

**2017 Obstetric Medical Homes
(OBMH) for High Risk Medicaid
Members User's Guide**

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Contacts

Clinics should contact the designated Health Maintenance Organization (HMO) Healthy Birth Outcome (HBO) liaison found in the contact list in Attachment 1.

HMO HBO liaisons should contact DHS staff at: DHSOBMH@dhs.wisconsin.gov

Introduction, Purpose, and Background

Introduction

This document provides basic information about the Wisconsin Department of Health Services' (DHS) medical home initiative for high-risk pregnant women enrolled in Medicaid. This medical home is commonly referred to as the "OB Medical Home (OBMH)." The OBMH is a joint effort of three divisions within DHS – the Division Medicaid Services (DMS), 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.

DHS- BadgerCare Plus and Medicaid SSI HMO contract (Contract) can be found here:

<https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/Providers/providerContracts.htm.spage>

Purpose

The purpose of this document is to serve as a user's guide for BadgerCare Plus (BC+) and Medicaid SSI (SSI) HMOs contracting with obstetric clinics designated as OBMHs. It is designed to provide a quick on-line reference for operationalizing OBMH Contract requirements. The guide also consolidates a variety of information regarding implementation and operations published since December 2014. Participating HMOs may find the guide useful in recruiting and working with clinics and community-based organizations.

Background

The OBMH Initiative was launched in January 2011. This initiative is part of DHS' long-standing efforts to improve birth outcomes and reduce birth disparities in Southeastern Wisconsin. Initially, the initiative was limited to BC= HMOs serving high-risk pregnant women in the six southeastern counties (Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha) and was a contract requirement for 2010 – 2013. In 2014, the initiative was expanded to include HMOs in Dane County and Rock County. Additionally, in July 2014, high risk pregnant women enrolled in SSI HMOs in these designated counties were also able to enroll in the OBMH initiative.

The OBMH Initiative is authorized by 2009 Wisconsin Act 28, which added patient-centered medical homes as a service delivery model for Wisconsin Medicaid. Pregnant women enrolled in BC+ were identified as one of the targeted populations eligible for medical home enrollment. Statutory authority for the Initiative is in Wisconsin Statutes, Sections 49.45(24j) and 49.45(24g). DHS made a decision to expand the include SSI members in the OBMH initiative as part of program expansion in 2014, as described above.

A list of the HMOs, the program(s) they provide and service areas is found in Attachment 2.

The OBMH, modeled after Patient-Centered Medical Homes (PCMH), is an approach to care based on:

- Accessibility
- Continuity of care
- Comprehensiveness
- Coordination of care
- Team-based care, including the patient and often her family as part of the care team, and
- Evidence-based practices and a focus on quality

Evolved from pediatric medical homes initiated in the 1960s for children with special health care needs and various models designed to manage chronic diseases, PCMHs are now viewed as a promising model to help transform primary care and subsequently meet the triple aims of higher quality care, increased patient satisfaction and lower costs. The model was embraced by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association in 2007, with issuance of the Joint Principles for the PCMH:

<http://www.pcpsc.net/joint-principles>

Research

To date, the evidence of effectiveness of patient-centered medical homes is scant. This is due, primarily, to insufficient research given the limited time since their initial implementation in 2007, (based on the Joint Principles) and the extensive variation in implementation. Other obstacles to rigorous evaluations include the lack of standard measurements, small sample sizes and the length of time required for quantitative evaluations to be completed and published. See Attachment 3 for a review of the research.

Evaluation

The DHS contracted with the University of Wisconsin – Madison, Population Health Institute to conduct an initial evaluation of the OBMH Initiative in Southeast Wisconsin.

- For 2014 – 2015, OBMHs in Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha Counties established in 2011, 2012 and 2013 agreed to continue to work with the DHS and the UW Population Health Institute in evaluating the OBMH Initiative.

- Evaluation activities included:
 - Completing pre- and post-implementation surveys.
 - Staff participation in interviews and/or focus groups.
 - Providing additional data and information, as requested.
 - Reviewing preliminary findings and offering comments.
 - Sharing findings with relevant stakeholders and distributing reports as requested by the DHS.

