

Increasing Access, Quality, and Equity in Postpartum Care in Medicaid and CHIP

A Toolkit for State Medicaid and CHIP Agencies
August 2023



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Introduction

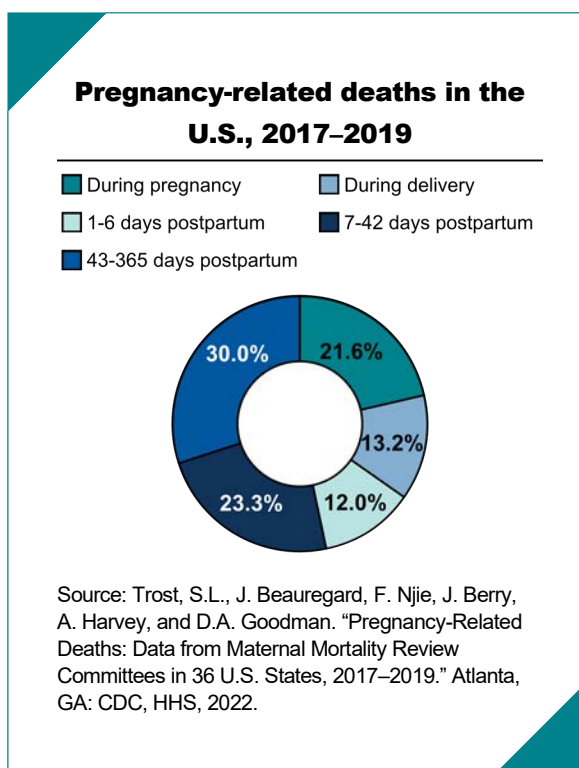
Reducing maternal morbidity and mortality is a goal of the White House,¹ the Department of Health and Human Services (HHS)² and Centers for Medicare & Medicaid Services' (CMS)³ Maternal and Infant Health Initiative (MIHI),⁴ and increasing the use and quality of postpartum care visits is a key step toward achieving this goal. This toolkit provides practical information to help state Medicaid and Children's Health Insurance Program (CHIP) programs maximize the use of existing authorities to increase postpartum care access, quality, and equity for people enrolled in Medicaid and CHIP. It includes:

- A postpartum care strategy checklist to assess current policies, gaps, and plans for improvement
- Suggestions for partnering with Medicaid and CHIP managed care plans (MCPs) to implement strategies
- Policy, programmatic, and payment mechanisms that state Medicaid and CHIP programs can adapt and implement
- Descriptions of evidence-based strategies to increase rates of postpartum care visits or the quality of postpartum care with highlights of state or MCP efforts
- Approaches to measuring progress to improve postpartum care access and quality and to advance equity

Background

As rates of mortality and serious complications during pregnancy and childbirth have increased in the United States, so has the focus on improving the quality of postpartum care to reverse these trends and eliminate preventable maternal mortality, severe maternal morbidity, and inequities. Nearly two-thirds of pregnancy-related deaths occur in the postpartum period, and about 30 percent occur 43 to 365 days postpartum.⁵ Pregnancy-related deaths are two to four times more common among Black, American Indian/Alaska Native, and Native Hawaiian or other Pacific Islander individuals than among their White counterparts.⁶

Pregnancy-related deaths also are nearly twice as common in the most rural counties than in metro counties.⁷ More than 80 percent of pregnancy-related deaths are preventable.⁸



According to 2011-2015 mortality data, the leading causes of death after six weeks postpartum include treatable conditions such as mental health conditions, cardiac and coronary conditions, infections, blood clots, and cardiomyopathy.⁹ Individuals who experience hypertension, gestational diabetes, and cardiac problems during pregnancy are also at an increased risk of being diagnosed with a chronic disease after the postpartum period.¹⁰ Postpartum care, including primary care during the postpartum period, is essential to mitigate the risks associated with these conditions.

To optimize the care during this period, the American College of Obstetricians and Gynecologists (ACOG) recommends postpartum care within at least the first three weeks after delivery, followed by individualized ongoing care as needed.¹¹ ACOG also highlights the importance of timely follow-up care with obstetricians-gynecologists or primary care providers for individuals who had pregnancy complications or who have chronic medical conditions, and for ensuring access to reproductive health planning. For example, a postpartum follow up visit with either the primary care provider or cardiologist is recommended within 7 to 10 days of delivery for individuals with hypertensive disorders or 7 to 14 days for individuals with heart disease/cardiovascular disorders.¹² Care should be tailored to the needs of the individual and support the transition to ongoing primary health care. As such, ACOG's recommendations extend the postpartum care period beyond a single six-week postpartum check and expand the scope of care beyond recovery from childbirth. ACOG also recognizes the importance of oral health care for overall health.¹³

While postpartum visits are important to ensure that people receive appropriate care after a delivery, there are major gaps in the rates of postpartum care for Medicaid and CHIP beneficiaries across states, as well as between Medicaid and commercial health plans (Box 1).¹⁴ ¹⁵ These gaps are more pronounced for Black or Hispanic individuals, rural residents,¹⁶ individuals who have lower educational attainment, and individuals with comorbidities (such as diabetes or hypertension).¹⁷

