OB Medical Home Initiative FAQ Clarifying Document

Published: November 14, 2014

Ref #	Question/Comment	DHS Response
1	Case Managers are employed by the HMO, not the clinic. So far, the HMO has provided these staff in-kind, but would like to use some of the $1,000 or $2,000 bonus payment to support their work.	The Department realizes that some HMOs are operating under different models that have been as successful as clinic hired care coordinators. The Department is willing to work with the HMO, on an individual basis, to set up potential solutions that meet the needs of the clinic and HMO while ensuring each high risk pregnant woman is provided with care coordination that meets the contract requirements. If the HMO wishes to seek an alternative method of care coordination and payment, they should email their Department contact to discuss.
2	If a woman is seen at an FQHC or CHC prior to 16 weeks, but doesn't come to an OBMH clinic until weeks 17 to 20, can she still be enrolled?	The Department would allow this exception if the following criteria are met: i. The clinic has an MOU with the FQHC or CHC; ii. The woman received care prior to 16 weeks at the FQHC or CHC; iii. The woman was seen at the OBMH clinic prior to 20 weeks; iv. The woman meets all additional criteria defined in Article III, Section R (9) of the contract; 1. This includes the minimum 10 visits at the OBMH clinic, visits to the FQHC or CHC cannot be counted towards meeting this requirement. v. The OBMH clinic's medical record must contain documentation of this scenario (including records from the FQHC or CHC) for review by the Department's EQRO. (Scanned copies of transferred records into an EMR are acceptable); and vi. The woman is entered into the registry as defined by policy that is to be determined; and vii. The HMO is notified by the OBMH clinic of the woman's enrollment.
3	Will this program include women covered under Title 19?	There are currently no specific proposals to include Medicaid FFS members.

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4	What resources are available to women covered under Title 19?	For pregnant women enrolled in Medicaid FFS, rather than an HMO, DHS encourages providers to work with local health departments and local community agencies to develop a list of resources. If a woman is newly pregnant, we suggest that she contact an enrollment specialist to determine if she is eligible for additional programs. Additionally, we recommend providing information regarding PNCC, WIC, and local health departments.
5	Entering information into the registry is duplicative for those with EMR's - especially if the EQRO is requesting records for review regardless.	The registry was developed during the Southeast pilot and not all OB Medical Home clinics have electronic records. The Department recognizes that the vast majority of clinics have electronic records, however, we also realize that not all OBMH clinic sites and HMOs share their information through EMRs. The Department is looking to simplify the registry and agrees that 40 areas of entry may be cumbersome to the majority of clinics. The Department is working on simplification, however, at this time we anticipate that entry into the registry will be required by clinics. The use of the registry will allow HMO's and clinics the ability to share information electronically and coordinate information sharing with non-clinic providers (LHD, PNCC).
6	When will the first semi-annual report be due for HMOs that began the program in 2014?	The first semi-annual report for HMOs new to the program in 2014 will be due on June 1, 2015. The report should discuss what actions are/will be taken to increase enrollments into the program and early identification of eligible women (i.e. partnering with community organizations such as churches or advocacy agencies).
7	If a woman's income is over 100% FPL, how long will she remain enrolled in BadgerCare Plus after delivery?	This information is located in the BadgerCare Plus Eligibility Handbook. A pregnant woman who is enrolled in BC+ stays eligible for: the balance of the pregnancy, and an additional 60 days after the last day of pregnancy through the end of the month in which the 60th day occurs.

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8	Are there additional resources available for women that are dis-enrolled from BadgerCare Plus after delivery?	There are Regional Enrollment Networks throughout the state that offer assistance in obtaining coverage to uninsured individuals. There are a variety of resources available for assisting consumers on the Department's website: http://www.dhs.wisconsin.gov/health-care/consumer.htm. Also, there is an enrollment directory available on the E4Health website that lists available Certified Application Counselors and Assistors around the state: http://enrollwi.org/.
9	How long does it take before a pregnant woman is enrolled into an HMO?	Once eligibility for a pregnant woman is on file, HMO selection time is dependent upon the scenario. For example, if a woman's eligibility is updated on the 25th day of the month, while if she selected an HMO right away it could be effective on the 1st of the following month, auto assignment would not place her in an HMO until the 1st day of the second subsequent month from her eligibility change. So if eligibility was on file October 25th, her auto assignment would become effective December 1st. However, if a woman's eligibility is on file the 2nd day of the month, she will likely be auto assigned by the 1st day of the following month. So if her eligibility was on file October 2nd, her auto assignment would become effective November 1st. It is important to note that eligibility can be back dated up to 3 months, so in some cases, it may appear there was a 3 or 4 month lag between enrollment and HMO assignment. The auto assignment process is based on the day eligibility is entered into the system, not the official day of enrollment.
10	There is a two year contract requirement that any woman with a poor birth outcome is to be managed by the HMO for two years post birth. What happens if the woman is dis-enrolled from BadgerCare Plus prior to the end of those two years?	If a woman is dis-enrolled from BadgerCare Plus, the Department views this as a disenrollment from the HMO and the contract term would no longer apply.