- OBMHs participating in the initial UW Population Health Institute evaluation received a copy of the final report.

Findings from the evaluation and the EQRO review of medical records are being used to inform policy with regard to the OBMH Initiative. Reports are found on the Forward Health Portal here:

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

Information from the evaluation and the EQRO review of medical records is also being used to assess the effectiveness and efficiency of OB Medical Home Initiative.

I. Program Description

The OBMH provides comprehensive, coordinated prenatal and postpartum care to BC+ and SSI HMO members who have been identified as high-risk. Care coordination is a key component, as is addressing psychosocial issues, e.g., domestic violence, unstable living conditions, inadequate support system, etc. Member engagement in her care is also a key component. A specific focus on identifying and engaging African-American members to address long-standing disparities in birth outcomes and infant mortality is a priority for this model. To learn more about other DHS efforts to eliminate racial and ethnic health disparities, see:

<https://www.dhs.wisconsin.gov/healthybirths/index.htm>

<https://www.dhs.wisconsin.gov/healthybirths/overview.htm>

OBMH Payments for Additional Services

Clinics serving as OBMHs will be reimbursed as under current HMO payment processes for standard prenatal and postpartum care for all enrollees.

- In addition to the standard Medicaid payment, OBMHs will receive \$1,000 per eligible, enrolled member who meet all of the following criteria:
 - Enrolled in the first 16 weeks of the pregnancy and remained continuously enrolled throughout the pregnancy,
 - Attended a minimum of 10 prenatal care appointments with the OB provider,
 - Remained continuously enrolled during her pregnancy, **and**
 - Had a postpartum appointment within 60 days of delivery.
- OBMHs will receive an additional \$1,000 per eligible enrolled member who meets all of the above criteria and has a healthy birth outcome. Healthy birth outcome is defined as: equal to or more than 5.5 pounds (2500 grams), at least 37 weeks gestational age and no neonatal death within 28 days post-delivery.
- All payments (either \$1,000 or \$2,000) are made to the HMO for pass-through to the clinics operating an OBMH.

****Important Clarifications****

- Payments for eligible members who have multiple births in a single pregnancy will be determined on an individual basis, as will payments for other unanticipated events based on documentation in the medical record.
- If the enrolled member fails to keep the postpartum appointment within 60 days of delivery, the OBMH should document all efforts made to encourage her attendance, including telephone calls, letters, e-mail or other electronic messages, and attempts to reschedule the appointment. DHS grants credit for efforts to ensure postpartum visit is scheduled, at a minimum.

Compliance with requirements associated with the OBMH and related payments is monitored via the DHS external quality review organization (EQRO), currently MetaStar, Inc., via quarterly chart reviews of enrolled members. For more information about the external review process, see Section III., Documentation, Reporting and Review.

What Providers can serve as an OBMH

Any clinic that provides obstetric services to BC+ or SSI HMO members *and* that has an OBMH agreement with a participating HMO which, at a minimum, meets the following requirements, may serve as an OBMH.

The OB clinic must:

- Agree to adopt a team-based approach to care that aligns with the DHS HMO Contract and which should be reflected in the HMO – Clinic(s) agreements related to implementing the OBMH; the care team shall include:
 - the OB provider who serves as the lead,
 - a designated care coordinator,
 - other clinic staff, e.g., RN, medical assistant, etc.,
 - other care providers, including primary care, specialists and behavioral health, and
 - members/patients.
- Agree to ensure that the member receives comprehensive care, including medical and behavioral health care and that her psychosocial needs are met, e.g., referrals for housing assistance, domestic violence counseling, etc.
- Promote patient self-management, e.g., the woman is encouraged to participate in developing her plan of care and managing her own health.
- Develop an individual care plan and monitor activities.
- Use an electronic health record system Note: Clinic/OBMH use of the DHS registry satisfies this expectation.

Who Can Enroll in an OBMH?

