WISCONSIN DEPARTMENT OF HEALTH SERVICES

OBSTETRIC MEDICAL HOMES FOR HIGH RISK MEDICAID MEMBERS

USER'S GUIDE

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DIVISION OF HEALTH CARE ACCESS AND ACCOUNTABILITY
DIVISION OF PUBLIC HEALTH
OFFICE OF POLICY INITIATIVES AND BUDGET

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Document Scope And Purpose

Scope

This document provides basic information about the Wisconsin Department of Health Services' (DHS) medical home initiative for high-risk pregnant women. This medical home is commonly referred to as the "OB Medical Home." The OB Medical Home is a joint effort of three divisions within DHS – the Division of Health Care Access and Accountability (DHCAA), 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. Article III, Section R of the BadgerCare Plus and Medicaid SSI HMO Contract for January 1, 2014 – December 31, 2015, should be consulted as needed for additional details. The 2014-2015 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

Further, HMOs have the flexibility to implement additional requirements not included in this document or in Section R of the existing Contract. This document does not address any such requirements.

Purpose

The purpose of this document is to serve as a user's guide for BadgerCare Plus and Medicaid SSI HMOs sponsoring obstetric clinics designated as OB Medical Homes. It is designed to provide a quick on-line reference for operationalizing OB Medical Home Contract requirements. The guide also consolidates a variety of information regarding implementation and operations, including a current list of questions about the OB Medical Home and DHS responses.

Participating HMOs may find the guide useful in recruiting and working with clinics and community-based organizations.

Wisconsin's OB Medical Home

Background

The OB Medical Home Initiative was launched in January 2011. The initiative was limited to BadgerCare Plus HMOs serving high-risk pregnant women in the six southeastern counties. In 2014, the initiative was expanded to include HMOs in Dane County and Rock County.

The OB Medical Home 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 BadgerCare Plus 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).

Establishment of the OB Medical Home was a requirement in the Southeast Health Maintenance Organization (HMO) contract for 2010 through 2013.

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

- Increasing accessibility,
- Fostering 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 1960's 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.

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 Appendix A for a review of the research.

Initial Pilot And 2014 Expansion

Initiated in January 2011, the OB Medical Home (Medical Home for High-Risk Pregnant Women) is part of DHS' long-standing efforts to improve birth outcomes and reduce birth disparities in Southeastern Wisconsin. The pilot program targeted BadgerCare Plus members enrolled in state-contracted Health Maintenance Organizations (HMOs) in six counties - Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha.

In 2014, the initiative, no longer considered a pilot, was expanded to Dane and Rock counties. The Contract includes OB Medical Home requirements for HMOs in Southeast Wisconsin, Dane County and Rock County. Beginning in July 2014, HMOs began implementing the initiative with obstetric practices in Dane and Rock counties. Additionally, in July 2014, high risk pregnant women enrolled in Medicaid SSI HMOs in these areas are also able to enroll in the OB Medical Home initiative.

Brief Description

The OB Medical Home provides comprehensive, coordinated prenatal and postpartum care to BadgerCare Plus and Medicaid 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 own care is also a key component. There is a specific focus on identifying and engaging African-American members to address long-standing disparities in birth outcomes and infant mortality. To learn more about other DHS efforts to eliminate racial and ethnic health disparities, see http://www.dhs.wisconsin.gov/healthbirths/.

Obstetric clinics serving as OB Medical Homes receive $1,000 for each high-risk member who enrolls in the medical home prior to her 16th week of pregnancy and receives medical home services through the postpartum period (60 days following delivery). See Article III, Section R of the 2014-2015 Contract. This payment is in addition to the Medicaid payment for the medical prenatal, delivery and postpartum care. If the delivery outcome is good – equal to or more than 37 weeks gestation, birth weight equal to or more than 5.5 pounds and infants surviving more than 28 days post-delivery – the clinic receives an additional $1,000 payment.

