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

Revised 12/23/2024

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Contacts
Clinics should contact the designated Health Maintenance Organization (HMO) Healthy Birth Outcome (HBO) liaison found in the contact list on the ForwardHealth website.

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

Introduction, Purpose, and Background

This document provides basic information about the Wisconsin Department of Health Services' (DHS) medical home initiative for high-risk pregnant members enrolled in Medicaid. This medical home is commonly referred to as the "OB Medical Home (OBMH)."

The simplified language in this document shall not be construed to replace or supersede the existing official Contract language. The BadgerCare Plus and Medicaid SSI HMO contract (Contract) can be found here:

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

Purpose

This document serves 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 HMO Contract and Quality Guide requirements specific to the OBMH initiative. Participating HMOs may find the guide useful in recruiting and working with clinics and community-based organizations.

Background

The OBMH Initiative was created by 2009 Wisconsin Act 28, which added patient-centered medical homes as a service delivery model for Wisconsin Medicaid. Pregnant members enrolled in BC+ were identified as one of the targeted populations eligible for medical home enrollment. Statutory authority for the Initiative is in Wis. Stat. §§ 49.45(24g) and 49.45(24j). The OBMH Initiative was launched in January 2011 and is part of DHS' long-standing efforts to improve birth outcomes and reduce birth disparities in Wisconsin, also reflected in the 2025-2027 Wisconsin Managed Care Quality Strategy. Initially the initiative was limited to BC+HMOs serving high-risk pregnant members in the six southeastern counties (Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha). In 2014, the initiative was expanded to include HMOs in Dane County and

Rock County. Additionally, in 2014, high risk pregnant members enrolled in Medicaid SSI HMOs in these designated counties were also able to enroll in the OBMH initiative.

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
- 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.pcpcc.net/joint-principles

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 abuse, unstable living conditions, inadequate support system, and other social determinants of health, etc. Member engagement in their care is also a key component. A specific focus on identifying and engaging African-American and other racial/ethnic minority members to address long-standing disparities in birth outcomes and infant mortality is a priority for this model.

The initiative is available in the following counties: Dane, Kenosha, Milwaukee, Ozaukee, Racine, Rock, Washington, and Waukesha.

A list of the participating HMOs and OBMH service areas is found in Appendix 1.

Which Providers can serve as an OBMH

Any ForwardHealth-enrolled clinic located in the target counties that provides obstetric services to BC+ or SSI HMO members ***and*** 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 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 their psychosocial needs are met, e.g., referrals for housing assistance, domestic abuse counseling, etc.
- Promote patient self-management, e.g., the member is encouraged to participate in developing their plan of care and managing their own health.
- Develop an individual care plan and monitor activities.
- Use an electronic health record system.
    - Clinic/OBMH use of the DHS OBMH Registry satisfies this expectation. See section below for additional information on accessing the Registry.

Which Members Can Enroll in an OBMH?

Any pregnant member enrolled in a participating HMO, receiving care at a clinic that has an OBMH agreement with the HMO, and meeting the following criteria may enroll in the OBMH.

- The member must be enrolled in the OBMH within the first 28 weeks of pregnancy. This includes members who enroll in an OBMH after receiving care through another HMO or participating clinic.
- Members 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 member's medical record. Clinic staff may assist the member 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, American Indian or Alaskan Native, Hispanic, Asian or Pacific Islander, and/or Laotian or Hmong
    - Be homeless,
    - Have a chronic medical or behavioral health condition which will negatively impact the pregnancy
    - 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), or
        - Stillbirth (fetus died after 20 weeks gestation).
- Meet the criteria for inclusion in the DHS Birth Outcome Registry Network (BORN) Report[1].

How Are Members Enroll in the OBMH?

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

- Upon their agreement to receive the additional services offered by the OBMH.
- Following their agreement to help develop a plan of care, keep appointments and work with members of the care team, especially the care coordinator.

Members 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 Documentation, Reporting and Review section for more information about the registry.

[1] Birth Outcome Registry Network (BORN) User Guide: https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Managed_Care_Medical_Homes/pdf/BORN_User_Guide.pdf.spage

OBMH Model

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.

DHS Responsibilities

The Division of Medicaid Services (DMS) within DHS leads the OBMH Initiative. DHS provides technical advice and assists with strategic planning and policy development, in addition to funding the incentives.