Box 1. The quality gap in postpartum care

The National Committee for Quality Assurance reported that the average rate of postpartum care visits for Medicaid health maintenance organization (HMO) plans in 2021 was 76 percent, compared with 82 percent for commercial HMO plans, demonstrating room for improvement for both Medicaid and commercial health plans.¹⁸

This toolkit is intended to support Medicaid and CHIP programs in their efforts to improve the delivery of postpartum care to reduce rates of morbidity, mortality, and disparities. The toolkit is the result of an environmental scan to identify strategies reported to be effective in improving postpartum care visit rates or the quality of postpartum care, particularly among Medicaid and CHIP populations. While the highlighted strategies were not all linked to outcomes specific to Medicaid and CHIP beneficiaries, they provide evidence about successful approaches that could be applied to these populations. As part of the scan, we identified published papers, reports, policy briefs, state documents, and other sources that described the strategies. We also identified

examples of state policies, procedures, and programs to deploy the strategies. Where possible, we present the impact on outcomes stratified by race and ethnicity.

This toolkit includes five sections and an appendix:

- Section I. How to Use the Medicaid and CHIP Postpartum Care Toolkit
- Section II. Strategies to Increase Access to Postpartum Care
- Section III. Strategies to Improve the Quality of Postpartum Care
- Section IV. Strategies to Address Disparities in Postpartum Care
- Section V. Strategies to Implement Quality Measurement and Improvement Approaches
- Appendix. 2023 Core Set of Maternal and Perinatal Health Measures for Medicaid and CHIP (Maternity Core Set)

Section I. How to Use the Medicaid and CHIP Postpartum Care Toolkit

Many strategies supported by existing federal authorities are available to advance access, quality, and equity for postpartum care in Medicaid and CHIP. The Medicaid and CHIP Postpartum Care Toolkit (“the toolkit”) lists and explains those authorities to help states begin the planning process for changes to postpartum care benefits, services, and care delivery. Although the toolkit is not exhaustive, it can be used by state Medicaid and CHIP staff, including maternal and child health program and policy staff, to assess what is already in place to support a robust maternal and infant health care program; determine whether different divisions or departments in Medicaid and CHIP agencies or other state agencies are engaged in complementary efforts; and identify new opportunities to improve access and quality and reduce disparities among Medicaid and CHIP beneficiaries. The strategies are suggestions for states to explore. They are not recommendations from CMS about how states should structure their Medicaid programs. All identified strategies may not be appropriate for individual states given their local contexts and delivery systems. For this reason, states are encouraged to review recommendations made by their respective Maternal Mortality Review Committees to inform improvement efforts.¹⁹

The toolkit begins with the Medicaid and CHIP Postpartum Care Strategy Checklist (Exhibit 1). States can use this checklist to assess the policies and practices supported by existing federal authorities that have the potential to enhance and improve postpartum care for Medicaid and CHIP beneficiaries. States are encouraged to create a postpartum care strategy that builds on their successful policies and practices already in place, identifies gaps, and then uses this toolkit to identify effective approaches that can fill the identified gaps.

Note that elements in each section may contribute to or complement strategies in other sections. For example, a strategy involving community members to improve access to care, which is described in Section II, could also be used to improve quality and/or reduce disparities, as described in Sections III and IV. This strategy could also be part of a quality improvement learning collaborative or an MCP’s performance improvement project (Section V), in which the state or MCP tests the effectiveness of an intervention using community health workers to help connect beneficiaries to services and offer education in a beneficiary’s primary language.

Each section of the checklist is broken into key strategies that have been identified to improve postpartum care access and quality and reduce disparities. Each key strategy is broken down into smaller, more incremental change ideas to strengthen Medicaid and CHIP benefits, services, and care delivery. By considering each strategy through the lens of their own Medicaid and CHIP programs, states can identify improvement ideas specific to their needs. States can partner with community-based organizations to help understand and address local needs. In addition, states can use the checklist to develop a strategy for implementing quality measurement and improvement approaches to document their progress toward increasing access, quality, and equity in postpartum care in Medicaid and CHIP.