Quality of care is monitored via the DHS external quality review organization (EQRO), currently MetaStar, Inc., via quarterly chart reviews of enrolled members. The University of Wisconsin-Madison Population Health Institute is conducting an evaluation and anticipates the final report will be available December 2015. Both efforts are used to inform policy with regard to the OB Medical Home Initiative.

Who Can Be An OB Medical Home?

Any clinic that provides obstetric services to BadgerCare Plus or Medicaid SSI HMO members that has an agreement with a participating HMO.

- The OB clinic must:
  - ✓ Agree to adopt a team-based approach to care; 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 or have a reliable, electronic method for tracking patient data and care activities.

Who Can Enroll In An OB Medical Home?

Any BadgerCare Plus or Medicaid SSI HMO pregnant member who is enrolled in a participating HMO and meets the following criteria may enroll in the OB Medical Home.

- The member must be enrolled in the OB Medical Home within the first 16 weeks of pregnancy.
- 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.
  - ✓ 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 (see Appendix B).

Note 1: Women who are pregnant and not currently enrolled in BadgerCare Plus or Medicaid SSI at the time of the initial prenatal visit may enroll in the OB Medical Home if they meet the above criteria and are subsequently determined eligible for Wisconsin BadgerCare Plus or Medicaid 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.

How Do Women Enroll In The OB Medical Home?

An eligible BadgerCare Plus or Medicaid SSI HMO member is considered enrolled:

- ✓ Upon her agreement to receive the additional services offered by the OB Medical Home.

- ✓ 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 OB Medical Homes must use the OB Medical Home Registry for reporting purposes.

What Is Care Coordination?

Care coordination is a process of ensuring that all of a patient's needs are identified and met and that individuals and organizations working with the patient share information to improve the patient's health. In general, care coordination = communication.

- Care coordination is ". . . a process to assess and meet the needs of patients, while helping them effectively navigate the health care system. It involves: a) determining where to refer the patient [what other providers need to be involved]; b) what information about the patient needs to be shared; and c) being responsible/accountable for managing this process."

  Adapted from the Agency for Healthcare Research and Quality

- In OB Medical Homes, care coordination includes:

  - ✓ 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 her 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.

Note 1: Care coordination activities should be documented in the medical record and should include, but are not limited to, the following: issues being addressed, strategies to address them and results, referrals made and the results, and interactions with the patient, e.g., purpose, result, date and member response to offered services and alternatives.

Note 2: If the OB Medical Home is working with an external Prenatal Care Coordination (PNCC) provider for care coordination services, the OB Medical Home 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 OB Medical Home, how information will be shared, and agreement that the PNCC provider will share all records related to the enrolled member and her pregnancy.

Note 3: The care coordinator should make at least one attempt to visit the enrolled member in her home to help establish relationships of trust and allow observation of other potential needs. OB Medical Home 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.

Why Is Care Coordination Important In An OB Medical Home?

According to staff from the original OB Medical Homes established in 2011, and research on patient-centered medical homes, effective care coordination:

- Reduces barriers to care.
- 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 to 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.

What Is Included In Postpartum Care Services?

OB Medical Home participants remain enrolled and should receive care for 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.

Note: For members with a poor birth outcome – low birth weight, preterm, infant death – the HMO is responsible for ensuring that the woman and the baby continue to receive appropriate, continuing health care.

What Documentation Is Required?

The following are requirements for tracking member participation and evaluation in the OB Medical Home as stated in Article III, Section R of the Contract.

1. *HMO Quarterly Report*

   Each participating HMO must submit the following information to DHS quarterly for each member enrolled in a medical home:

   - Clinic name.
   - Mother's Medicaid Identification (ID) number.
   - Mother's name.
   - Mother's birthday.
   - Mother's address, including county of residency.
   - Enrollment date (per DHS definition) in the OB Medical Home.
   - Anticipated and actual delivery date.
   - Date of termination from the medical home, i.e., date of withdrawal/termination from the medical home and reason for termination.
   - Birth outcome (including, baby's birth weight, gestational age).

