Centers for Medicare & Medicaid Services
Medicaid & CHIP
Maternal & Infant Health Quality Improvement

QUALITY IMPROVEMENT AFFINITY GROUP HIGHLIGHTS

February 2024

Highlights from the Improving Postpartum Care Affinity Group

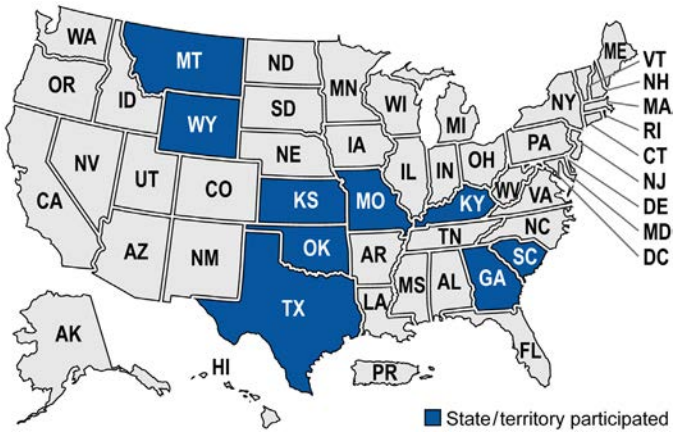
Background

The United States has high rates of preventable maternal mortality and morbidity with large, persistent disparities by race and ethnicity, geography, and age.[1] As the largest payer for maternity-related care, Medicaid and the Children's Health Insurance Program (CHIP) play an essential role in improving maternal health outcomes.[2]

Nearly two-thirds of maternal deaths occur during the postpartum period.[3] Timely postpartum care is crucial in preventing maternal mortality and morbidity and improving the health of postpartum individuals. Postpartum visits provide opportunities to support physical recovery from pregnancy and childbirth, address chronic health conditions (such as diabetes and hypertension), assess mental health status (such as screening for postpartum depression), and assist with contraceptive care. Recognizing the importance of postpartum care, as of January 2024, 44 states and territories have extended Medicaid coverage beyond 60 days postpartum.[4]

To support state Medicaid and CHIP programs in improving postpartum care, the Centers for Medicare & Medicaid Services (CMS) convened the Improving Postpartum Care Affinity Group from April 2021 to April 2023. Nine states participated in the affinity group (Figure 1). Each state team worked with CMS by using a data-driven approach to identify, test, implement, and evaluate a quality improvement (QI) project to improve the quality of and access to postpartum care and address disparities.

Figure 1. State Participation in the Improving Postpartum Care Affinity Group



Using a Data-Driven Approach to Develop Postpartum Care QI Interventions

Data and measurement are essential to initiating, assessing, and sustaining QI efforts. CMS provided technical assistance (TA) to help state teams use data to identify disparities and quality improvement opportunities, select measures to monitor their QI projects, and review data to understand the impact of QI interventions.[5] CMS also provided TA to help state

[1] More information on disparities in maternal health outcomes is available at https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf.

[2] https://www.medicaid.gov/medicaid/quality-of-care/downloads/beneficiary-profile-2023.pdf.

[3] https://www.cdc.gov/reproductivehealth/maternal-mortality/docs/pdf/Pregnancy-Related-Deaths-Data-MMRCs-2017-2019-H.pdf.

[4] A map of states and territories that extended coverage is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/image-maternity-care-expansion.png.

[5] A measurement strategy that provides examples of measures for monitoring postpartum care projects is available at https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/maternal-infant-health-care-quality/postpartum-care/index.html.

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teams overcome measurement challenges during the affinity group's tenure.

Most states participating in the postpartum care affinity group reported the Prenatal and Postpartum Care: Postpartum Care (PPC) measure on the 2020 Adult Core Set (Box 1). This measure provided a starting place for state teams to understand their performance in delivering postpartum care to Medicaid and CHIP beneficiaries. Many state teams also partnered with other organizations, such as state and local health agencies and managed care plans (MCPs), to collect and review data to identify opportunities for improving postpartum care in their state.

Box 1. Postpartum Care (PPC) Quality Measure

The PPC quality measure assesses whether individuals delivering a live birth received timely postpartum care, defined as having a postpartum visit between 7 and 84 days after delivery. PPC is part of the Healthcare Effectiveness Data and Information Set (HEDIS), the Medicaid and CHIP Adult Core Set, Child Core Set and the Medicaid and CHIP Scorecard. Starting with the 2024 Core Set, the Prenatal and Postpartum Care measure in the Child and Adult Core Sets includes both the prenatal and postpartum care rates. For the Child Core Set, the rates are reported for beneficiaries under age 21. For the Adult Core Set, the rates are reported for beneficiaries age 21 and older.