Exhibit 1. Medicaid and CHIP Postpartum Care Strategy Checklist

Strategies to Increase Access to Postpartum Care	
Promote Medicaid and CHIP coverage continuity	
<input type="checkbox"/>	Facilitate continuity of coverage for individuals following the end of their pregnancy.
<input type="checkbox"/>	Extend Medicaid and CHIP coverage beyond 60 days postpartum to 12 months.
Improve the capacity of the health care system to support postpartum beneficiary engagement with health care delivery teams	
Provide access to postpartum home visits and telehealth	
<input type="checkbox"/>	Include home visiting services for pregnant and postpartum individuals and case management services as a part of the home visit.
<input type="checkbox"/>	Identify home visiting pathway via Section 1915(b) and 1915(c) waivers or Section 1115 demonstrations.
<input type="checkbox"/>	Utilize telehealth and home monitoring services.
Increase access to transportation for postpartum care	
<input type="checkbox"/>	Provide easy access to non-emergency medical transportation for beneficiaries who need to get to and from medical visits but have no means of transportation.
Strategies to Improve the Quality of Postpartum Care	
Assess payment arrangements and financial incentives	
<input type="checkbox"/>	Implement quality and cost incentive payments in the primary care case management (PCCM) plan and other payment models, seeking a state plan amendment (SPA) if necessary.
<input type="checkbox"/>	Develop a mechanism for per member per month payments with quality incentives and requirements via a SPA or Section 1115 demonstration.
<input type="checkbox"/>	Implement integrated care models, such as pregnancy medical homes, using PCCM plan guidance, Section 1115 demonstrations, or 1915(b) waivers.
Implement managed care contracting strategies	
<input type="checkbox"/>	Ensure contracts with managed care plans (MCPs), PCCM providers, community care networks, or accountable care organizations identify specific strategies to address state goals to improve postpartum and interpregnancy care.
<input type="checkbox"/>	Include language in managed care contracts that directs MCPs to implement specific policies to improve timely postpartum visit rates.
<input type="checkbox"/>	Identify incentives for Medicaid and CHIP providers and MCPs to provide high-quality, evidence-based care in the postpartum and interpregnancy periods.
Implement person-centered care models	
<input type="checkbox"/>	Support innovative models to deliver person-centered, coordinated, integrated care.
Pursue strategies to improve specific postpartum outcomes	
Connect postpartum individuals to primary and continuing care	
<input type="checkbox"/>	Establish outreach and case management requirements to support transitions to primary care, other insurance coverage, state programs, community-based resources, and other specialty care as needed including assistance with appointment scheduling.

Postpartum depression screening, referral, and treatment strategies	
<input type="checkbox"/>	Allow providers to perform and bill for postpartum depression screening as part of the well-child visit under the Early and Periodic Screening, Diagnostic, and Treatment benefit.
<input type="checkbox"/>	Educate providers on accepted screening tools for postpartum depression, Medicaid and CHIP billing codes, and referral and treatment options.
<input type="checkbox"/>	Educate beneficiaries about postpartum depression screening and treatment options.
<input type="checkbox"/>	Expand coverage options for screening and treatment for postpartum depression (such as through the preventive services benefit or other licensed practitioner benefit).
<input type="checkbox"/>	Cover treatment directed at enhancing the health and well-being of the child, such as family therapy, to reduce the effects of the postpartum individual's condition on the child.
Smoking cessation coverage strategies	
<input type="checkbox"/>	Cover smoking cessation services and pharmacologic therapy for pregnant and postpartum individuals.
<input type="checkbox"/>	Include language in managed care contracts that requires coverage of smoking cessation services and pharmacologic therapy for pregnant and postpartum individuals.
<input type="checkbox"/>	Provide access to a state-run quitline for pregnant and postpartum individuals.
Strategies to improve lactation services	
<input type="checkbox"/>	Ensure that the benefit package for individuals who are breastfeeding addresses education, lactation support, and equipment.
<input type="checkbox"/>	Cover breastfeeding education and lactation support as separate services, in addition to offering the option to bill for the services as part of an exam.
<input type="checkbox"/>	Eliminate variation in coverage for lactation services among Medicaid and CHIP MCPs by requiring MCPs to provide breastfeeding education by referral to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC program) or by directly providing the education.
<input type="checkbox"/>	Cover lactation education and evaluation as part of home visits.
Contraceptive care strategies	
<input type="checkbox"/>	Produce MCP and provider bulletins with prenatal care standards that include anticipatory guidance during the prenatal period on planning for contraceptive care after delivery.
<input type="checkbox"/>	Pay for immediate long-acting reversible contraceptive (LARC) device and insertion unbundled from the global maternity care bundle.
<input type="checkbox"/>	Implement measures that facilitate immediate postpartum LARC insertion, when a person chooses this option, and increase provider awareness of postpartum LARC policies.
<input type="checkbox"/>	Discourage requirements to order LARCs before a birth to facilitate access to LARCs on the same day of delivery.
<input type="checkbox"/>	Develop arrangement with manufacturers to furnish LARCs to providers without upfront costs and instruct providers to bill for the device and insertion in anticipation of paying the manufacturer for the device.
<input type="checkbox"/>	Seek Medicaid matching funds at a 90 percent federal match rate to maintain a state inventory of LARCs for providers, restocking as necessary.
<input type="checkbox"/>	Eliminate barriers to individuals undergoing postpartum permanent contraception (tubal surgery), if desired, by ensuring informed consent is acquired at least 30 days before the expected date of delivery.
<input type="checkbox"/>	Include language in managed care contracts that reinforces the requirement to cover the full range of family planning services without cost sharing and with freedom of choice of providers.

