Follow-up Responses to Questions Posed at the 2023 OBMH Best Practices Seminar

Questions	Answer
How do we see MetaStar record review results? When records are submitted to MetaStar directly, can those records be shared with the HMO instead of the current met/not met that we receive from MetaStar?	After MetaStar completes their medical record reviews for enrolled members for the year, a report is sent to DMS indicating which criteria each member met. DMS sends this report to HMOs to validate and provide any rebuttals if the HMO disagrees with MetaStar's findings. Each HMO can determine how they share the results with providers. MetaStar does not release medical records to a 3rd party. If a provider submits medical records directly to MetaStar, the HMO will need to request the records from the provider directly.
How often are payments for incentives made to HMOs? When will payments be made for the catch-up years of 2018-2021? What about 2022?	Prior to 2022, prospective payments were made semi-annually from the Department to the HMOs based on HMOs' estimates of the number of women they expected to complete the program. DMS just completed the reconciliation of those prospective payments for 2018-2021. DMS is recouping any overpayments made to HMOs who overestimated and making an additional payment to those HMOs who underestimated the incentive amount that would be earned. HMOs were issued a payment or recoupment the week of November 13, 2023. Since the prospective payment process was discontinued, there were no prospective payments for 2022. MetaStar completed the review of medical records for deliveries that occurred in 2022 and submitted the report to DMS in September 2023. DMS submitted that report to HMOs in November, and HMOs had until 11/30/2023 to validate or provide rebuttal information. DMS anticipates incentive payment will be made in January 2024, depending on how long the rebuttal process takes. DMS does not dictate how frequently HMOs make payments to providers. Providers need to follow-up with the HMO directly regarding a specific payment schedule or refer to their own MOUs.

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I thought for OBMH, the postpartum visit was to be within 60 days of delivery?	Per the BadgerCare Plus contract, the postpartum period is the 60 days after delivery. A part of the design for that 60-day postpartum period initially was to make sure the postpartum visit occurred, and members were transitioned to any sort of ongoing care, before an individual lost their Medicaid eligibility. In 2020, the HEDIS measure for Prenatal and Postpartum Care (PPC) changed the specifications to percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery. Although the HEDIS measure specifications of 84 days does not align with the current contract, MetaStar looks for a postpartum visit to occur within 84 days of delivery and gives credit for visits that occur prior to 84 days post-delivery. There is currently discussion within DHS regarding extending postpartum eligibility up to 90 days, but this requires WI Legislative and federal approval. Unless approved, the contract will continue to list 60 days for the post-partum period and will be updated when possible.
What is meant specifically by "enrollment postpartum" for the $1000 incentive? Why is the date of the PPV in the OB registry? Does documenting a cancelled postpartum visit meet the eligibility requirement? Do we need to go back and update invoices?	According to the current BadgerCare Plus HMO contract, the member is considered to have continued OBMH enrollment through 60 days if they have a postpartum visit scheduled within 60 days of delivery, including the date of the scheduled postpartum visit, and any documentation of no shows or appointment refusals. The date of the postpartum visit (PPV) in the OB registry is a point of data collection - it is not used in the medical review done by MetaStar. MetaStar reviews the record to determine if a postpartum visit occurred or if there is documentation as to why the visit did not occur, efforts by the provider to assist the member in rescheduling the appointment or supporting members to address barriers to attending the PPV. Documenting a no show or cancelled postpartum visit **does meet** contract expectation for incentive eligibility. DMS is not requiring providers change their incentive invoices submitted to HMOs. Providers and HMOs should work together on any process changes.

Questions	Answer
After the 5/11/2023 end to the public health emergency, will telehealth visits be covered, and will they continue to count toward incentive eligibility?	Temporary telehealth policy was established to ensure access to health services during the COVID-19 pandemic. Certain temporary federal public health emergency (PHE) allowances ended on May 11, 2023 (the date the PHE expired). Permanent telehealth coverage policy and billing guidelines went into effect June 1, 2023. For additional information and resources, refer to the Telehealth chapter of the ForwardHealth Online Handbook for additional information on permanent telehealth policy and reimbursement requirements. To the extent that the postpartum visit is covered by ForwardHealth (such as through in-person consultation per ForwardHealth Topic 510), HMOs may encourage OBMH providers to use telehealth services to identify problems early in the pregnancy and provide treatment to avoid further complications and preterm labor. Best practice is to have a physical examination as part of the postpartum visit. However, a postpartum visit conducted via telehealth, documented in the medical records, will be counted toward incentive eligibility criteria for a postpartum visit.
Is there an update to the User's Guide?	We have multiple user guides available, including the BORN Registry, OBMH Registry, and the OBMH User Guide. It will take MetaStar and DMS some time to review these, as well as incorporate any changes based on the evaluation of the OMBH initiative. If you have specific questions, please send those to DMS at mailto:DHSOBMH@dhs.wisconsin.gov
We communicate to the PCP prenatally and postpartum but rarely get any input. Does this still count as collaboration?	Any attempt to collaborate or share information with the PCP is counted if documented in the medical record. A response from the PCP is not required. Note – the documentation should include the name of the PCP. Simply mentioning communication with a Dr. Smith, for example, does not alert the MetaStar reviewer that Dr. Smith is the PCP.
“Pregnancy-related appt within the first 16 weeks" - is this any provider/pregnancy visit, not just a prenatal physical?	If the visit is with any of the following provider types, it counts even if it is not a full physical. Provider types include Primary Care Physician (PCP), Nurse Practitioner, Obstetrician, Maternal Fetal Medicine, Care Coordinator, Nurse Midwife, and Physician Assistant. However, an appointment, lab visit, or ER visit for just a pregnancy test does not count.

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Does hospital observation include admission to hospital OB triage? How can we document this so it is counted as a prenatal visit?	If the member had less than 10 prenatal visits and was admitted for hospital observation during the prenatal period, each hospitalization would count as a visit. If using additional documentation only count PNCC or hospitalizations until the number of prenatal visits reaches 10. The documentation of these visits would need to be sent with the record for review or at least documented in the record that it occurred.
Do ultrasound appointments count as a prenatal visit?	Ultrasound and lab appointments count if the OB provider was consulted with on the same day **and** the OB provider had contact with the member. Visits to monitor vital signs must include a consultation with the OB provider to be counted.
When DHS does audits and rates each OBMH site on things like education on breastfeeding, birth control and other topics, can you indicate what criteria is being looked at for the Medical Record Reviews for these topics?	These requirements are met if a discussion or education occurs around the topic during the prenatal and/or postpartum period. Education at the time of delivery (while in the hospital) does not count to meet this requirement. Example for birth control: Documentation of a discussion regarding contraception meets this requirement even if notes indicate the member is undecided.
Can Community Health Workers be counted as the staff doing the home visit?	Criteria for meeting a home visit is based on if a home visit was offered to the member at least twice, not if the home visit occurred. MetaStar tracks if the visit occurred, but it is not a condition of meeting this requirement. Meeting this eligibility criteria is not contingent on the type of provider who does the home visit, although the purpose of the visit should be to support the mother, not for another purpose, such as a visit for a sibling. The home visit, if it occurs, should be documented and notes shared with the Care Manager if completed by another provider type.
Can HMO's have regular (perhaps quarterly) interfaces with MetaStar point of contact so that we stay on the same page through the year?	Currently, Danielle Sersch is the primary contact for MetaStar. She coordinates the selection and record submission process. Questions should be directed at Danielle at dsersch@metastar.com and she will work to obtain a response.