South Carolina analyzed its claims data to examine existing utilization before considering additional policy strategies to improve postpartum care. The state team learned that behavioral health screenings (such as the Screening, Brief Intervention and Referral to Treatment [SBIRT]) were underutilized (Box 2).

Georgia worked with several MCPs to improve provider use of postpartum visit codes. Because Georgia uses global billing for maternity care, providers do not bill separately for postpartum visits. However, using postpartum visit codes enables more accurate identification of care gaps and supports QI monitoring. One MCP tested a few ideas for improving provider use of codes: conducting training via QI practice advisors (QPAs), offering incentives, and providing a combination of QPA training and incentives. Results showed that the use of postpartum visit codes increased most among practices that combined the strategies of conducting QPA training and offering incentives.

Box 2. Spotlight on South Carolina: Using Data to Identify QI Needs

The state team's data work showed an underutilization of SBIRT screenings during the postpartum period. Working with the Medical University of South Carolina's Listening to Women program, the state team began a pilot to address gaps in SBIRT use. The pilot offered virtual postpartum visits with nurses that include SBIRT screening. When beneficiaries' screenings showed a need for mental health or behavioral health care, nurses offered referrals and resources. Submission of data collected as part of the state team's affinity group work led to funding from the Patient-Centered Outcomes Research Institute (PCORI) to continue the program.

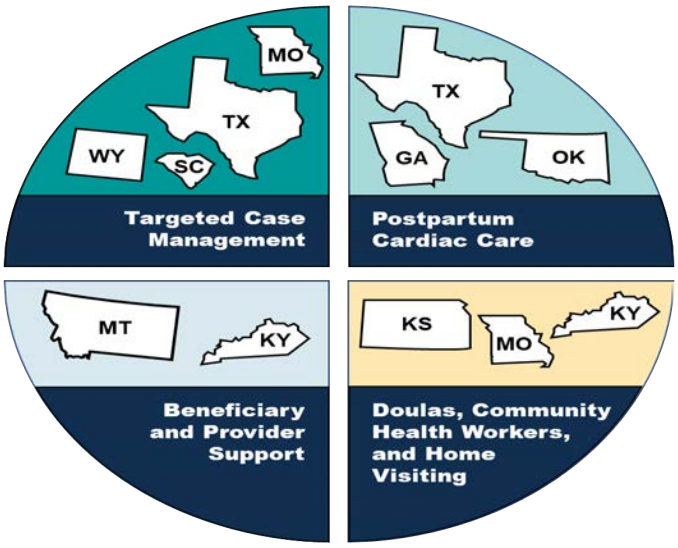
Oklahoma reviewed data from the state health agency to understand the causes of maternal morbidity and mortality and found that hemorrhage and cardiomyopathy were the state's most common causes of maternal death. The state team also stratified its data and found gaps in care for Black and Native American pregnant and postpartum beneficiaries. In response, the state team prioritized a QI project designed to improve cardiac care for these populations.

Tailoring Interventions to Improve Postpartum Care

Once state teams understood the opportunities for improvement, they worked with their partners and CMS to identify QI interventions, also known as change ideas.[6] Each state team tested interventions tailored to its needs. Several themes emerged across state projects: targeted case management; postpartum cardiac care; doulas, community health workers, and home visiting; and beneficiary and provider support (Figure 2, next page).

[6] A postpartum care change idea table that presents evidence-based and evidence-informed postpartum QI interventions for Medicaid and CHIP is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/ppc-diagram-ci-table.pdf.

Figure 2. Focus Areas for State Team QI Projects



Targeted Case Management Interventions

Maternity case management services can help ensure that postpartum beneficiaries receive the services and supports they need, including referrals to appropriate social services and assistance in overcoming barriers to accessing health care.

South Carolina partnered with the Blue Cross Blue Shield Foundation's Management of Maternal (MOMs)[7] program to offer case management to pregnant and postpartum beneficiaries with diabetes. Among MOMs participants, the percentage completing postpartum visits increased steadily, from 58 percent in 2020 to 84 percent in 2022. Furthermore, 89 percent of participants either maintained hemoglobin A1c control below 6.5 percent or decreased levels by at least 5 percent after program enrollment.

Texas worked with two MCPs to provide intensive case management services. One MCP promoted a mental health app that connects users to resources, including case management, to improve motivation and address depression and loneliness. High-risk pregnancy users of the app demonstrated a 6 percentage point improvement in postpartum visits.

Missouri provided case management to high-risk beneficiaries in rural areas, including home and telehealth visits, as well as patient navigation support. Beneficiaries in the pilot demonstrated higher postpartum visit rates than those who did not receive care management.

Wyoming identified underutilization of the state's web-based referral process in its maternity case management program. The state worked to increase provider awareness of and referrals to the Medicaid case management benefits available to high-risk beneficiaries. This pilot effort increased postpartum referrals and outreach expanded to more providers. The state team used text messaging to link beneficiaries to the Wyoming Department of Health website, where they could find information on contraceptive options.

