HIGHMARK WESTERN NEW YORK

Medicaid Managed Care
Child Health Plus

Provider Bulletin
February 2022

2021 New York State prenatal audit

Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) partners with Amerigroup companies to administer certain services to Medicaid Managed Care (MMC) and Child Health Plus (CHPlus) members. Please note, this information is specific to the MMC and CHPlus programs only.

Selection criteria

This document is a comprehensive review of the medical record documentation standards audit as it applies to prenatal and postpartum care. Comprehensive care should include the integration of psychosocial and medical needs, reflecting the special needs of the MMC population. The medical records are reviewed to assess:

- The overall quality of care provided to pregnant and postpartum members.
- Timeliness of prenatal care with initial prenatal visit in the first trimester or within 42 days of enrollment in Highmark BCBSWNY.
- Total number of prenatal visits.
- Complete medical exam and review of obstetrics (OB) symptoms at each visit.
- Appropriate treatment and monitoring plan, along with follow-up for any significant issues.
- Documentation in the medical record of HIV/AIDS testing, and pre- and post-test counseling.
- Risk assessments and referral of high-risk pregnancies to case management services.
- Documentation of assessment of social determinants of health and/or referral to social services when necessary.
- Timely postpartum visit 7 to 84 days after delivery.

The care provided should meet accepted standards and use evidence-based guidelines per the American Congress of Obstetrics and Gynecology (ACOG) and the American Academy of Pediatrics (AAP), [1] the New York State Department of Health (NYSDOH), [2] and the *2021 Clinical Practice Guidelines*. [3] Additionally, Highmark BCBSWNY participates in the Western New York Prenatal Collaborative.

Members were identified using HEDIS®/Quality Assurance Reporting Requirements (QARR) technical specifications through claims submitted for the delivery of a child.

Quantifiable measures

QARR 2022 reporting year specifications were used to collect data for the 2021 measurement year.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
1 *ACOG/AAP Guidelines for Perinatal Care* at: **https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx**
2 Prenatal care standards at: **health.ny.gov/health_care/medicaid/standards/prenatal_care/**
3 *2021 Clinical Practice Guidelines* at:
https://providerpublic.mybcbswny.com/docs/gpp/NYNY_NYW_ClinicalPracticeGuidelinesMatrix.pdf?v=202104272105

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Visits that occur prior to the enrollment start date (during the pregnancy) meet audit criteria. Telehealth services provided via telephone, e-visit, or virtual check-in are eligible for use in reporting both rates and can be used to satisfy audit criteria.

Reviewed elements include:

- Records that are provided as electronic medical records (EMR).
- Patient name or ID on each page.
- Entries that are dated.
- Entries that are legible.
- Culturally competent care.
- Complete physical exam including review of eight or more body systems.
- Medical history.
- Obstetrical history, past and current.
- Psychosocial history.
- Family history.
- Genetic history.
- Nutrition history.
- Significant illnesses on problem list.
- Medication allergies.
- Current medication list.
- Immunization status.
- Initial risk assessment.
- Nutrition risk assessment.
- Environmental assessment.
- Laboratory testing and HIV counseling.
- Follow-up on labs/abnormal results.
- Care coordination.
- Total prenatal visit count.
- Adequacy of prenatal visits.
- Review of OB symptoms at each visit.
- Updated risk assessment at 26 to 28 weeks.
- Follow-up for any missed appointments.
- Additional lab testing ordered.
- Orientation to birth facility.
- Patient rights and responsibilities reviewed.
- Postpartum visit 7 to 84 days after delivery.
- Postpartum physical exam documented.
- Maternal/infant outcomes.
- Incorporation of newborn into family.
- Problems post-delivery.
- Infant feeding method.
- Screening for psychosocial, nutritional, and harmful substances post-pregnancy.
- Preconception counseling.
- Identified method of contraception.
- Pediatric linkage.
- Identification of needs/referrals.
- Overall management of pregnancy as appropriate.

- Evidence of major error in diagnosis, management, judgment, or technique identified.

* Postpartum visits are not assigned a point value in the rating system. Subsequent postpartum criteria points are noted as *N/A* in charts where no postpartum visit was completed.

