaid managed long-term programs, including Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly. In addition, the company conducts EQR of MCOs serving BadgerCare Plus, Supplemental Security Income, Pre-paid Inpatient Health Plans, Foster Care Medical Home Medicaid recipients, and the Children with Medical Complexity (CMC) program in the State of Wisconsin. MetaStar also conducts EQR of Home and Community-based Medicaid Waiver programs that provide long-term support services for children with disabilities. MetaStar provides other services for the state as well as for private clients. For more information about MetaStar, visit its website at www.metastar.com.

MetaStar Review Team

The MetaStar EQR team is comprised of registered nurses, a clinical nurse specialist, a physical therapist, a recreational therapist, a counselor, licensed and/or certified social workers, and other degreed professionals with extensive education and experience working with the target groups served by the MCOs. The EQR team is supported by other members of MetaStar's Managed Health and Long-Term Care Department as well as staff in other departments, including a data analyst with an advanced degree, a licensed Healthcare Effectiveness Data and Information Set (HEDIS®)[1] auditor, certified professional coders, and information technologies staff. Review team experience includes professional practice and/or administrative experience in managed health and long-term care programs as well as in other settings, including community programs, schools, home health agencies, community-based residential settings, and the Wisconsin

[1] "HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)."

Department of Health Services (DHS). Some reviewers have worked in skilled nursing and acute care facilities and/or primary care settings. The EQR team also includes reviewers with quality assurance/quality improvement education and specialized training in evaluating performance improvement projects.

Reviewers are required to maintain licensure, if applicable, and participate in additional relevant training throughout the year. All reviewers are trained annually to use current EQR protocols, review tools, guidelines, databases, and other resources.

Review Methodology

On a quarterly basis, MetaStar pulls a dataset that identifies members enrolled in the Obstetric Medical Homes (OBMH), with delivery dates occurring during the previous quarter. The datasets are compiled from the OBMH data registry.

The datasets are shared with the identified MCO for confirmation of eligibility for review and subsequent delivery of the applicable medical records. DHS holds MCOs accountable for securing records from clinics for submission to MetaStar. MCOs and clinics submit member records to MetaStar. Where possible, MetaStar develops arrangements with clinics that have electronic medical records (EMR) to establish remote, direct access to conduct the record reviews.

MetaStar continues to use a review tool and guidelines for OBMH reviews developed in partnership with and agreed upon with DHS. Reviewers abstract relevant data from medical records, regardless of whether the MCO submitted an entire or partial medical record.

Review Criteria

The review team used a review tool and reviewer guidelines based on the DHS-MCO contract and agreed upon with DHS. The review evaluated four indicators that reviewers used to evaluate compliance with the OBMH requirements:

1. Enrollment; including program eligibility, date of enrollment and prenatal visit requirements.
2. Care Coordination; including identification of the care coordinator, member education, and follow-up for any chronic conditions.
3. Care Planning; including assessment, creation of the care plan and communication of the care plan.
4. Discharge Planning; including coordination with the primary care provider, documentation of the birth outcome, postpartum visit and member education regarding depression, newborn care, breast feeding and family planning.

The review team also collected data regarding immunizations and smoking cessation efforts for all enrollees. This additional data was not used to determine contract compliance.

MetaStar reviewers used the following guidelines to abstract data from the medical record(s) submitted by the clinics and/or the MCOs. The elements align with contract requirements for the MCOs, and include other data elements requested by DHS for program planning and evaluation.

Demographics
Member, MCO, clinic and care provider demographics recorded as available.
Enrollment Requirements
The member must be enrolled in the medical home after 1/1/2014 and within the first 16 weeks of pregnancy. The reviewer will calculate the date at 16 weeks by entering the EDC via ultrasound date in the date calculator, subtract 24 weeks and enter the result on the review tool. Use the first ultrasound date (usually around 20 weeks) for the calculation. If the EDC is unknown, the staff person who enters the data into the DXC portal will calculate the 16/18 week date using the calculator and the EDC auto-populated in the portal following entry of the last menstrual period date (LMP). Record the date of the member's last menstrual period (LMP), if found in the record. Record the actual delivery date. If the date of delivery in the medical record does not match the documented in the DHS dataset, staff will conduct additional research in ForwardHealth interChange to determine which date has been verified through data exchanges used in the eligibility systems. Document the date of the first OB provider visit or the first visit with a care coordinator. This date will serve as the Medical Home enrollment date – The DXC system will automatically determine whether the enrollment by 16/18 weeks requirement is met, using this date and the date at 16/18 weeks referenced above.

Prenatal Visits

Members must attend a minimum of 10 appointments with the OB care provider.
Count and record the number of pre-natal visits with an OB health care provider that the member attended after enrolling in medical home prior to delivery. Count pregnancy support group visits, like Centering Pregnancy if specifically documented, toward the 10 prenatal visits.

Postpartum Visit

Members must remain enrolled and receiving services through the 60 days associated with the postpartum period.

Document the date of the postpartum visit with an OB care provider. Document the reason for any delay or the reason that the visit did not take place at all from information in the medical record. The DXC system will automatically determine whether the postpartum visit date meets the 60 day requirement.

Verification of Care Plan Requirement

A care management plan was developed as a result of an initial intake process where all needs are identified.

The reviewer will read the medical record submissions to identify the needs identified at intake and determine if the care plan addresses those identified needs. Needs may be medical or nonmedical. Care plans are dynamic but evidence should include that the plan was initiated within the first 3 visits in order to record a positive result for this element. Enter a negative result if not all needs appear on the plan and/or if the plan was not initiated within the first three visits. Document a note on the worksheet, if plan is initiated after first 3 visits.