2. *HMO Semi-Annual Report*

   Each participating HMO must submit the following information to DHS semi-annually evaluating its medical home initiative:

   - A list of participating clinics and primary contact information.
   - A narrative describing how the medical home satisfies criteria in Article III, R.2 (a) through (f).
   - A narrative that includes specific examples of processes and outcomes detailing how the medical home, in conjunction with the care coordinator, provides comprehensive and patient-centered care, and correctly identifies the needs of the member.

- Status report on patient access standards from Article III, R. 2 (b).
- Any corrective action that is being taken to meet the requirements of the medical home initiative.

3. Clinic-Level Patient Data Management

Each clinic serving as a medical home must have an EHR 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 to Appendix B.

The OB Medical Home Registry

The OB Medical Home Registry is a web-based tool to track Medicaid members who are enrolled in the OBMH. The Registry is used by the HMOs and DHS to determine clinic eligibility for the bonus payments – $1,000 or $2,000 – above the DHS standard payment for prenatal and postpartum care and delivery. The Registry captures basic demographics, including race and ethnicity, enrollment, limited clinical and delivery information, e.g., birth outcome data.

The Registry is accessible to all clinics serving as OB Medical Homes, participating HMOs and DHS. Participating clinics and HMOs only have access to their patients and members. The Registry was developed and originally 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.

External Quality Review Organization

The Department of Health Services contracts with an External Quality Review Organization (EQRO) – currently MetaStar, Inc. – to review records from each participating HMO to verify that the OB medical home Contract requirements, located in Article III, Section R of the Contract, were met. 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.

Record Request To The HMO

Prior to the review, DHS sends a memorandum to the Contract Administrator for each HMO. The memorandum requests records for OB Medical Home enrollees who delivered during a specified period of time. The memorandum includes the following information:

- **The Review Period.** The memorandum will specify the quarter to be reviewed (e.g., January 1, 2014 – March 30, 2014).

- T**he Reason for the Record Request.** The record request is limited to information that provides verification that OB Medical Home Contract requirements were met. At a minimum, the documentation must show that:

    - The member met the enrollment criteria,

    - Care coordination requirements were met,

    - The member had a care management plan that meets the stated criteria,

    - The member had at least 10 visits with her OB care provider,

    - The member remained enrolled in the OB Medical Home through the 60th day postpartum and had at least one postpartum visit during this time, and

    - The member had a discharge plan that addressed:

        - ✓ Member education: family planning, breast feeding, newborn care, interconception care,

        - ✓ Post-delivery transition back to her primary care provider (PCP), including communication with the PCP, as appropriate, and

- ✓ Care for the baby, including assistance in establishing a relationship with a pediatrician (or PCP that also works with infants).

- If the birth outcome was poor, the member had a care 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. This should include a referral to or coordination with the member's HMO.

Note: OB Medical Home 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 OB Medical Home 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.

Instructions for Submitting Documents. The HMO and OB Medical Home have three options for submitting documents to the EQRO:

1. Grant remote access to the member's EHR.

2. Submit the medical records electronically via secure file transfer.

3. Mail paper copies.

The memorandum provides specific instructions for each option.

Documentation Criteria

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 Appendix B for the documentation criteria.

OB Medical Home Payments For Additional Services

Clinics serving as OB Medical Homes 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, OB Medical Homes will receive $1,000 per eligible, enrolled member who:

  - ✓ 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.

- OB Medical Homes will receive an additional $1,000 per eligible enrolled member who meets the above criteria and has a good birth outcome, i.e., equal to or more than 5.5 pounds, 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 OB Medical Home.

Note 1: 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.

Note 2: If the enrolled member fails to keep the postpartum appointment within 60 days of delivery, the OB Medical Home 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.

The Partnership – DHS, HMOs, Clinics

Roles And Responsibilities

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

The below information is an overview of roles and responsibilities for each organization. However, it is not comprehensive. For comprehensive requirements, please refer to Article III, Section R of the Contract.