Performance goals

Measure	2019 (report year [RY]) rate	2020 (RY) rate	2021(RY) rate	2021 (RY) goal	2022 (RY) goal
Timeliness of first prenatal visit	87.35%	90.51%	88.81	88.3%	90%
Postpartum visit	72.26%	81.02%	77.13	80.3%	80%

The 88.3% goal for 2021 (RY) *Timeliness of first prenatal visit* was met (88.81%) and exceeded by 0.51%. A decrease from the 2020 rate of 90.51% to the 2021 rate of 88.81% is noted. The 2022 (RY) goal for *Timeliness of first prenatal visit* rate is 90%.

The *Postpartum visit* rate (77.13%) decreased by 3.89% points and failed to meet the 2021 (RY) goal of 80.3% by 3.17% points. The 2022 (RY) goal for *Postpartum visit* rates is 80%.

Final 2022 (RY) rates will be available following the *HEDIS Medical Record Collection and Validation* from February to May 2022.

Sample size and methodology

Documentation of the 2021 QARR methodology for quality measure Prenatal and Postpartum Care (PPC) include:

- Random selection of 50 members.
- Live births occurring October 8, 2020, to October 7, 2021.
- All claims (both paid and denied).

Methodology details:

- Charts unable to be read due to fax quality were eliminated from sample.
- Providers were given a detailed letter of required documentation for review.
- Quality Management staff contacted providers regarding charts missing critical elements to provide any supplemental or missing clinical documentation.
- Upon receipt of additional information prior to the close of the audit process, individual member chart audit scores were updated to reflect the supplemental clinical information.