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.
- Managing the payments to participating HMOs who subsequently issue enhanced payment to the clinic. 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 clinics 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 clinics serving large populations of Medicaid members.
- Recruiting obstetric clinics to participate in the program, including explaining the benefits and 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 members.
- Identifying members 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 that ensures timely processing of invoices and issuing enhanced payment to the clinic.
- Notifying 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.
- Ensuring 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 members receive high quality, comprehensive, coordinated prenatal and postpartum care, including services to address psychosocial needs or needs based on social determinants of health. Responsibilities include:

- Identifying members who meet the criteria for enrollment, providing information about the program, and enrolling interested members into the program.
- Assisting identified members 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, including medical, mental health, substance use disorder, and social determinants of health (SDoH) screening 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

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

- Identifying needs and helping the member access community resources.
- Engaging the member in helping to develop the care plan and helping them understand the benefits of working with a care coordinator.
- Providing information to the member about their specific conditions/risk factors and helping them be a partner in their own care.
- Providing information on a wide array of topics that may help them improve their 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 members are connected with a primary care provider and pediatrician following delivery.
- Ensuring members are connected with local resources to address social issues/risk factors.
- Consider home visits by an appropriate team-member or referral to home visiting programs when available.

Importance of Postpartum Care and the Postpartum Visit

DHS follows recommendations from the American College for Obstetricians and Gynecologists (ACOG) for postpartum care.

In particular, ACOG's article "Optimizing Postpartum Care[2]" states that, "The weeks following birth are a critical period for a woman and her infant, setting the stage for long-term health and well-being. During this period, a woman is adapting to multiple physical, social, and psychological changes. She is recovering from childbirth, adjusting to changing hormones, and learning to feed and care for her newborn. In addition to being a time of joy and excitement, this "fourth trimester" can present considerable challenges for women, including lack of sleep, fatigue, pain, breastfeeding difficulties, stress, new onset or exacerbation of mental health disorders, lack of sexual desire, and urinary incontinence."

OBMH members 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 with the OB provider for at least one postpartum visit.
- 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, breastfeeding, and newborn care should be shared 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., inter-conception care. The HMO should assist with this effort.

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. The HMO is responsible for ensuring that the member and the baby receive appropriate health care and care coordination services.

[2] ACOG Committee Opinion Number 736 (May 2018) "Optimizing Postpartum Care: https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2018/05/optimizing-postpartum-care.pdf

Documentation, Reporting, and Review

Clinic-Level Patient Data Management

Each clinic serving as a medical home must have an electronic health record or an electronic system to manage patient data 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.
- 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
    - Screening and referrals made to other providers/local agencies and the results
    - Interactions with the member
- If the OBMH clinic is working with an external Prenatal Care Coordination (PNCC) provider for care coordination services or serving a member who is receiving PNCC 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
    - Agreement that the PNCC provider will share all records related to the enrolled member and their pregnancy, including for the purpose of the EQRO review

For documentation criteria specific to medical chart reviews conducted by DHS's External Quality Review Organization (EQRO), please refer to the EQRO Review Guidelines in Appendix 2.

Use of the DHS OBMH Registry

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.

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. Member Name
d. MA ID number
e. Date of Birth
f. Date member enrolled in OB Medical Home initiative
g. Date member first seen at the clinic (if different from enrollment)
h. Number of weeks of gestation at enrollment
i. County of Residence
j. Was the patient transferred from another provider?
k. Date terminated from OB Medical Home initiative, if prior to completion
l. Reason for termination
m. High Risk Category(ies)
n. Delivery information
o. Attestation: Were home visits offered throughout enrollment?
p. Did any home visits occur?
q. 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)

Chart reviews are completed quarterly by the Department's EQRO. The EQRO uses a list pulled from the registry, verified by the HMO, to inform the EQRO and DHS which records require review.

The member information must be entered into the registry within 30 days of enrollment in the OBMH. Timely entry into the registry is needed for HMOs to track enrollment and for the EQRO to complete the chart review.

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. OBMH 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 Appendix 4, Memorandum Record Review Request Template and includes instructions for providing access to or submitting medical records for review.

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.

Payments

- Clinics serving as OBMHs will be reimbursed under current HMO payment processes for standard prenatal and postpartum care for all enrollees.
- DHS will issue payment to HMOs, and the HMO subsequently issues the enhanced payment to the OBMH of $2,000 per eligible, enrolled member who meets all of the following criteria:

- Enrolled in the first 28 weeks of the pregnancy and remained continuously enrolled throughout the pregnancy,
- Care plan developed by OBMH Care Coordinator, including completion of mental health, substance use disorder, and social determinants of health (SDoH) screening and referrals,
- Healthy birth outcome, 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 or stillbirth after 20 weeks.
- No maternal mortality, defined as:
    - death of a pregnant member from any cause related to or aggravated by the pregnancy or its management. This definition does not include deaths from accidental or incidental causes.
    - Time frame will be within 60 days of termination of pregnancy.