Any BC+ or SSI HMO pregnant member, who is enrolled in a participating HMO, is receiving care at a clinic that has an OBMH agreement with the HMO and meets the following criteria may enroll in the OBMH.

- The member must be enrolled in the OBMH within the first 16 weeks of pregnancy. This includes members who enroll in an OBMH after receiving care through another HMO/participating clinic/OBMH.

- Women who are pregnant and not currently enrolled in BC+ or SSI at the time of the initial prenatal visit may enroll in the OBMH if they meet the below criteria and are subsequently determined eligible for BC+ or SSI HMO enrollment. All services provided prior to enrollment in a participating HMO must be documented in the woman's medical record. Clinic staff may assist the woman in accessing and enrolling in Wisconsin Medicaid.
- The member must also meet one or more of the following criteria:
 - Be less than 18 years of age.
 - Be African American.
 - Be homeless.
 - Have a chronic medical or behavioral health condition which will negatively impact the pregnancy, as specified in the DHS HMO contract, at a minimum.
 - Had a prior poor birth outcome, defined as one or more of the following:
 - Baby born at low birth weight (less than 2,500 grams or 5.5 pounds).
 - Baby born preterm (gestational age less than 37 weeks).
 - Neonatal/early neonatal death (baby died within the first 28 days).
 - Stillbirth (fetus died after 20 weeks gestation).
 - Meet the criteria for inclusion in the DHS BORN (Birth Outcome Registry Network) Report. The guide for the BORN report is found on this website:

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

How Do Women Enroll In The OBMH?

An eligible BC+ or SSI HMO member is considered enrolled:

- Upon her agreement to receive the additional services offered by the OBMH.

- Following her agreement to help develop a plan of care, keep appointments and work with members of the care team, especially the care coordinator.

Note: Women enrolled in the medical home must be identified and tracked separately to ensure that DHS and HMO reporting requirements are met and that appropriate payments are made for OB Medical Home enrollees. All clinics serving as OBMH must use the DHS OBMH Registry, maintained by the EQRO, for reporting purposes (See Section III., Documentation, Reporting and Review for more information about the registry).

II. OBMH Model

The Partnership – DHS, HMOs, Clinics; Roles and Responsibilities

The OBMH Initiative is a partnership among DHS, participating HMOs and participating clinics who have agreed to provide additional services to high-risk pregnant Medicaid HMO members. Each organization has specific roles and responsibilities which, when combined, helps ensure that enrolled members have healthier births.

The information below is an overview of roles and responsibilities for each entity in the partnership. However, the overview is not comprehensive. For comprehensive requirements, please refer to the DHS-HMO Contract.

DHS Responsibilities

The OBMH Initiative is led by the DMS within DHS. The DPH provides technical advice and assists with strategic planning and policy development. OPIB provides policy analysis, research on evidence-based practices, serves on the internal work team and managed the initial evaluation with the University of Wisconsin Population Health Institute.

Responsibilities include:

- Providing leadership and guidance to the HMOs.
- Managing the day-to-day tasks, including monitoring the strategic workplan, responding to and tracking questions and responses, etc.
- Managing the DHS partnership with participating HMOs.
- Assisting HMOs in identifying high-risk Medicaid members via the BORN Report which is described in a guide noted on the previous page.

- Managing the bonus payments to participating HMOs for pass-through to clinics serving as OBMHs. Payment methodology to OBMHs may change in the future due to recent Federal Managed Care Rule changes.
- Working with the DHS EQRO on medical record reviews and technical assistance.
- Maintaining the OBMH Registry in partnership with the DHS EQRO.