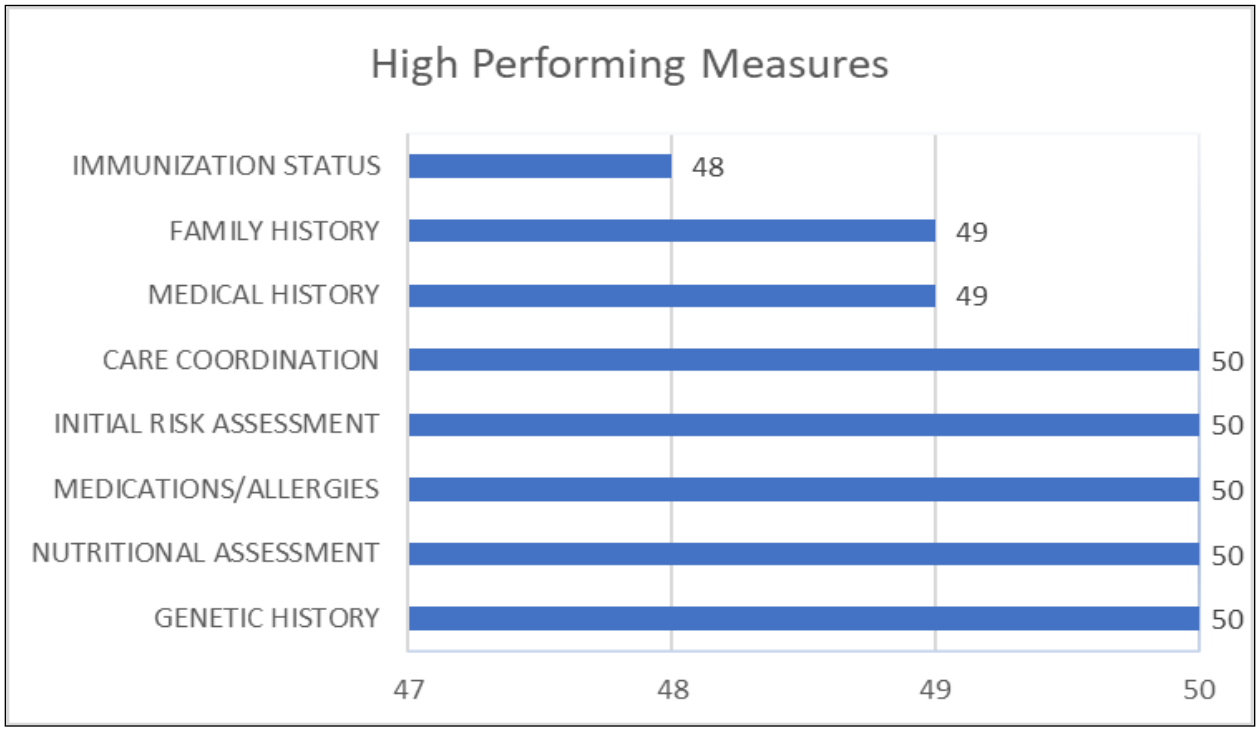
Results

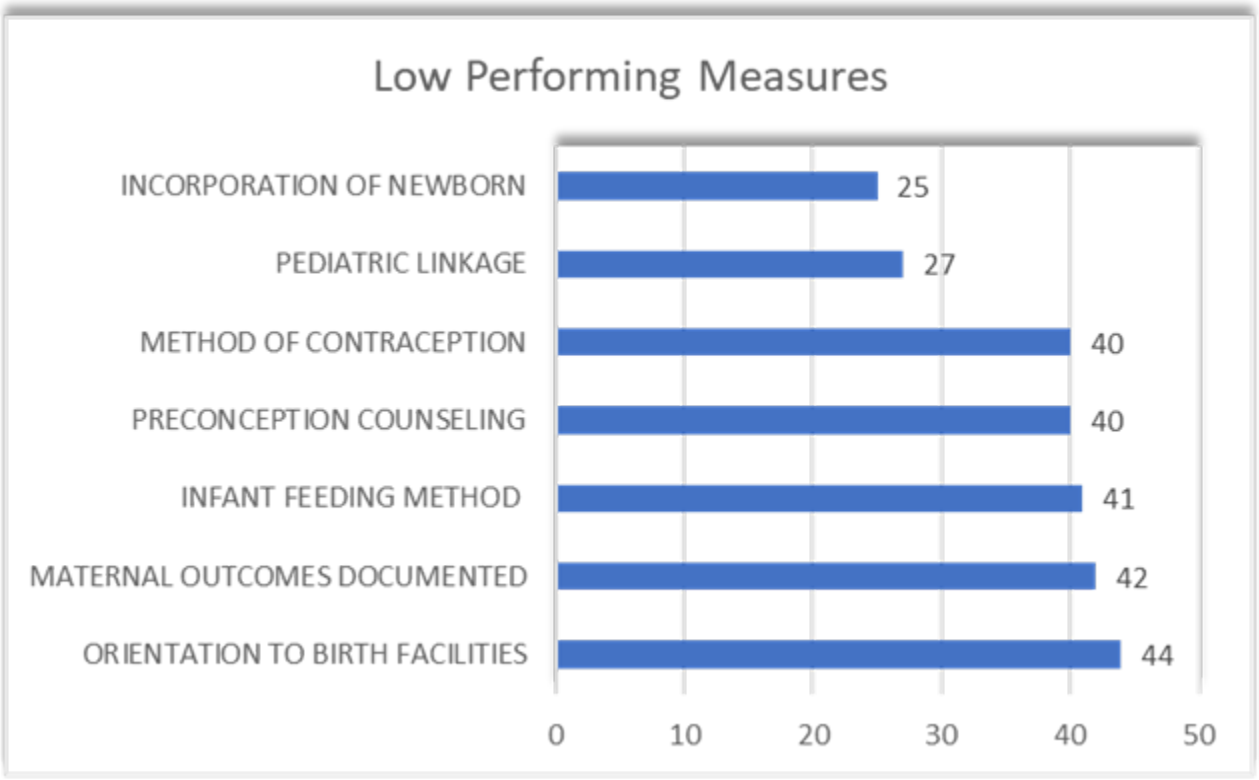
Initial measurement:

- Chart audits were completed between October 2021 and December 2021.
- Medical records were requested from multiple high-volume provider groups.
- 50 medical records were received from 12 different provider groups and reviewed for documentation of care standards.
- Results were based on documentation as submitted for review (as previously noted, provider outreach was made for charts missing critical elements to request additional information).