- Incentive payment is per member, not per child delivered.
- Compliance with requirements associated with the OBMH and related payments is monitored by the DHS external quality review organization (EQRO) via quarterly chart reviews of enrolled members.

Payment Process and Schedule

1. EQRO sends reminder to update the Registry to HMOs to share with clinics.
2. EQRO sends list of members to HMOs to validate (noting any missing) for inclusion in records review and attestation of no known maternal mortality.
3. EQRO sends request for records to the HMO for births in Q1 (January 1 – March 31st) at the start of Q3 (July)
4. Records are due to EQRO approximately 30 days after request for records submitted.
5. EQRO reviews all submitted records for Q1 deliveries, verifying eligibility criteria for the incentive.
6. EQRO will issue preliminary findings for eligibility criteria to HMOs for Q1 deliveries.
7. HMOs may submit a re-score request for the following incentive eligibility criteria and should include supporting documentation.
    - Pregnancy-related appointment with an OBMH health care provider within first 28 weeks of pregnancy
    - Continued enrollment through 60 days postpartum, evidenced by postpartum visit or good faith effort to schedule postpartum appointment.

EQRO will look for evidence up to 84 days postpartum to align with HEDIS measure specifications

- Birth outcome

8. Once the re-scoring process is complete, EQRO will submit the final quarterly report to DHS.
9. DHS will review the final quarterly report and submit to fiscal agent for payment, approximately 30 days after final results are submitted.

Steps 1-9 will be completed each quarter. See Appendix 3 for Review and Payment Schedule.

Appendix 1: Participating HMOs and OBMH Service Areas

This table identifies the HMOs and the counties where the HMO has established OBMH clinic agreements.

HMO	Dane	Rock	Kenosha	Milwaukee	Ozaukee	Racine	Washington	Waukesha
Anthem		X	X	X	X	X	X	X
Chorus			X	X	X	X	X	X
Dean	X	X						
GHC-SCW	X							
iCare	X		X	X	X		X	X
MercyCare		X						
MHS		X	X	X	X	X		X
Molina			X	X	X	X	X	X
NHP		X	X	X	X	X		X
Quartz	X							
UHC	X	X	X	X	X	X	X	X

Appendix 2: EQRO Review Guidelines

OBMH Review Criteria

Section 1: Member Information		
THE FOLLOWING FIELDS SHOULD BE COMPLETED		
Reviewer: **Member Name:** **Date of Birth (DOB):** **Age During Pregnancy:** Age during the majority of the pregnancy **Review Date:** Date the Review is Completed **MCO:** **Clinic:**		
Section 2: Race/Ethnicity/Primary Language		
THE FOLLOWING IS FOUND IN THE MEMBER RECORD (IF NOT IDENTIFIED, MARK NOT IDENTIFIED IN RECORD)		
Identify Race: ☐ **American Indian/Alaska Native** ☐ **Asian** ☐ **Black or African American** ☐ **Multi-Racial** ☐ **Native Hawaiian or Other Pacific Islander** ☐ **Laotian or Hmong** ☐ **White** ☐ **Prefers not to answer** ☐ **Not identified in record**	**Ethnicity:** ☐ **Hispanic/Latino** ☐ **Not Hispanic/Not Latino** ☐ **Prefers not to answer** ☐ **Not identified in record**	**Primary Language:** ☐ **English** ☐ **Other language (please specify):** ☐ **Not identified in record**
Section 3: Medical Providers		
Evidence of Provider and Care Coordinator		
☐**Yes** ☐**No (Check missing items)** ☐ PCP ☐ Obstetrician ☐ Care Coordinator		
Section 4: Record Submission		
A Complete Record Was Submitted for Review		
☐**Yes** ☐**No (Check missing items)** ☐ Clinic Records-Prenatal and Postpartum ☐ PNCC Documentation ☐ Delivery/Birth Outcome If all necessary information is present, the record is considered completed.		