HMO Responsibilities

HMOs in the targeted counties are responsible for recruiting obstetric practices to serve as OBMHs and providing on-going support. Each HMO will have an identified DHS HBO program liaison. Responsibilities include:

- Using data to identify obstetric practices serving large populations of Medicaid members.
- Recruiting obstetric practices to participate in the program, including explaining the benefits, requirements and providing technical assistance to participating clinics.
- Partnering with clinics, Federal Qualified Health Centers, local community organizations and others to ensure early identification of high risk pregnant women.
- Identifying women who meet the criteria for enrollment, providing information about the program, and referring to or enrolling in participating clinics.
- Supporting on-going partnerships with participating clinics, including answering questions (or forwarding to DHS for response and relaying response to the clinic), assisting the clinic as needed in identifying specialists, e.g., behavioral health or dental care, and offering suggestions for partnerships with other community-based organizations.
- Developing a payment process with the clinics that ensure timely processing of invoices, and pass-through of bonus payments.
- Notifying the DHS of any obstacles encountered and seeking assistance, as needed.

- Ensuring that the EQRO is provided medical records, or timely access to electronic medical records, for review purposes.
- Submitting reports to the DHS, as specified.
- HMOs must ensure that contracted OBMH clinics are meeting the program requirements.

Participating Clinic/OBMH Responsibilities

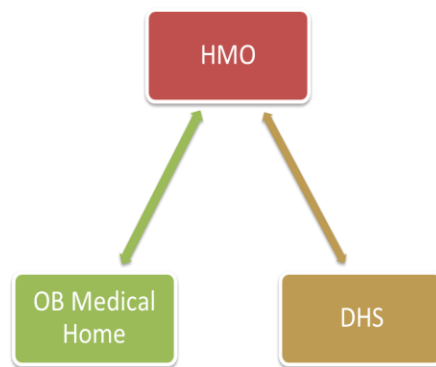
The primary role of the OBMH is to provide medical and care coordination services which ensures that enrollees receive high quality, comprehensive, coordinated prenatal and postpartum care, including services to address psycho-social needs or needs based on social determinants of health. Responsibilities include:

- Identifying women who meet the criteria for enrollment, providing information about the program, and enrolling interested members into the program.
- Assisting identified women who are not enrolled in Wisconsin Medicaid in applying for health care benefits either directly or via referrals to other organizations that provide such assistance. The online application is located at <https://access.wisconsin.gov/>.
- Completing a comprehensive assessment – medical and psycho-social – to identify strengths and needs.
- Developing an individual plan of care for each enrolled member.
- Documenting information about enrolled members in the OBMH Registry.
- Working in partnership with the HMO to resolve questions or issues as they arise, including identifying specialists or making referrals to meet individual care plan goals.
- Providing medical records to the DHS EQRO either via the HMO or directly, including information about care coordination activities.

- Participating in OBMH forums/best practice seminars and sharing information with their peers.
- Submitting invoices for payments to the HMO in a timely manner based on processes established by the HMO.

Communication Among Partners

Frequent and on-going conversation among the partners is critical to the success of the OBMH Initiative. In general, participating HMOs are the hub of information-sharing. The HMO serves as the conduit for relaying information from the clinics to DHS and from DHS to the clinics.



Care Management Model and Care Coordination

As defined in the BC+ and SSI HMO contract, the care management model is a health care delivery process to arrange, deliver, monitor and evaluate the member's care, including all medical and social services, with the goal of helping members achieve their self-identified goals. Care coordination is the purposeful organization by care management staff to seamlessly deliver comprehensive services in response to a member's needs and work toward achieving desired health outcomes. According to research on patient-centered medical homes, effective care coordination:

- Reduces barriers to care (i.e., social determinants of health such as housing and food insecurity, transportation, etc.).
- Helps individuals navigate the health care system.
- Increases efficiency in the health care system; reduces duplication, e.g., no repeat tests.
- Helps ensure the best possible care for patients.
- Helps ensure a comprehensive approach to care.
- Increases patient self-management.
- Encourages patients to seek resources for care following the pregnancy.

- Improves patient satisfaction.
- Improves satisfaction among care providers/physicians.
- Improves satisfaction among clinic staff.
- Enhances productivity.