The Department Of Health Services (DHS)

The OB Medical Home Initiative is led by the Division of Health Care Access and Accountability (DHCAA) within DHS. The Division of Public Health provides technical advice and assists with strategic planning and policy development. The Office of Policy Initiatives and Budget provides policy analysis, research on evidence-based practices, serves on the internal work team and manages the evaluation with the UW Population Health Institute.

Responsibilities include:

- Providing leadership and technical assistance 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 bonus payments to participating HMOs for pass-through to clinics serving as OB Medical Homes.
- Working with the DHS EQRO on chart reviews and technical assistance.
- Maintaining the OB Medical Home Registry in partnership with the DHS EQRO.

Health Maintenance Organizations (HMOs)

HMOs in the targeted counties are responsible for recruiting obstetric practices to serve as OB Medical Homes and providing on-going support. Each HMO will have an identified DHCAA contact. 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, FQHC's, 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.

Participating Clinics/OB Medical Homes

The primary role of the OB Medical Home is to ensure that member 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 OB Medical Home Registry.

- Working in partnership with the HMO to resolve questions or issues as they arise, including identifying specialists as needed.

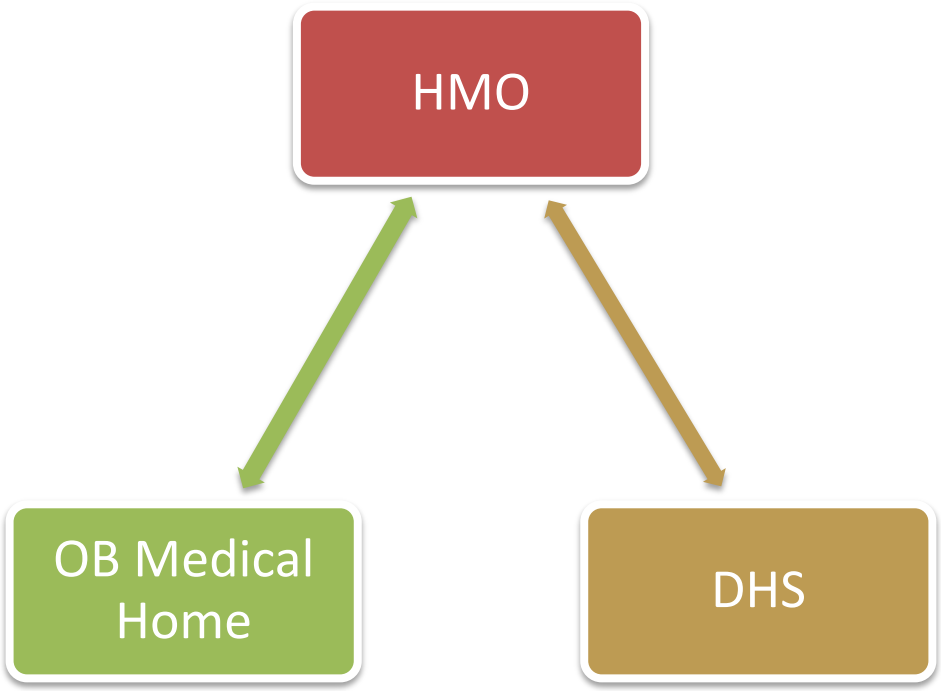
- Providing medical records to the DHS EQRO either via the HMO or directly, including information about care coordination activities.

- Participating in OB Medical Home forums and sharing information with their peers.

- Submitting invoices to the HMO in a timely manner based on processes established by the HMO.

Communication Among the Partners

Frequent and on-going conversation among the partners is critical to the success of the OB Medical Home 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.



See Appendix E for a listing of participating HMOs in Dane County, Rock County and Southeast Wisconsin.

What About Evaluation?

The DHS has contracted with the University of Wisconsin – Madison, Population Health Institute to conduct an evaluation of the OB Medical Home Initiative in Southeast Wisconsin.

- For 2014 – 2015, OB Medical Homes in Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha Counties established in 2011, 2012 and 2013 must agree to continue to work with the DHS and the UW Population Health Institute in evaluating the OB Medical Home Initiative.