Postpartum Cardiac Care Interventions

Adverse cardiovascular events, including cardiomyopathy, are the leading causes of death during the pregnancy and postpartum periods.[8] In response, several state teams tested interventions that provided cardiac care to postpartum beneficiaries at high risk for cardiovascular events.

Texas worked with participating MCPs to address postpartum hypertension. Three MCPs offered high-risk beneficiaries blood pressure (BP) cuffs, education, and case management. One MCP attempted to partner with providers; however, encountered issues with coordinating with provider offices to start the intervention. After finding that the BP cuff distribution and associated member self-measurement education was effective in monitoring and managing high-risk patients, one MCP plans to continue offering BP cuffs as a value-added benefit to the target population. To further support the scaling of this intervention, one MCP is developing a clinical practice guideline on hypertension to support providers with referrals and member education.

Georgia worked with one MCP to provide BP cuffs with remote monitoring to high-risk hypertensive beneficiaries in one county. Providers received the BP results automatically and sent messages to members through the monitoring device. Remote monitoring was coupled with behavior modification and medication

[7] More information on MOMs is available at https://www.southcarolinablues.com/web/public/brands/sc/blog/categories/diabetes-free-sc/preventing-diabetes-improving-birth-outcomes/.

[8] https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2019/05/pregnancy-and-heart-disease.

management strategies. Initial tests showed improvement in monitoring and medication adherence. The MCP intends to spread and scale up the intervention in other counties.

Oklahoma reviewed data and identified cardiomyopathy as a factor in maternal morbidity and mortality. The state team designed a case management protocol for pregnant and postpartum beneficiaries at risk for cardiomyopathy and completed an internal restructuring to support case management without additional staffing. The state plans to incorporate this cardiomyopathy program into its new managed care program.

Doulas, Community Health Workers, and Home Visiting Interventions

Doulas,[9] community health workers (CHWs), and home visiting provide postpartum beneficiaries with physical, emotional, and information support. All three have been shown to effectively reduce postpartum complications and improve maternal and infant outcomes.[10] Several state teams tested interventions involving doulas, CHWs, and home visiting.

Missouri partnered with an MCP to engage and support CHWs in conducting home visits for postpartum beneficiaries. Beneficiaries were highly receptive to the home visits, and all beneficiaries who received them attended their postpartum visits. The state plans to spread this model to Federally Qualified Health Centers (FQHCs).

Kansas partnered with one MCP to pilot a program in which doulas and CHWs worked with an MCP's housing, employment, and food specialists to address the social needs of postpartum beneficiaries. The state team also worked with a community organization to conduct home visits within three weeks of delivery to address potential behavioral health care and social determinant needs.

Kentucky partnered with three MCPs and a local doula initiative to address beneficiary transportation challenges. The doulas provided support throughout the birthing process, including transporting beneficiaries to their prenatal and postpartum appointments and childbirth education classes and arranging child care for newborns and siblings during these appointments and classes.

Beneficiary and Provider Support Interventions

Montana worked with a care coordinator at an FQHC to interview postpartum beneficiaries to understand their barriers to attending postpartum visits. From this outreach, the state team learned that beneficiaries were unaware they did not have to return to their birthing hospital for postpartum visits and could seek care at locations closer to home. To address this, the state team created education tools for beneficiaries and providers on the importance of postpartum care. The tools included a flyer on postpartum care for distribution by providers and two videos shown in waiting rooms and posted on the clinic's Facebook page. [11]

Kentucky developed a provider dashboard for public reporting and state use that, among other information, reported the rate of postpartum care visits.

For More Information

More information about Improving Postpartum Care is available at https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/maternal-infant-health-care-quality/postpartum-care/index.html.

To obtain technical assistance, please email MedicaidCHIPQI@cms.hhs.gov.

About the CMS Medicaid and CHIP Quality Improvement (QI) Program

The CMS Medicaid and CHIP QI program provides state Medicaid and CHIP programs and their QI partners with the information, tools, and expert support they need to improve access, care, and outcomes for Medicaid and CHIP beneficiaries. Technical assistance is available to help states build QI knowledge and skills; develop QI projects; and implement, spread, and scale up QI initiatives. Participation is voluntary and involves collaboration between Medicaid and CHIP program leaders and other partners, including MCPs and public health agencies.

[9] Doulas are trained nonclinical health care personnel who provide one-on-one care during pregnancy, labor, and the postpartum period.

[10] https://aspe.hhs.gov/sites/default/files/documents/dfcd768f1caf6fabf3d281f762e8d068/ASPE-Doula-Issue-Brief-12-13-22.pdf.

[11] One of Montana's videos can be viewed at https://www.youtube.com/watch?v=cIlRYAVchkk