Specific examples of expected care coordination for the OBMH include, but are not limited to:

- Identifying needs and helping the patient/member access community resources.
- Engaging the patient in helping to develop the care plan and helping her understand the benefits of working with a care coordinator.
- Providing information to the patient about her specific conditions/risk factors and helping her be a partner in her own care.
- Providing information on a wide array of topics that may help her improve her health and the health of the baby.
- Providing follow-up on missed appointments and on referrals.
- Working with other care providers (collaboration); integrating care between other providers, e.g., dental, primary care, specialists, behavioral health.
- Ensuring connection with a primary care provider and pediatrician following delivery.
- Ensuring connection with local resources to address social issues/risk factors.

****Important Care Coordination Clarifications****

- Care coordination activities should be documented in the medical record and should include, but are not limited to, the following:
 - member goals,
 - care plan as developed with member and provider,
 - issues addressed,
 - strategies to address identified issues and the results,
 - referrals made to other providers/local agencies and the results, and
 - interactions with the patient.
- If the OBMH clinic is working with an external Prenatal Care Coordination (PNCC) provider for care coordination services, the OBMH clinic and/or HMO is strongly encouraged to develop a written memorandum of understanding (MOU) between the parties that identifies clear roles and responsibilities including:
 - staff member engagement as a member of the care team,
 - consistent, meaningful communication between the PNCC provider and the OBMH,
 - how information will be shared, and

- agreement that the PNCC provider will share all records related to the enrolled member and her pregnancy, including for the purpose of the EQRO review.
- The care coordinator should make at least one attempt to visit the enrolled member in her home or at a community location to help establish relationships of trust and allow observation of other potential needs. OBMH enrollees may refuse the home visit; such refusals must be documented in the medical record. Home visits should continue to be offered throughout the pregnancy, as appropriate.

Importance of Postpartum Care and the Postpartum Visit

DHS follows recommendations from the American Congress for Obstetricians and Gynecologists for postpartum care found on this website:

<http://www.acog.org/About-ACOG/News-Room/News-Releases/2016/Ob-Gyns-Stress-the-Importance-of-Postpartum-Care-The-Fourth-Trimester>

In particular, this quote can be used as guidance for implementing postpartum practice in the WI OBMH: "[Optimizing Postpartum Care.](#)" states that patient-centered, maternal postpartum care has the potential to improve outcomes for women, infants and families and to support ongoing health and well-being. In the weeks after birth, a woman must adapt to multiple physical, social and psychological changes. She must recover from childbirth, adjust to changing hormones, and learn to feed and care for her newborn. In addition to being a time of joy and excitement, this “fourth trimester” can present major challenges like lack of sleep, pain, depression, lack of sexual desire and urinary incontinence. Postpartum care visits with obstetrician-gynecologists or other obstetric care providers can help women navigate the challenges of motherhood.”

OBMH participants should remain enrolled and receive care for at least 60 days following delivery. Postpartum care should address the following:

- An appointment for the member should be made prior to hospital discharge with the OB provider for at least one postpartum visit.
- An appointment for the baby should be made prior to hospital discharge with a pediatrician or other primary care provider.
 - The baby should be seen by a health care professional within two (2) days following hospital discharge.
- Information about the delivery and any concerns should be shared with the primary care provider prior to the appointment.

- Basic information about caring for the baby and what to do/who to call with concerns should be shared with the member.
- The member should be screened for depression and information about family planning should be shared. Family planning information should be shared with the member prior to delivery, and again during the postpartum period.
- The member should be encouraged to identify a primary care provider for on-going medical care, i.e., interconception care. The HMO should assist with this effort.
- The member should be reminded about how to access additional resources and information about child care assistance should be shared.

If the baby was low birth weight or preterm or there is a fetal death, the HMO shall be notified immediately to facilitate appropriate care planning over the long-term. If a member has a poor birth outcome – low birth weight, preterm, infant death – the HMO is responsible for ensuring that the woman and the baby receive appropriate health care and care coordination services.

III. Documentation, Reporting and Review

The following are requirements for tracking member participation and evaluation in the OBMH as stated in DHS-HMO Contract. Because requirements may change over time, the most current version of the DHS-HMO contract will supersede information found in this section of the guide.