- Evaluation activities may include, but are not limited to:

  - ✓ 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.

- OB Medical Homes participating in the evaluation will receive 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 OB Medical Home Initiative.

- 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.

Note: Expanding the evaluation to new clinics (those not participating as of September 2012), including those in Dane and Rock Counties, is dependent on additional funding, as is continuing the evaluation beyond December 2015.

Appendix A – A Preliminary Review Of The Research

A Preliminary Review of the Research: Patient-Centered Medical Homes

Wisconsin Department of Health Services – November 2013

Background

The Patient-Center Medical Home (PCMH) is an approach to primary care based on six key elements:

- ✓ Increasing accessibility
- ✓ Fostering continuity
- ✓ Comprehensiveness
- ✓ Coordination of care
- ✓ Team-based care, including the patient and often their family as part of the care team
- ✓ Evidence-based practices and a focus on quality

Evolved from pediatric medical homes initiated in the 1960's 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.

Early Evidence

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. Numerous rigorous evaluations are currently underway for PCMHs implemented since 2010, including Medicare's Comprehensive Primary Care Initiative. While current evidence is lacking, researchers and policy makers should continue to ask "in what context, with what populations, with what supports and what payment incentives does the medical home work; and how long does it take to see the impact." The following brief summaries are based on a preliminary review of the existing research.[1]

[1] This limited review did not include evaluations of individual patient-centered medical homes or clusters of PCMHs within an integrated health system. It should also be noted that the majority of PCMHs established between 2007 and 2010 focused on populations with chronic health conditions or serious medical conditions.

1. *Early Evidence on the Patient-Centered Medical Home.* Mathematica Policy Research. Agency for Healthcare Research and Quality. February 2012. http://pcmh.ahrq.gov/.

Based on a systematic review of almost 500 quantitative evaluations of the medical home model (as promoted by the Joint Principals) undertaken by researchers at the Agency for Healthcare Research and Quality and Mathematica Policy Research, there is evidence of favorable effects on the three triple aim outcomes, a few unfavorable effects on costs and mostly inconclusive results due to small sample sizes and methodological issues. These initial findings should be considered in the context of nascent models: implemented between 2007 and 2010, that included at least three of the Joint Principles for PCMH and were rigorously evaluated. The authors caution that the 14 interventions selected for inclusion in the review should be viewed as precursors to the PCMH model implemented after 2010. Summary findings from the 14 studies that met the criteria for review are highlighted below.

Quality – Only one evaluation found statistically significant favorable results in terms of quality.

Costs – One evaluation found some evidence of savings which were limited to a high-risk subgroup, but increased costs for the overall target population. One study found a reduction in hospitalizations of 18% for all Medicare Advantage patients. A second study found favorable effects among a subgroup of high-risk patients. One of three studies examining the use of emergency departments found favorable effects in year two.

Improving the Experience of Care – Two of the three studies examining patient experience found a preponderance of favorable results.

Improving Professional Experience – Findings from the single evaluation that examined professional experience were inconclusive.

2. "A Randomized Trial of Augmented Prenatal Care for Multiple-Risk, Medicaid-Eligible African American Women." *American Journal of Public Health.* January 2001. www.ncbi.nlm.nih.gov/pubmed/11189800

While this intervention preceded PCMHs by several years, the augmented care included a number of strategies consistent with the Joint Principles. Among these were increased access to appointments; more time with care providers (physicians and nurses); self-management; assistance in reducing smoking and stress; and efforts to improve positive social supports. Findings included increased satisfaction with care, increased understanding of their risk factors, increased attendance at prenatal appointments and decreases in smoking. Women in the treatment group also had lower rates of preterm births and cesarean deliveries and stays in neonatal intensive care units occurred in smaller proportions. There were no reductions in low birth-weight babies.