<input type="checkbox"/>	Include language in managed care contracts requiring plan networks to include essential community providers for family planning services.
<input type="checkbox"/>	Allow 6- to 12-month prescriptions for contraception supplies.
<input type="checkbox"/>	Submit SPA or Section 1115 demonstration waiver to expand eligibility for Medicaid family planning services for postpartum individuals who are losing Medicaid.
Strategies to Address Disparities in Postpartum Care	
Partner with MCPs to address disparities	
<input type="checkbox"/>	Require MCPs to report postpartum visit rates (stratified by race, ethnicity, language, disability, and geography).
<input type="checkbox"/>	Establish performance improvement projects (PIPs) focused on reducing identified health disparities.
Provide access to culturally appropriate providers, information, and care	
Involve community members to help connect individuals to postpartum care	
<input type="checkbox"/>	Review and consider expanding state plan summary of qualifications for non-licensed practitioners who, with a licensed provider's prescription, can deliver preventive telehealth services and education.
<input type="checkbox"/>	Cover services delivered by doulas or community health workers as permitted under a SPA or Section 1115 demonstration.
Provide language and translation services	
<input type="checkbox"/>	Ensure easy access to information on maternity care in appropriate languages and accessible formats, as provision of such resources is a requirement.
<input type="checkbox"/>	Implement a mechanism to document administrative costs to claim increased federal matching funds for interpretation and translation services.
<input type="checkbox"/>	Include cost of interpretation and translation services in MCP capitation rates for medical assistance services or carve out the services and contract separately for them as an administrative activity.
Strategies to Implement Quality Measurement and Improvement Approaches	
<input type="checkbox"/>	Calculate and report state-level rates of postpartum care access and quality.
<input type="checkbox"/>	Stratify state-level rates of postpartum care by race, ethnicity, language, disability, geographic location, and other relevant characteristics.
<input type="checkbox"/>	Calculate rates of postpartum care at the plan, provider or program level to monitor performance (including stratified rates, where feasible).
<input type="checkbox"/>	Link quality measurement and quality improvement using a family of measures.
<input type="checkbox"/>	Partner with MCPs, providers, other state agencies, and other interested partners to establish collaborative learning opportunities to implement rapid-cycle tests of change to drive improvement.
<input type="checkbox"/>	Work with MCPs and External Quality Review Organizations (EQROs) to implement and validate PIPs related to postpartum care quality.

Section II. Strategies to Increase Access to Postpartum Care

Postpartum individuals' reasons for not attending postpartum care visits include lack of health coverage, lack of childcare, transportation issues, mental health issues, challenges with work or school schedules, not feeling well or feeling tired, or feeling they do not need the care.^{20,21,22} This section describes strategies to increase access to and use of postpartum care visits.²³ The strategies in this section are divided as follows:

- Promote Medicaid and CHIP coverage continuity
- Improve the capacity of the health care system to support postpartum beneficiary engagement with health care teams

Ensure Medicaid and CHIP coverage continuity

Fundamental to increasing equitable access to postpartum care is access to coverage. For Medicaid and CHIP beneficiaries to receive postpartum care as envisioned in the ACOG recommendations, they need access to postpartum care for more than the mandatory 60 days after delivery. Individuals with continuous Medicaid eligibility have a higher rate of postpartum visits than those with Medicaid coverage based on pregnancy.²⁴ States that expanded Medicaid eligibility to cover low-income adults reported an increase in postpartum visits, continuity of coverage, and engagement of postpartum individuals in their care.²⁵

Maintain continuity of coverage for individuals with pregnancy Medicaid coverage

Pregnant individuals covered under Medicaid remain continuously eligible for Medicaid at least through the end of the month in which the 60-day period following the end of pregnancy ends, regardless of changes in income that would otherwise result in a loss of eligibility (see [42 CFR §435.170](#) and Sections 1902(e)(5) and 1902(e)(6) of the Social Security Act). States that opt to cover low-income pregnant individuals under the separate CHIP state plan may cover the cost of services for the individuals through the end of the state's postpartum period. See Box 2 for more information on federal guidance. As discussed below, states have the option to extend postpartum coverage through the end of the twelfth month after the end of the pregnancy.

Box 2. Federal guidance on redetermining eligibility following the postpartum period

- The Center for Medicaid and CHIP Services (CMCS) Informational Bulletin (CIB) on [Medicaid and CHIP renewal requirements](#), December 4, 2020, reminds states about current federal renewal requirements as codified in 42 C.F.R. §435.916 and 42 C.F.R. §457.343. The CIB includes a section on the interaction between redeterminations and eligibility periods for pregnant Medicaid enrollees. More information regarding redeterminations related to extended postpartum coverage is available in a [State Health Official Letter](#) issued in December 2021.

The steps the state must take to redetermine individuals' Medicaid eligibility following the postpartum period differ depending on whether this period ends before or after their renewal date. Box 3 provides more information about eligibility redeterminations following the postpartum period.