Audit results:

- 94% (n = 47) of the records passed, demonstrating a minimum score of 85% or above in addition to all critical elements.
- 6% (n = 3) failed to reach a score of 85% or higher.
- 2% (n = 1) of the records were missing at least one critical element. This chart also failed to reach the 85% threshold. Elements missing included the following components of the *Complete Physical Exam*:
    - Documentation of psychosocial and family history.
    - Documentation of past medical history.
    - Documentation of OB symptoms each visit.
- 8% (n = 4) charts did not have a documented postpartum visit. Of the charts with postpartum visits documents, all completed postpartum visits were within the 7- to 84-day time frame.
- Multiple low performing measures in the postpartum section (see charts on pages 4 and 5), including:
    - 50% (n = 25) of charts missing documentation of incorporation of newborn into family.
    - 46% (n = 23) of charts missing documentation of pediatric linkage.
    - 20% (n = 10) of charts missing documentation of family planning and contraception method.
    - 18% (n = 9) of charts missing documentation of infant feeding method.
- Difference in *Timeliness of first prenatal visit* rate from reporting year 2020 (90.51%) to reporting year 2021 (88.81%) indicates a 1.7% decrease.
- Difference in *Postpartum visit* rate from reporting year 2020 (81.02%) to reporting year 2021 (77.13%) indicates a 3.89% rate decrease.
- 2021 (RY) goal for *Timeliness of first prenatal visit* rate was 88.3%, meeting the goal.
- 2021 (RY) goal for *Postpartum visit* rate was 80.3%, missing the goal by 3.17% points.
- Result letters are sent to all providers, including pass/fail status of the documentation review and recommendations for improvement.





Interventions: Key 2021 initiatives:

- Tracking of all provider OB referral forms to assist Case Management staff in identification of new and high-risk pregnancies for OB case management and care coordination services.
- Ongoing member interventions included:
  - Prenatal and postpartum education via interactive voice response (IVR) and formal mailings.
  - OB case management outreach.
  - Pregnancy risk assessment.
  - Education and enrollment in high-risk case management and care coordination services.
  - Member rewards incentive program to improve timeliness of prenatal and postpartum services.
- OB case management continues to coordinate care with heath home care coordinators for high-risk members.
- Revision of maternal child prenatal and postpartum member education packets, now available as a digital packet.
- Development of a cross-functional maternal child workgroup that will focus on quality initiatives, member and provider education and outreach, and community engagement.

Barriers:

- Timely identification of pregnancy.
- Successful contact of newly pregnant members/member engagement.
- COVID-19 overall impact on members receiving prenatal and postpartum care in 2020 and 2021.
- Plan enrollment late in pregnancy.
- Late entry to prenatal care, regardless of insurance coverage.
- Low provider engagement with OB case management programs.
- Member self-reporting of prenatal and postpartum visits required to earn incentive not helpful in promoting timely prenatal and postpartum care.
- Continued difficulty in obtaining complete prenatal records for review.

- Provider utilization of vendors for medical record requests oftentimes results in inaccurate and/or incomplete return of records impacting medical record review outcomes.

Analysis/conclusions

Prenatal:

- 2021 (RY) goal for timely prenatal care (88.3%) was met, with the 2021 rate listed at 88.81%.
- Increase in documentation of cultural considerations, genetic history, immunization status, and environmental assessment across provider groups was noted.
- Initial exam components documented in majority of charts (48 of 50) with one chart missing multiple critical elements — overall capture of prenatal criteria increased from 2020 to 2021.
- Improvement in documentation of care coordination was maintained from 2020 to 2021 with zero charts deficient.
- Lowest performing prenatal criteria included orientation to birth facilities (n = 44) and patient rights and responsibilities (n = 45), which are identified as educational opportunities for provider groups.

Postpartum:

- 2021 (RY) goal (80.3%) for *Postpartum visit* was not met (actual rate 77.13%).
- Decrease in rate of postpartum visits from RY 2020 (81.02%) to RY 2021 (77.13%) indicates a 3.89% rate reduction.
- Overall performance on postpartum documentation criteria low compared to prenatal criteria.
- Measures with continued low performance include documentation of:
    - Incorporation of infant into family.
    - Pediatric linkage.
    - Infant feeding.
    - Preconception/contraception counseling.
- Postpartum measures are identified as educational opportunities for provider groups.

General:

- Incomplete submission of records may have a negative impact on audit results.
- Despite multiple requests, some providers/facilities/hospital systems did not submit charts timely enough to be included in the audit submission.
- One provider office (1 of 12) maintains handwritten clinic visit notes that are difficult to read, which will be addressed in provider review.