3. "Health Care Savings with the Patient-Centered Medical Home: Community Care of North Carolina's Experience." *Population Health Management.* September 2013. www.ncbi.nlm.nih.gov/pubmed/24053757

This study examined the financial impact of implementing a comprehensive care management intervention program in North Carolina for non-elderly Medicaid members with disabilities over almost five years. Findings reveal significant cost avoidance for enrollees with savings increasing with the length of time in the program. Savings were greater for those with multiple chronic diseases.

4. *Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results, 2012.* Patient-Centered Primary Care Collaborative. 2012. http://pcpcc.org/guide/benefits-implementing-primary-care-medical-home

This report is based on a review of 46 studies of PCMHs that differed in scope and implementation and used different methods of analysis. It highlights results from peer-reviewed research as well as analysis from the industry / health plans. In general, the review found evidence of improvements in quality – e.g., increased access to care, improvements in health – e.g., for those with manageable chronic conditions, lower costs – e.g. reductions in emergency department visits and avoidable hospitalizations and increased provider satisfaction.

Appendix B – Documentation Criteria For Medical Home Record Reviews

The OB Medical Home Initiative targets high-risk pregnant Medicaid members who are enrolled in participating Health Maintenance Organizations (HMO) providing health care services for BadgerCare Plus and SSI Medicaid members. Requirements for the OB Medical Home are articulated in Article III, Section R of the current Contract.

The DHS contracts with its EQRO to conduct medical record reviews of each woman enrolled in the OB Medical Home. These review findings are used to determine whether members enrolled in the OB Medical Home met the eligibility requirements and whether the participating clinic met the Contract requirements for receiving bonus payments.

The following guidelines for documentation are based on review criteria used by the EQRO and should be used by OB Medical Home clinics. The documentation criteria align with the Contract requirements and include other data elements requested by the DHS for program planning and evaluation.

Demographics
Member Medicaid Identification Number (MCI)
Member Last Name
Member First Name
Member Middle Initial
Member Date of Birth
HMO Name
Medical Home Clinic Name
Name and credentials of primary care provider
Name and credentials of OB provider
Name and credentials of designated care coordinator
Name and credentials of other care providers
Enrollment Requirements
Document the date of the first visit with a health care professional.
Document the date of the first visit with the care coordinator.
Documentation of HMO enrollment date may be needed if the enrolled member was fee-for-service upon enrolling in the OBMH initiative.
Document the date of the member's last menstrual period (LMP).
Prenatal Visits
Document the dates of each prenatal visit with the OB provider that the member attended prior to delivery.
Document the number of Centering Pregnancy visits attended, if applicable.
Document any reason for delayed, missed or rescheduled appointments and the follow-up conducted, e.g., telephone calls to patient and/or collateral contacts, letters sent, home visits attempted, etc.

Postpartum Visit
Document the date of the postpartum visit with the OB provider.
Document the reason for any delayed, missed or rescheduled appointments.
The Care Plan
Document the needs identified at intake and following the initial, comprehensive assessment. Needs should include medical and non-medical issues. Care plans are dynamic, but the documentation should reflect that the plan was initiated within the first three (3) prenatal visits (these visits may include at least one visit with the care coordinator).
Document the individuals involved in the development of the care plan by signature or by reference (e.g., a listing of participants).
Engaging the member in her own care is a core aspect of the OB Medical Home. Document evidence of the following self-management skills – problem solving, decision-making, appropriate use of available resources, formation of a patient/provider partnership, action planning and/or self-tailoring. Other examples of self-care/self-management include medical management, role management and emotional management, and/or participation in a Centering Pregnancy program.
Care Coordination
At a minimum, the record must include documentation of regular conversations between the care coordinator and the member.
Document evidence of regular communication between the OB provider and the care coordinator.
Document evidence of any referrals and communication with other providers, e.g., the primary care provider, if any, or any specialists.
Document home visits by the care coordinator or other designated clinic staff. Regular visits at locations other than the clinic (non-medical sites) may be considered in place of a home visit. If no home visit occurred, documentation must reflect one or more offers of a visit to the home or other convenient location and that the member refused such offer(s).
Delivery Information
Document the delivery date, delivery type, gestational age at delivery, infant weight and hospital where delivery occurred.
Document any information about a fetal demise within 28 days of delivery, if such an event occurred, or if a still-birth occurred.
Postpartum Visit and Services
Document the date of the postpartum visit.
Document any information related to the reasons for no postpartum visit, delayed or rescheduled postpartum visits (including the number of these events) and information about efforts that encouraged the member to attend the postpartum visit.
Communication with the PCP. Document evidence of post-delivery communication with the member's PCP, if identified (the OB provider may also be the member's PCP). A letter, phone call or other form of communication informing the PCP (if any) of delivery and any concerns meets the requirement.
Communication and/or Referral to a Pediatrician. Document evidence that the member received a referral to a pediatrician (if the PCP is not providing infant care).