Box 3. Eligibility redetermination policies following the postpartum period

If the postpartum period ends before the renewal date:

- The end of the postpartum period may represent a change in circumstances between regularly scheduled renewals.
- If the postpartum period represents a change in circumstances that may impact eligibility, states follow the same policies and procedures as for any other change in circumstances to determine whether individuals will remain eligible under another eligibility group.
- If the individual remains eligible, the renewal date stays the same at 12 months following the initial determination.
- The end of the postpartum period would represent a change in circumstances for individuals enrolled in mandatory and optional categories (except medically needed) for which pregnancy status is a factor of eligibility.

If the postpartum period ends after the renewal date:

- States must conduct a full renewal at the end of the postpartum period.

Extend Medicaid and CHIP coverage beyond 60 days postpartum

The COVID-19 public health emergency further exacerbated the risks for individuals enrolled in Medicaid and CHIP who lose coverage 60 days postpartum. Legislation passed in response to the public health emergency provided options to state Medicaid and CHIP programs for permanently extending postpartum coverage to 12 months postpartum. Under the American Rescue Plan, as of April 1, 2022, states may extend continuous coverage for individuals beyond the required end of the month in which the 60-day postpartum period concludes through the end of the month in which the 12-month postpartum period concludes. Electing to extend postpartum coverage ensures continuity of coverage for more people. Box 4 provides details on policies to extend coverage for postpartum individuals.

Box 4. Consolidated Appropriations Act of 2023 state option for extending postpartum care coverage

The [Consolidated Appropriations Act of 2023](#) (Section 5113) made permanent the 12-month extended Medicaid and CHIP postpartum coverage option created by the [American Rescue Plan Act of 2021](#) (Sections 9812 and 9822), which would have previously expired in 2027. States have the option to extend the postpartum coverage period under Medicaid and CHIP from 60 days to one year after the end of pregnancy by filing a state plan amendment to their Medicaid program. States that choose to provide one year of postpartum coverage under Medicaid must also extend the coverage period under CHIP. The postpartum extension provides continuous eligibility during the extended eligibility period, regardless of changes in circumstances that would otherwise lead to loss of eligibility (with limited exceptions). States electing the postpartum extension must provide a comprehensive benefit package during pregnancy and the postpartum extension for Medicaid and CHIP beneficiaries.

To help with implementation, states that elect to provide the extended postpartum coverage option are encouraged to educate beneficiaries about the availability of continuous extended postpartum coverage, including posting information on the state agency website and collaborating with providers and stakeholders in their state to provide outreach and education about the new option. States may use Medicaid and CHIP administrative matching funds for beneficiary and provider education and outreach. In addition, states are encouraged to update their notices to ensure pregnant individuals and beneficiaries are aware they are eligible for continuous extended postpartum coverage. States are reminded that program information on Medicaid and CHIP must be provided in plain language and in a manner that is accessible to individuals who have limited English proficiency or are living with disabilities, as required at 42 C.F.R. §§ 435.905(b) and 457.110(a). More detailed information about how states can best implement the postpartum coverage extension is available in a [State Health Official Letter](#) issued in December 2021.

Improve the capacity of the health care system to support postpartum beneficiary engagement with health care teams

Effective strategies for supporting postpartum individuals' engagement in postpartum care and facilitating access to care teams include the following:

- Provide access to postpartum home visits and telehealth services
- Increase access to transportation for postpartum care

Provide access to postpartum home visits and telehealth services

During prenatal visits or home visits conducted in the prenatal period, staff can work with individuals to increase awareness of the postpartum visit's importance and facilitate access to postpartum appointments. Some Medicaid and CHIP programs use nurse home visits to provide services to high-risk individuals, thus addressing some of the barriers to attending clinic- or hospital-based visits. For example, Michigan runs the Michigan Maternal Infant Health Program, which provides home visits for Medicaid beneficiaries. People who participated in this program were 1.5 times more likely to receive an appropriately timed postpartum care visit than those who did not participate (Box 5).²⁶

Box 5. Examples of state Medicaid home visiting programs

North Carolina

North Carolina's [home visiting program](#) focuses on postpartum individuals with high-risk medical conditions. Components include assessment of high-risk medical conditions (such as hypertension, preeclampsia, and diabetes); referral to a pregnancy care manager, the WIC program, and other needed services; and consultation with a nurse.

Michigan

Michigan's [home visiting program](#) uses the Maternal Risk Identifier, a validated risk assessment tool, to identify individuals for home visiting services. Individuals receive a standardized plan of care, including care coordination by registered nurses and licensed social workers. There are 150 statewide certified agencies (federally qualified health centers, hospital clinics, private providers, local health departments, and tribal communities) that conduct the home visits.

States also have several options for providing voluntary, evidence-based home visiting services to pregnant individuals and families with young children through the Maternal, Infant, and Early Childhood Home Visiting Program.²⁷ CMS and the Health Resources and Services Administration (HRSA) issued a joint informational bulletin to help states design a home visiting benefit package (Box 6). States can use the guidance to address two major policy issues as they consider the use of home visiting to improve postpartum care: (1) the types of services provided during the home visit, and (2) the range of providers making home visits and their credentials.