Section 5: Prenatal and Postpartum Dates
REQUIREMENT
Last Menstrual Period (LMP) **Estimated Date of Confinement (EDC)** **28-Week Gestation Date** **First OB Visit Date** **Delivery Date**
REQUIREMENT
Postpartum Visit Date within 84 days of delivery: **Rationale the Visit was Not Completed:** ☐ Incomplete documentation ☐ No Show ☐ Rescheduled ☐ Efforts made to schedule/reschedule postpartum visit
Section 6: Prenatal Visits
SCORING OPTIONS
Number of Prenatal Visits ☐ No Visits ☐ 1-4 ☐ 5-9 ☐ 10-12 ☐ 13 +
Section 7: Care Coordination
Care Plan
A Care Management Plan was Developed Including Initial Intake Process and All Needs are Identified
SCORING OPTIONS
☐ **Met** ☐ **Not Met** ☐Incomplete Documentation ☐ Refused ☐ Other:
A Care Management Plan was Developed in Collaboration with the Member, Care Coordinator, PCP, and Others
SCORING OPTIONS
☐ **Met** ☐OB is PCP ☐ **Not Met** ☐Incomplete Documentation ☐ Refused ☐No PCP Documented in Record

☐ Other:

The Care Management Plan Contained a Self-Management/Self-Care Component

SCORING OPTIONS

☐ **Met**
☐ **Not Met**
☐Incomplete Documentation
☐ Refused
☐ Other:

Collaboration and Coordination

The Record Contained Evidence of Documentation of Follow Up for a Chronic Condition

SCORING OPTIONS

☐ **Met**
☐ **Not Met**
☐Incomplete Documentation
☐Other:
☐ **N/A**

The Member Had the Following Chronic Conditions:

☐ Asthma ☐ Behavioral Health
☐ Cardiac Disease ☐ Diabetes
☐ HIV/AIDS ☐ Hypertension
☐ Class III Obesity ☐ Other:

The Record Contained Evidence of Regular Communication Between the Member, OB Provider, and PCP

SCORING OPTIONS

☐ **Met**
☐ OB is PCP
☐ **Not Met**
☐ Incomplete Documentation
☐ Refused
☐ PCP Not Documented in Record
☐ Other:

The Record Contained Evidence of Communication with the PCP Post Delivery

SCORING OPTIONS

☐ **Met**
☐ OB is PCP
☐ **Not Met**
☐ Incomplete Documentation
☐ PCP is not Documented in Record
☐ Other:

Section 8: Screening and Education
Substance Use Screening
SCORING OPTIONS
Member Screened for Substance Use ☐ **Yes** ☐ **No** ☐ Incomplete Documentation ☐ Other:
Substance Use Resources Provided
SCORING OPTIONS
Counseling, Referrals, and/or Resources Were Provided ☐ **Yes** ☐ **No** ☐ Incomplete Documentation ☐ Other: ☐ **NA**
Social Determinants of Health Screening
SCORING OPTIONS
☐ **Yes** ☐ **No** ☐ Incomplete Documentation ☐ Other:
Depression Screening
SCORING OPTIONS
☐ **Yes (Check all that apply)** ☐ Prenatal ☐ Postpartum ☐ **No** ☐ Incomplete Documentation ☐ Other:
Education Regarding Family Planning
SCORING OPTIONS
☐ **Yes (Check all that apply)** ☐ Prenatal ☐ Postpartum ☐ **No** ☐ Incomplete Documentation ☐ Other:
Education Regarding Breastfeeding
SCORING OPTIONS
☐ **Yes (Check all that apply)**

☐ Prenatal
☐ Postpartum

☐ **No**
☐ Incomplete Documentation
☐ Other:

Education Regarding Newborn Care

SCORING OPTIONS

☐ **Yes (Check all that apply)**
☐ Prenatal
☐ Postpartum

☐ **No**
☐ Incomplete Documentation
☐ Other:

Section 9: Birth Outcome

SCORING OPTIONS

Gestational Age:
☐ Less than 37 weeks
☐ 37 weeks or greater

Weight:
☐ Less than 2500 grams
☐ 2500 grams or greater

Stillbirth: ☐No ☐Yes ☐Unknown

Neonatal Death: ☐No ☐Yes ☐Unknown

Poor Birth Outcome: ☐No ☐Yes ☐Unknown

Poor Birth Outcome Follow-Up

SCORING OPTIONS

☐**Met**

☐**Not Met**

☐**N/A**

Appendix 3: Review and Payment Schedule

Legend: EQRO | HMO/Clinic | DHS

Q1 Births Jan 1- Mar 31	Q2 Births April 1- June 31	Q3 Births July 1- Sept 30	Q4 Births Oct 1- Dec 31
EQRO send registry update reminder (June)	EQRO send registry update reminder (Sept)	EQRO send registry update reminder (Jan)	EQRO send registry update reminder (Mar)
HMOs & Clinics Update Registry (June)	HMOs & Clinics Update Registry (Sept)	HMOs & Clinics Update Registry (Jan)	HMOs & Clinics Update Registry (Mar)
Record Request Issued (July)	Record Request Issued (Oct)	Record Request Issued (Feb)	Record Request Issued (April)
EQRO confirms selection List (July)	EQRO confirms selection List (Oct)	EQRO confirms selection List (Feb)	EQRO confirms selection List (April)
Records due to EQRO (August)	Records due to EQRO (Nov)	Records due to EQRO (March)	Records due to EQRO (May)
EQRO issues preliminary results to HMOs (October)	EQRO issues preliminary results to HMOs (Jan)	EQRO issues preliminary results to HMOs (May)	EQRO issues preliminary results to HMOs (July)
HMO validate results or submit re-score request (October)	HMO validate results or submit re-score request (Jan)	HMO validate results or submit re-score request (May)	HMO validate results or submit re-score request (July)
EQRO rescores if requested and submits final results to DHS (November)	EQRO rescores if requested and submits final results to DHS (Feb)	EQRO rescores if requested and submits final results to DHS (June)	EQRO rescores if requested and submits final results to DHS (Aug)
DHS issues payment to HMOs (November)	DHS issues payment to HMOs (March)	DHS issues payment to HMOs (June)	DHS issues payment to HMOs (Aug)

Appendix 4: Memorandum Record Review Request Template

MetaStar
GUIDING CHANGE IN HEALTH CARE SINCE 1973

To: HMO Contract Administrator
HMO Medical Home Liaison
From: Jenny Klink, Vice President
MetaStar, Inc.

Subject: OB Medical Home CY [year, quarter] Review and Request for Records

This request for records for OB Medical Home enrollees includes **members who delivered infants between [insert dates in quarter].** The list of eligible members was pulled from the OB Registry has been uploaded to MetaStar's secure EQRO Portal.

Within 10 business days please confirm the accuracy of your HMO's specific list with each clinic. Identify any discrepancies between MetaStar's list and the medical home site records per instructions in spreadsheet including **transfer of clinics**, **pregnancy loss** (exclude if prior to 20 weeks) and upload the information to the MetaStar EQR Portal. MetaStar will provide a final list of members following the 10-business day review period.

Any records that meet the above criteria but are not included as part of this record review will not be reviewed at a later date. Please work with your OB Medical Home clinics to ensure that all women enrolled in the medical home and who meet the review criteria for this selection are included in this review. **DHS will not issue payment for any member whose record was not reviewed.**

Please submit or provide electronic access to these patient records to MetaStar no later than close of business [date}. Communicate with MetaStar as soon as possible if you are unable to meet the deadline, and include the requested timeframe for submission of documents.

Please use the attached OB Medical Home Document Submission Form to ensure the record is submitted in its entirety. If a member received service from different clinics that were both contracted with the HMO, please make sure the record is submitted from each clinic.

Please use the following naming convention for each record (last name, first name, delivery date (xxxx4digityear)

Instructions for Submitting Documents
Two options are available for submitting documents to MetaStar.

1. Grant remote access for MetaStar to review requested documents by contacting Danielle Sersch at: dsersch@metastar.com or 608-441-8224
2. Submit electronic documents. See below for instructions on submitting electronic documents to MetaStar.

For electronic documents:
Submit to Danielle Sersch via MetaStar's Secure EQRO Portal
MetaStar - Portal

- Please utilize the bulk upload feature in the portal.
- If difficulty with uploading and zipping/compression is needed, please do **Not** use a Third-Party compression program such as 7Zip. Extracting files from a program such as 7Zip takes additional time and may delay the review.

If there are any questions about document requests and submissions, please contact **Danielle Sersch 608-441-8224**.

Thank you for your assistance and cooperation with the Medical Home Review process.

CC: Jenny Klink, MetaStar
Melissa Erickson, MetaStar
Danielle Sersch, MetaStar
DHSOBMH@wi.gov

Appendix 6: Resources

ForwardHealth.wi.gov: Managed Care Medical Homes

Medicaid.gov: Maternal & Infant Health Care Quality

WI Department of Health Services: Maternal and Child Health Resources and Data

BadgerCare Plus and Medicaid: Covered and Noncovered Services : Mental Health and Substance Abuse Screening for Pregnant Women

Substance Abuse and Mental Health Services Administration (SAMHSA): Resources for Screening, Brief Intervention, and Referral to Treatment (SBIRT)

American College for Obstetricians and Gynecologists (ACOG)

Mental health screening tools:

- Edinburgh Postnatal Depression Scale (EPDS)
- Beck's Depression Inventory (BDI-II)
- Center for Epidemiologic Studies Depression Scale (CES-D), NIMH
- Patient Health Questionnaire (PHQ-9)

Substance abuse screening tools:

- The 5Ps Prenatal Substance Abuse Screen for Alcohol and Drugs
- T-ACE Screening Tool
- TWEAK Screen
- ASSIST Screening Tool