Opportunities identified:

- Work with provider groups to increase knowledge of New York State MMC prenatal care standards, including provider-specific review of deficiencies.
- Educate providers on available maternal child and OB case management programs to assist in managing high-risk members.
- Incorporate discussion of social determinants of health factors into provider educational materials.
- Continue member outreach, intervention, education, and assistance to newly pregnant and newly delivered women to promote timely and appropriate prenatal and postpartum care.
- Educate pregnant and non-pregnant members on available maternal child programs and member incentives to help promote and improve prenatal and postpartum care.
- Enhance community outreach efforts and leverage value-added benefits (VABs) — such as strollers and car seats — and Healthy Rewards incentives available for specific maternal-child populations.
- Provider education on Healthy Rewards and VABs available to their patients.

- Continue collaboration with Western New York Prenatal Collaborative and participate in upcoming quality improvement projects.
- Identify contact at large hospital facilities to assist with record retrieval.

Planned interventions for 2022:

- Aggregated audit results to be posted on provider portal.
- OB practice consultants to make virtual visits to various provider groups (new as of 2022).
- Work with Western New York Prenatal Collaborative to develop education for OB providers on case management services to promote provider referral and engagement with Highmark BCBSWNY programs.
- Educate providers regarding maternal child and OB case management programs and member incentive programs.
- Collaborate with providers to improve information exchange, including timely notification of new pregnancy and management of OB risk factors.
- Monitor high-risk pregnant members via Western New York Prenatal Collaborative OB provider referral tracking forms.
- Continue case management member outreach for risk assessment, identification, education, and follow-up.
- Participate in community events targeting potential and existing members (COVID-dependent).
- Continue to support New York's doula pilot program expansion.
- Continue monitoring documentation standards in prenatal charts by medical record review.
- Investigate alternate methods of record collection to promote timely and complete medical record return.
- Educate providers on audit criteria and documentation needed to satisfy audit requirements.
- My Advocate ― New 2022 enhancements:
    - Phasing out of the texting channel option and adding a new digital app and website content. The new model will combine current predictive models with a new high-risk pregnancy claims identification model.
- Member:
    - Digital enhancement for prenatal nurse case managers, which allows a community-facing care component for collaboration via a telehealth platform to support management of behavioral/social and medical issues via the SydneyCare application.
- Transitioning to new clinical information system ― Healthy Innovation Platform (HIP).
- Population health model:
    - Workplan development in 2021 for social determinants of health-related services model includes housing specialists, community navigators, social workers, and use of **findhelp.org** (formerly Aunt Bertha).
- Utilization of A3C community health workers (CHWs) to mitigate barriers to accessing care and to address social determinants of health.

Goals for 2022:

- Increase member engagement and participation in plan sponsored prenatal care programs and events through collaboration with Marketing and Enrollment team.
- Improve quality-focused measures through community outreach, provider relationship-building, and interdisciplinary health plan team collaboration.
- Increase enrollment in OB case management and care coordination services.
- Improve identification of high-risk pregnant members through internal and external sources.
- Enhance outreach to members identified as having high-risk pregnancy status via multiple channels, including:

  - Texts to members.
  - IVR messaging.
  - Community outreach.
  - Case management identification.
  - Member engagement in case management.
  - Member engagement in Healthy Rewards programs and utilization of VABs.
- Increase provider communication with health home case managers.
- Increase case management engagement, collaboration, and education with health home staff.
- Educate providers on capturing documentation of standard criteria and use of CPT® II codes to capture quality measures when using global billing for pregnancy.
- Increase plan presence in community through events (dependent upon COVID-19 restrictions).
- Develop provider education on New York State resource, Project Teach,[4] for support related to maternal mental health and linkage to psychiatric consults.
- Develop provider education on use of My Diverse Patients, an educational tool to address health disparities and promote birth equity.
- Partner with WIC to identify plan members with social determinants of health issues and support programs that mitigate those issues.
- Address social determinants of health issues through leverage of VABs, Healthy Rewards programs, **findhelp.org** (formerly Aunt Bertha), and other community partners/relationships.
- Address social determinants of health through updated population health model and ongoing collaboration in Highmark BCBSWNY population health workgroup.

4 Project Teach is a program funded by the New York State Office of Mental Health. Information at: **https://projectteachny.org/**.