Case management could help eligible individuals gain access to needed medical, mental health and behavioral health, social, educational, and other services as part of a home visiting program. States may cover a wide range of providers, beyond physicians and licensed practitioners, who are acting within their scope of practice under state law to provide care in the beneficiary's home. For example, nonlicensed practitioners, such as doulas, who meet the state's qualifications may deliver services if the care is recommended by a physician or licensed practitioner. Such care could include counseling, screening, and lactation support. See Box 25 for additional information on coverage for nonlicensed practitioners. Some states also may have case management and care coordination services available as part of HRSA's [Healthy Start program](#).

Box 6. Summary of federal guidance and state actions regarding the use of home visits to support postpartum care

Federal guidance:

- [CMCS and HRSA Informational Bulletin, March 2, 2016, Coverage of Maternal, Infant, and Early Childhood Home Visiting Services.](#)

State actions:

- Submit state plan to include home visiting services for pregnant and postpartum individuals.
- Include case management services as a component of home visiting.
- Explore using demonstrations to close gaps in funding, services, or populations served.

Federal regulations allow services to be greater in amount, duration, and scope for pregnant individuals than for other adults. This flexibility could help states deliver needed services to pregnant individuals in their homes.

For postpartum individuals who live in rural areas or who have chronic conditions, states can complement these efforts with [telehealth](#), which is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, home monitoring, and information across distance. CMS has developed a [State Medicaid and CHIP Telehealth Toolkit](#)²⁸ and [Supplement](#)²⁹ that outline policy considerations for states interested in expanding access to care with telehealth.

Increase access to transportation for postpartum care

Addressing social determinants of health (SDOH) or health-related social needs, such as access to transportation and nutritious food, can help improve postpartum outcomes. CMS describes opportunities for states to address SDOH in a January 2021 [State Health Official Letter](#). This section focuses on transportation to and from appointments, which can be a barrier to accessing timely postpartum care. State programs must cover non-emergency medical transportation for beneficiaries who need to get to and from medical services but have no other means of transportation.³⁰ See Box 7 for examples of how states have structured such services.

Some clinic or practice-based initiatives also include the use of ridesharing companies to transport people to and from medical appointments to increase access to care in outpatient settings, reduce no-show rates, divert care from emergency rooms, and ultimately lower inpatient hospital use. For example, one safety net provider developed software that integrates its electronic health record with a rideshare program to streamline access to transportation for its clinic patients.³¹

Box 7. Examples of state non-emergency medical transportation for prenatal and postpartum care³²

- **Colorado** provides mileage payment through a transportation broker.
 - Patient schedules a trip with a customer service representative and completes a mileage payment form.
 - A medical office signs the form, and the patient submits it within 14 days of the medical appointment. Single-trip and standing-order forms are available (the latter allows a claim for up to two weeks' worth of trips).^{33, 34}
 - Mileage is paid at a state-determined rate per mile.
 - Broker uses mapping software to find the most direct route from a patient's home to the provider.
 - Trips more than 25 miles require prior approval.
- **Washington State** provides transportation for beneficiaries to and from covered services through contracted brokers as part of its First Steps program.³⁵
 - Transportation may be authorized for people who have no other means to access medical care.
 - The transportation broker arranges and pays for the most appropriate type of transportation to the closest medical provider offering the type of service needed.
- **Wisconsin** includes transportation as part of its BadgerCare Plus perinatal care coordination program.³⁶
 - Care coordinators are trained to connect pregnant and postpartum individuals with transportation to medical appointments; care coordinators often call and schedule appointments for their patients.
 - Mileage payment, bus tickets, ambulatory vehicles, and wheelchair/stretchers are also managed by the transportation broker.

Section III. Strategies to Improve the Quality of Postpartum Care

ACOG describes the postpartum period as an ongoing process rather than a single encounter and recommends that all individuals have contact with their obstetric care provider within the first three weeks postpartum.³⁷ This initial assessment should be followed up with ongoing care as needed, including a comprehensive postpartum visit no later than 12 weeks after birth.

Postpartum individuals with chronic medical conditions such as hypertensive disorders, diabetes, and behavioral health conditions may need, and should receive, early and ongoing coordination of care by their obstetrician, gynecologist, or primary care provider. All postpartum individuals should transition to ongoing preventive care.

High-quality postpartum care includes attention to individuals' physical, social, and psychological well-being; reproductive health; chronic disease management; and health maintenance. Such care can have a long-term impact on the health of postpartum individuals and their infants, particularly when postpartum individuals receive high-quality care focused on postpartum depression (PPD), lactation support, and chronic disease management. This section describes approaches to improving the content and quality of the postpartum care visit, specifically by:

- Assessing payment arrangements and financial incentives
- Establishing contracts with MCPs to achieve quality goals
- Implementing person-centered care models
- Pursuing strategies to improve specific postpartum outcomes

Assess payment arrangements and financial incentives

Several states have successfully used payment incentives for a range of person-centered services, such as midwifery-led care, doula care, and birth centers, to improve maternal and infant health care quality, including postpartum care.^{38, 39, 40, 41} Furthermore, some states have changed their payment policies to increase access to contraceptive care in the immediate postpartum period.⁴²

CMS supports states' efforts to try innovative payment strategies to improve quality of care, including maternity and contraceptive care. Payment reform could accelerate improved maternity care outcomes because the outcomes are easily measured and tracked, and strategic changes can be made quickly in response.