Clinic-Level Patient Data Management

Each clinic serving as a medical home must have an electronic health record or an electronic system manage patient data in order to document the following:

- Enrollment date (date of initial prenatal visit and agreement to receive extra prenatal and postpartum care, including care coordination services).
- Clinical information, e.g., from the comprehensive prenatal assessment.
- Test results, including abnormal test results.
- Referrals, follow-up and results.
- Birth outcomes.

- Any other information required by the member's HMO as agreed to by both parties.

For documentation criteria specific to medical chart reviews conducted by the EQRO, please refer Attachment 4.

Use of the DHS OBMH Registry

The Registry was originally developed and maintained by the Center of Urban Population Health at the University of Wisconsin – Milwaukee. The Registry was transitioned to MetaStar, Inc., the DHS EQRO, in September 2014.

The OBMH Registry is a web-based tool to track Medicaid HMO members who are enrolled in the OBMH. The Registry is used by the clinics, HMOs and DHS to document and monitor data related to projecting and confirming payments above the DHS standard payment for prenatal and postpartum care and delivery. The EQRO uses the registry information to create datasets for medical record reviews to verify compliance with requirements and provide information to DHS to process payments. See the description of the MetaStar review process later in this section.

Participating clinics and HMOs only have access to their patients and members.

Use this link to access the registry, obtain information about obtaining administrative and user access and view a training video about using the registry:

<https://apps.metastar.com/apps40/commercial/OBMH/OBMH/Login.aspx>

The registry includes the following 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
- h. Reason for termination
- i. Mothers demographic information
- j. High Risk Category(ies)
- k. Delivery information
- l. Attestation: Did the mother attend a minimum of 10 prenatal visits?
- m. Attestation: Were home visits offered throughout enrollment?
- n. Did any home visits occur?

- o. 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)
- p. 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.
- q. Automatically generate a time stamp for when the record was created.
- r. Allow future pregnancy episodes of care and the ability to distinguish the different records.
- s. 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 EQRO. The EQRO uses a list pulled from the registry, and verified by the HMO, to inform the EQRO and DHS which records require review.

Beginning with member enrollments in the OBMH effective 1/1/2017, the member information must be entered in to the registry within 30 days of enrollment. If the clinic does not meet this timeframe, a chart review will not be conducted by the EQRO and the clinic will be ineligible for OBMH payments.

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. A copy of the memo is found in Attachment 5, *DHS Prospective Payment Reconciliation Process*. 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 OBMH 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.

HMO Annual Report

Each participating HMO must submit a report to DHS annually evaluating its medical home initiative, using the template provided by the Department. The template associated with report due in June 2017 is found in Attachment 6, *OBMH Annual Report Template*.

EQRO Review

DHS contracts with an EQRO to review records from each participating HMO to verify that the OBMH Contract requirements, located in DHS-HMO the Contract, were met. In addition, data collected from the medical record review allows DHS to monitor OBMH implementation and informs potential policy changes. HMOs may send the records to the EQRO or direct the medical home to provide the records. Medical home providers that use electronic health records (EHRs) may choose to grant the EQRO remote, direct access to enrolled members electronic health records. In partnership with DHS, the EQRO developed a tool and guidelines for the review of OB Medical Home records. Regardless of completeness, all records are included in the review. DHS will use the results of the review in the payment process and to determine the need for technical assistance and quality improvement activities. Refer to Attachment 4, *EQRO Review Guidelines* for the documentation criteria.

Record Request to the HMO

Prior to the review, the EQRO sends a memorandum to the HBO liaison for each HMO. The memorandum requests records for OBMH enrollees who delivered during a specified period of time. The memorandum template is found in *Attachment 7, Memorandum Record Review Request Template* and includes instructions for providing access to or submitting medical records for review.

Note: OBMH providers must ensure that documentation of care coordination activities is included in the medical record or otherwise easily accessible, even if care coordination is provided by an external provider (i.e., a prenatal care coordination agency). The HMO and/or OBMH should notify the external care coordination provider of this requirement. The EQRO must have access to clinical and other records for all enrolled members regardless of the provider or location.