Member/Patient Education. Document evidence that information was shared by the care coordinator or other member of the care team about the following: interconception care, family planning, depression, including a screening and the results, breastfeeding and who to call for assistance, and newborn care.
Enrolled members with Poor Birth Outcomes or Chronic Conditions
In the event of a poor birth outcome, document the date this information was shared with the member's HMO and any follow-up that should be done.
In the event of chronic conditions, document the date that this information was shared with the member's HMO and any follow-up that should be done. The following conditions are specifically identified in the current Contract for OB Medical Home participants – asthma, HIV/AIDS, cardiac disease, diabetes mellitus, hypertension, pulmonary disease, behavioral health/mental health.

Appendix C – Frequently Asked Questions

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.
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.

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.
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 towards the 10 required visits?	Yes, participation in Centering Pregnancy counts towards the 10 required prenatal visits. Such participation does <u>not</u> count as a 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.

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.

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.

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 postpartum and had at least one postpartum 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

Appendix D – List Of HMOs In Dane County, Rock County And The Southeast Counties

Dane County

The following health plans participate in Wisconsin Medicaid SSI and/or BadgerCare Plus:

1. Dean Health Plan
2. Group Health Cooperative of South Central Wisconsin
3. iCare
4. Physicians Plus Insurance
5. Unity Health Insurance

Rock County

The following health plans participate in Wisconsin Medicaid SSI and BadgerCare Plus:

1. Anthem Blue Cross and Blue Shield
2. Dean Health Plan
3. MHS Health Wisconsin
4. MercyCare Insurance Company
5. Network Health Plan
6. UnitedHealthcare Community Plan of WI

Southeastern Counties

The southeastern counties include Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha. The following health plans participate in Wisconsin Medicaid SSI and/or BadgerCare Plus:

Kenosha

1. Children's Community Health Plan
2. Anthem Blue Cross and Blue Shield
3. iCare
4. MHS Health Wisconsin
5. Molina Health Care
6. Network Health Plan
7. UnitedHealthcare Community Plan of WI

Milwaukee

1. Children's Community Health Plan
2. Anthem Blue Cross and Blue Shield
3. iCare
4. MHS Health Wisconsin
5. Molina Health Care
6. Network Health Plan
7. Trilogy Health Insurance
8. UnitedHealthcare Community Plan of WI

Ozaukee

1. Children's Community Health Plan
2. Anthem Blue Cross and Blue Shield
3. iCare
4. MHS Health Wisconsin
5. Molina Health Care
6. Network Health Plan
7. Trilogy Health Insurance
8. United Healthcare Community Plan

Racine

1. Children's Community Health Plan
2. Anthem Blue Cross and Blue Shield
3. MHS Health Wisconsin
4. Molina Health Care
5. Network Health Plan
6. Trilogy Health Insurance
7. UnitedHealthcare Community Plan

Washington

1. Children's Community Health Plan
2. Anthem Blue Cross and Blue Shield
3. iCare
4. Molina Health Care
5. United Healthcare Community Plan

Waukesha

1. Children's Community Health Plan
2. Anthem Blue Cross and Blue Shield
3. iCare
4. MHS Health Wisconsin
5. Molina Health Care
6. Network Health Plan
7. Trilogy Health Insurance
8. UnitedHealthcare Community Plan