OBMH Incentive Eligibility FAQ

Revised 12/21/2023

The following is a list of the minimum requirements for HMOs/providers to earn an incentive as part of the OBMH initiative.

Note that best practices for prenatal and postpartum care may include many services that are not measured in this chart review process. The DMS chart review process is only capturing data on a subset of measures of interest (e.g. breastfeeding education, newborn care, family planning) and only a subset are requirements for incentive criteria. The below list **is not** representative of all the best practice interventions used to support an at-risk mother in having a healthy birth outcome. For purposes of prenatal and postpartum care that counts towards the OBMH incentive criteria, we are evaluating member consultation with a provider specific to the pregnancy care and care coordination (e.g. PNCC appointments). There are Medicaid-covered services that a pregnant or postpartum member may receive, but do not meet the criteria needed for incentive eligibility (e.g. a dietician appointment, an ultrasound without a provider visit, lab work, wound checks). Additional documentation that goes beyond meeting the eligibility requirements for an incentive is best practice from a medical home delivery model.

For a detailed description of the OBMH care delivery model, see the appropriate BadgerCare Plus and SSI HMO contract for complete policy by year:
https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Contracts/Home.htm.spage

What criteria are used to determine if HMO/provider is eligible for the $1000 incentive?

The member must meet all four of the criteria listed below:

1. Member was enrolled in OBMH Registry within 30 days of enrollment in OB Medical Home
    - Participating clinics must enter enrolled women into the Department's OB Medical Home Registry (Registry) within 30 days of enrollment into the OB Medical Home.
    - The HMOs are responsible for informing participating clinics of this requirement.
    - The HMOs will ensure that all clinics are well informed of the requirements and initiative criteria to ensure HMOs are invoicing only for those women who complete all program requirements.
    - This is validated using the 1st date of a member's OB visit as a start date compared to the date the provider enters member into the registry. If the first OB visit date does not meet the 16-week enrollment date criteria, evidence of a Medical Home enrollment date or first visit with the care coordinator documented in the record that preceded the first OB visit is sufficient to meet criteria.
2. Member had a pregnancy-related appointment with a health care provider within the first 16 weeks of pregnancy.
    - Provider types include Primary Care Physician (PCP), Nurse Practitioner, Obstetrician, Maternal Fetal Medicine, Care Coordinator, Nurse Midwife, and Physician Assistant
    - An appointment, lab visit, or ER visit to just confirm pregnancy does not count toward this requirement.

3. Member attended a minimum of 10 medical prenatal care appointments with the OB care provider.
    - Member participation in group prenatal visits (e.g. Centering Pregnancy) counts towards the 10 required prenatal visits, if the member's attendance is documented in the medical record.
    - A PNCC visit on the same day as an OB visit can be counted.
    - 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.
    - 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.
    - Prenatal visits conducted via telehealth are included in the total prenatal visits, beginning with the public health emergency declaration of 3/12/2020.

4. Member has continued enrollment through 60days postpartum, including the date of the scheduled medical postpartum visit (PPV).
    - For births prior to 1/1/2020, the required length of continued enrollment was 60 days. The postpartum time frame increased to 84 days in CY2020 to align with changes made to the HEDIS Prenatal and Postpartum Care (PPC) measure. 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.
    - To determine continued enrollment postpartum, EQRO is reviewing records for member participation in PPV.
        a. PPV no shows or cancellations are counted as meeting the eligibility criteria, provided attempts by providers to engage and reschedule members are documented in the medical record.
        b. Appointments for incision checks or single medical issues (e.g., illness) after delivery are not considered a PPV.
        c. Telehealth postpartum visits are counted as a PPV, beginning with the public health emergency declaration of 3/12/2020.

What criteria are used to determine if HMO/provider is eligible for an additional $1000 incentive (total of $2000 incentive)?

The member must have been eligible for the $1000 incentive **and** the mother has a healthy birth outcome.

For this initiative, the Department has defined a poor birth outcome as:

- Preterm birth – gestational age less than 37 weeks
- Low birth weight – birth weight less than 2500 grams (5.5 pounds)
- Neonatal/early neonatal death – death of a live-born infant within the first 28 days of life
- Stillbirth – a fetal demise after 20 weeks gestation