Most states pay for maternity care in Medicaid using a global fee for professional services provided during the pregnancy continuum of care, including prenatal care, labor and delivery, and postpartum care. Facility fees for the birth are paid separately. Because payment of this bundle is often triggered by delivery and is not tied to performance on quality metrics, this

payment structure can inadvertently act as a disincentive to the provision of postpartum care because providers receive the same payment regardless of whether the individual attends the postpartum visit.⁴³

One approach to ensuring that postpartum individuals receive high-quality care is to be explicit about (1) all components of care and models of care delivery included in a payment, and (2) the parameters that trigger payment during the prenatal, labor and delivery, postpartum, and newborn periods.⁴⁴ States can “unbundle” or divide reimbursement of the global obstetrics fee into components to incentivize risk assessment, referral for high-risk care, and provision of postpartum care.⁴⁵ Some states, such as Louisiana, North Carolina, Ohio, and Wyoming, have unbundled the postpartum visit from the global fee.^{46, 47} Another approach is to offer episode-based payments for all the clinically appropriate services for maternity care.⁴⁸ See Box 8 for an example of one state’s approach.

Box 8. Focus on New York: Alternative payment model to improve maternity care

New York developed the [Maternity Care Value-Based Payment Arrangement](#) to help maternity care providers focus on prenatal, delivery, postpartum, and newborn care in an integrated way. The model incorporates an all-inclusive budget for pregnancy, delivery, early postpartum, and newborn care. Quality measures related to each stage of care help reinforce the care connections built into the model and provide a standardized approach for assessing quality for maternity care providers statewide. The measures cover maternal and infant outcomes, including rates of postpartum complications. Providers can realize shared savings for outcomes such as increased uptake of prenatal care, pre- and interconception counseling, appropriate C-section rates and resource use, screening for PPD, evidence-informed home visits, and other evidence-based interventions that lead to improvement in maternal care and newborn outcomes.

Implementing alternative payment methods in Medicaid and CHIP can support several evidence-based options for improving postpartum care, including the use of doulas to engage individuals in their care; the use of care managers or community health workers for more meaningful care coordination; and incentive payments tied to specific goals, such as the percentage of individuals who have a postpartum care visit. Existing authorities authorize payments for coordinating services and for incentive payments for improved quality.⁴⁹ States may use the state plan authority to offer outreach, coordination, and monitoring services and to furnish incentive payments to providers or facilities that show improved performance on quality measures.

Implement managed care contracting strategies to achieve quality goals

The state Medicaid and CHIP managed care quality strategy gives a framework to clearly define and document the priorities of state Medicaid and CHIP programs and to set expectations for MCPs.⁵⁰ It lays the foundation for a strong quality improvement (QI) program and creates an environment that holds MCPs accountable for engaging in QI activities. States may use their contracting authority to (1) hold MCPs accountable for reaching quality goals related to improving postpartum care, (2) give MCPs more leverage to require providers to improve

postpartum care, and (3) align state priorities for improving postpartum care between state agencies and MCPs.

States can convene MCPs to discuss issues related to the quality and content of postpartum care, identify state priorities, brainstorm possible solutions, and offer strategies to align efforts across MCPs. States can facilitate a discussion of the issues and solutions among MCPs to find common practices to increase access to and quality of postpartum care including recommendations made by states' respective Maternal Mortality Review Committees. MCP contracting provides a mechanism to reach and educate providers and to promote effective use of benefits and services among Medicaid and CHIP beneficiaries. MCPs can bring additional resources to serve Medicaid and CHIP beneficiaries, such as care coordination, and might provide other benefits, such as car seats for infants.

States can utilize the Medicaid and CHIP managed care delivery system to improve postpartum care through the following:

- Requests for proposals for MCP contractors with specifications related to postpartum care quality
- MCP contract updates that articulate postpartum care quality goals
- Incentive agreements for MCPs and/or providers based on postpartum care quality performance
- Partnerships with MCPs to develop Performance Improvement Plans (PIPs) related to postpartum care quality
- Use of external quality review organizations (EQROs) to validate PIPs and performance measures, validate network adequacy (especially for cardiology, psychiatry, or other specialists willing to see pregnant individuals), or conduct focused studies related to postpartum care quality
- Alignment of provider contracts, communications, and incentives with state priorities
- Explicit expectations for maternal health and postpartum care reporting and performance

Implement person-centered care models

Person-centered models of care, such as doula support and group-based care, are associated with improved health outcomes. Doula support is linked to a decreased likelihood of PPD and near-universal breastfeeding among low-income individuals.^{51, 52}

Pregnancy-centered medical homes that provide care coordination and perinatal, medical, and behavioral health services—particularly for high-risk individuals—have shown promise to increase standardized PPD screening, counseling on reproductive life planning during the postpartum period, and transition to ongoing primary care.⁵³

Support innovative models to deliver person-centered, coordinated, and integrated care

States may use CMS policy guidance on integrated models of care to support their efforts to redesign postpartum care (Box 9). Integrated care models emphasize person-centered, coordinated, and comprehensive care as a strategy to improve access to services and outcomes. States may use a Medicaid state plan or use demonstration or waiver authority to redesign their systems.