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11	If BadgerCare Plus is the second payer, would a woman still be eligible for the OBMH?	As long as the woman meets all other eligibility criteria and is enrolled in your BC+ HMO, she would be eligible for the OBMH initiative, even if BC+ is the secondary payer.
12	Does Centering OB count as one of the 10 visits?	Yes, Centering OB could count towards one of the 10 required visits, but would not count towards the home visit.
13	In regards to the home visit, is the clinic considered a community location?	The goal of the home visit is to allow the care coordinator to assess a woman's living situation. While we have found that some women may decline a home visit, they may be amendable to meeting in a neutral, community location. We do not consider the clinic to be a neutral, community location for purposes of meeting the home visit criteria, however, as long as home visits are offered and a woman's response (decline, cancel, hesitation) are documented, the Department will consider the offer and documentation of decline as meeting the criteria.
14	If a woman is receiving home visits as part of the ECI program, do those count towards the home visits or would we require the OBMH to offer additional visits?	As long as the home visitor/care coordinator with ECI "becomes" part of the care team, we agree that multiple home visits are not necessary. The Department is less concerned with the which program completes the home visit and more about working together to meet the member's total needs. A agreement, or MOU, may be necessary for the sharing of information, care coordination and communication in order to ensure that the OBMH care coordinator is able to document that the home visit requirements are being met, as well as coordinate any other care necessary.
15	When will we have access to the registry?	We are currently working to implement two changes to the registry before granting access. MetaStar will reach out to the HMO's once these changes are complete to provide login information and set up a training. It is important to note that the Department is looking at other changes to the registry including what data are needed for collection. We anticipate those changes to be made in 2015. There will be more communication to HMOs coming.
16	How does the Department want the HMO to pay the clinic?	The Department does not structure how the HMO works with their OBMH clinics to distribute payment. This process is to be determined by the HMO.

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17	Very high-risk women are referred out to other providers/clinics that are not OBMH clinics. Does this make the woman ineligible to be part of the OBMH?	This question was clarified in the Medical Home Pilot Clarifying Document 8/15/12. However, additional clarification has been requested. *8/15/12* : The "specialist" becomes part of the care team. The medical home provider remains responsible for care coordination and ensuring all the woman's needs are being met in a coordinated manner. Payment will be made to the HMO to be passed on to the provider/medical home. The distribution of payment (i.e., the reimbursement process and how the clinic will be reimbursed) will depend on the contract agreement between the HMO and the individual clinics and providers. The HMO is required to provide an annual report to the Department (as part of its Annual Performance Report) detailing their process. To further clarify, the expectation is that the care coordinator would still remain in contact with the woman, offering the home visits – or meeting in a community location, working to ensure that she is attending her appointments, and continues meeting all of the requirements of the contract. This care coordination would need to be documented in the medical record. If there is an MOU between the OBMH and the "specialist" clinic, and the woman agrees to remain in the OBMH, then the OBMH clinic should be able to obtain medical records for the woman and scan them in to their EMR as documentation of the visits. The OBMH would potentially be eligible for the bonus payment, if the requirements are met, regardless of which clinic the woman is referred to for specialty/high risk care.
18	What about women that are not identified until after 16 weeks of their pregnancy?	Some HMOs/clinics have decided to enroll these women into the OBMH initiative despite not being eligible for the additional bonus payment. We encourage HMOs to work with their clinics to determine their best practices for this situation.

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19	There are barriers to enrolling women by 16 weeks.	The additional bonus payment is given as an incentive to identify women in their early stages of pregnancy through innovative outreach. Examples of this outreach may include partnering with local FQHCs or CHCs, area drug stores that sell pregnancy tests in targeted areas, and community based organizations such as churches and advocacy groups that may assist in identifying and referring potentially high risk populations as early as possible. We realize that the target population may have barriers to seeking care, including distrust of healthcare organizations or false information that care isn't necessary. Partnering with community based organizations can assist in creating trust and encouraging these women to get the care they need in a timely manner. HMOs and providers should work together to identify newly pregnant women and share that information with her HMO or encourage her to apply for BadgerCare Plus if she is currently not enrolled. Pregnant women currently on fee-for-service can enroll in the OBMH if she meets the eligible criteria prior to HMO enrollment becoming effective. Another consideration the Department looked at when setting the 16 week enrollment requirement is 17P and its effectiveness and appropriate use before 17 weeks. The enrollment time-frame is a 'best practice' for high-risk pregnant women. In addition, early enrollment has proven helpful in improving birth outcomes in the medical home clinics in the Southeast. At this time, the Department will continue to require enrollment within 16 weeks.
20	Are women who are referred for methadone or opioid treatment required to disenroll from the HMO?	No. Members are required to be informed of the option to disenroll from the HMO if services are needed outside of the network. The Department will work with methadone and opioid treatment providers to ensure they are informed of Medicaid policy.

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21	What is included in the record review criteria?	The EQRO will accept any documentation from the medical records that verifies the following: - Enrollment was within the first 16 weeks of pregnancy - The member met the stated criteria (i.e. is African American, or <18) - The basic requirements of the program were met. At a minimum, the documentation must show that the member: - Received care coordination services from a designated provider, e.g., regular communication with the patient, other care providers and other service providers were initiated and maintained throughout the pregnancy and included monthly home visits or alternative if home visits were refused, - Had a care management plan developed by the care team that met the stated criteria (e.g., includes a patient self-care component and monthly home visits; if no home visits occurred, there must be a documented reason or alternative) - Had a minimum of 10 appointments with her OB care provider - Remained enrolled in the medical home through the 60th day post-partum and had at least one post-partum visit (or documentation of refusal) - Had a discharge plan that addressed: - Member education: family planning, breast feeding, newborn care, interconception care - Post delivery transition back to her PCP, including communication with the PCP, as appropriate - If her birth outcome was poor, had a treatment plan that documents referrals to ongoing services and that there was follow-up to ensure the initial appointment(s) were kept and needed services offered Also include any explanation for missing documentation. The EQRO will not review PNCC records. Care coordination should be an active component of the medical home with patient information shared among providers. The medical home or the HMO is responsible for providing documentation that this on-going communication is occurring