The OB care provider developed the care management plan in conjunction with the care coordinator, the primary care physician (PCP), and the member.

Enter a positive result if the care plan is signed by the OB care provider or if it lists the OB care provider as a team member. Evidence that others were involved in the development of the care plan may be by signature or by reference (it may be a listing of participants). It is more likely that someone other than the OB provider, probably the care coordinator, would take the lead on developing the care plan.

The care management plan includes a self-management/self-care component.

Self-care/self-management is a core aspect of Centering Pregnancy. Enter a positive result if the medical record contains evidence of this model or other pregnancy support group. Other examples of self-care/self-management include: medical management, role management, and emotional management—and/or any of these six self-management skills--problem solving, decision making, resource utilization, the formation of a patient-provider partnership, action planning, and self-tailoring.

Verification of Care Coordination Requirements

The care management plan includes information regarding monthly home visits by nurse, social worker or care coordinator.

The required monthly home visit is designed to help the care coordinator establish a personal relationship with the medical home member in a non-medical setting. It is also designed to help ensure a comprehensive assessment of the member's needs, including identification of any psycho-social issues. Home visits should be presented as an opportunity to help the member become an active partner in their care team and should be scheduled at the convenience of the member.

Determine if home visits have been presented to the member by the care coordinator and if the member declines, that the care coordinator offered to meet at a more convenient neutral site, e.g., a library, a local restaurant, or a community center. Pregnancy support groups may be another alternative if the member agrees and has the opportunity to consult personally with the care coordinator. If the member agrees to home visits or visits at an alternate community location, document a positive result. In the event a member refuses to allow the home visit, the refusal and alternatives offered must be documented in the medical record in order for the reviewer to document a positive result for this element.

The care management plan should include an indication of frequency of home visits. Count and record the number of actual home visits. The plan may reference home visits by the medical home care coordinator, the HMO, or by a PNCC provider. Count visits associated with agreements for alternate locations. Do not count postpartum home visits.

Beginning with the dataset for members with post-partum visits scheduled July 1, 2016 and after, reviewers did not look for evidence that an offer of an alternate location to a home visit was made after the member refused.

Regular Care Coordination communications between the OB-care provider, the PCP and the member must be documented in medical record.

Document a positive result if evidence of communication with the PCP as part of the care plan development and as part of the discharge planning, at a minimum is present in the medical record. This communication may happen directly with the OB care provider or through the care coordinator.

Ideally, communication between the OB care provider and the care coordinator should roughly coincide with the prenatal visits.

Care plan updates showing results of prenatal or primary care visits and member contacts may also show evidence of communication.

Verification of Postpartum Care Coordination and Discharge Planning

At least one postpartum visit within 60 days post-delivery if the member had a healthy birth outcome.

In addition to recording the date of the actual postpartum visit as described above, the reviewer will document any information related to the reasons for no postpartum visit, delayed or rescheduled postpartum visits (including the number of these events) and the types of outreach strategies that are used to encourage the member in securing postpartum care.

Poor Birth Outcome

From the available medical records determine if the birth outcomes fit the DHS definitions of a poor birth outcome as follows:

Pre term (<37 weeks), low birth weight (< 2500 grams), or infant demise within 28 days. The reviewer should not use postpartum visit information that is "general," i.e. "the baby is healthy and doing well" for determining the outcome OTHER than for infant demise within 28 days.

Communication with the PCP post-delivery if the PCP is other than the OB provider

The reviewer should document a positive result for any evidence of post-delivery communication with the member's PCP, if identified, or if the OB provider is documented as the member's primary care provider. A letter or phone call informing the PCP of delivery meets the requirement. If the member does not have a PCP or if the OB provider is not serving as the PCP, document a negative result for this element.

Member education on inter-conception care specific to the member's needs, family planning preferences, and depression screening.

The reviewer should document a positive result if evidence is present in the medical record for any one or more of the focus areas noted in the requirement above. Beginning with the dataset associated with members who scheduled post-partum visits July 1, 2016 and after, reviewers

were directed to document when the education and screening was provided during the prenatal, postpartum or both care periods.
Member education regarding breastfeeding and newborn care The reviewer should document a positive result if evidence is present in the medical record for one or both of the focus areas noted in the requirement above. Pre-birth classes only count if the curriculum is documented for the member and shows evidence that these topics were covered. Beginning with the dataset associated with members who scheduled post-partum visits July 1, 2016 and after, reviewers were directed to document when the education was provided during the prenatal, postpartum or both care periods.
Follow-up care for any member with a chronic condition The reviewer will document the member's chronic conditions on the worksheet using the following definition: A chronic condition is one that is of ongoing duration, but is actively treated, assessed or monitored. Do not include conditions that were part of the member's past history unless it is an active issue. These chronic conditions are specifically identified in the DHS HMO contract: pulmonary disease, asthma, cardiac disease, hypertension, diabetes. The reviewer will document a positive result if the record includes the chronic conditions were followed-up on. This can include evidence of referrals to specialists, when needed, and if so, whether the woman went to the referral, including any needed changes in the care plan as a result. The reviewer will document details related to these circumstances on the worksheet. Beginning with the dataset associated with women who scheduled a post-partum visit July 1, 2016 and after, reviewers were directed to also consider morbid obesity and obesity as chronic conditions.