Under the state plan option, states may design a primary care case management (PCCM) program that supports care coordination, as long as the state does not restrict beneficiaries' freedom of choice of providers. The PCCM model can include policies and procedures for tracking and monitoring care coordination services along with payment and incentive structures that reward higher performance. For example, the North Carolina Medicaid PCCM program established a Pregnancy Medical Home model, a comprehensive patient-centered model for improving maternity care, including postpartum care.⁵⁴ Similarly, Montana used a SPA to implement a group care model (Box 10). States may also use contracts with MCPs to establish the necessary structure and requirements for integrated care models within managed care.

Box 9. Summary of federal guidance and state actions to design innovative delivery systems and payment models

Federal guidance:

- [State Medicaid Director Letter #12-001, July 10, 2012, Integrated Care Models.](#)
- [State Medicaid Director Letter #12-002, July 10, 2012, Policy Considerations for Integrated Care Models.](#)
- [CMCS Informational Bulletin, November 2, 2017, Delivery System and Provider Payment Initiatives Under Medicaid Managed Care Contracts.](#)

State actions:

- Explore the use of Section 1115 demonstrations or SPAs to propose new models in the fee-for-service system.
- Explore the use of demonstration projects to implement integrated care models, on a statewide basis or based on geographic area, for specific needs such as pregnancy or through select providers.
- Use managed care contracts to implement integrated care models in managed care.
- Submit a SPA for per member per month payments that includes a methodology for rate setting and a process to review and demonstrate the reform's impact.
- Implement process-based, outcome-based, or both types of quality incentive payments.

Depending on the model, states might need to use a combination of state plan and waiver authority. They might need to seek authority using a Section 1115 demonstration or 1915(b) waiver if they want to test models in specific geographic areas; limit freedom of choice of providers; or vary the amount, duration, and scope of services for different populations.

Box 10. Examples of state maternal care models

North Carolina

The North Carolina [Pregnancy Medical Home](#) (PMH) program is a partnership between the North Carolina Divisions of Medical Assistance (North Carolina Medicaid) and Public Health and Community Care of North Carolina (CCNC). The PMH program seeks to improve the quality of maternity care, improve birth outcomes, and reduce costs among the pregnant Medicaid population. About 90 percent of North Carolina's Medicaid maternity care providers participate in the PMH program. The CCNC network's PMH team consists of a nurse coordinator and a physician champion. The providers are expected to meet the terms of CCNC, which include using a standardized risk screening; providing no elective deliveries at less than 39 weeks of gestation; maintaining a primary cesarean delivery rate of 16 percent or lower among term, singleton, vertex pregnancies; completing a postpartum visit within 60 days of delivery but ideally at 14 to 42 days postpartum; and coordinating with a pregnancy care manager assigned to the practices. Medical home providers receive an incentive payment for the postpartum visit if it is completed within 60 days of delivery. Visit requirements include screening for PPD using a validated tool, reviewing the patient's reproductive life plan, and offering referrals for ongoing primary care.

Montana

The Montana [Promising Pregnancy Care Program](#) (PPC) enables approved providers to be reimbursed for state-approved group pregnancy care, offered to pregnant individuals and their partners or support persons. The program is based on the [CenteringPregnancy](#)⁵⁵ group prenatal care model. The Montana PPC is designed to reduce preterm births, which can present health risks for both the birthing parent and baby. Montana Medicaid pays federally qualified health centers an enhanced prospective payment system (PPS) rate whenever a Medicaid member attends a PPC session or group educational session, provided along with an obstetric visit. PPC-approved providers receive the rate for the face-to-face visit with a provider and an additional payment for each member attending the group session. Montana's Health Resources Division oversees the program, including its requirements, performance measures, and data, and the fiscal impact and payment aspects for Montana Medicaid.

Pursue strategies to improve specific postpartum outcomes

This section summarizes flexibilities in federal policies and guidance that support state efforts to promote access to models of person-centered care and strategies to improve the content of the postpartum care visit related to five essential components of postpartum care: (1) connecting postpartum individuals to primary and continuing care; (2) postpartum depression screening, referral, and treatment; (3) smoking cessation; (4) lactation services; and (5) contraceptive care.

Connect postpartum individuals to primary and continuing care

The prevalence of pre-pregnancy diabetes is 3.1 percent; pre-pregnancy hypertension is 10.9 percent; and pre-pregnancy depression is 21.9 percent.⁵⁶ While prenatal care providers manage chronic conditions throughout pregnancy, postpartum individuals need access to ongoing

primary care to address both primary preventive care and chronic medical conditions that could affect their long-term health and future pregnancies. The goal of this care is to promote wellness, minimize risk, and ensure a future pregnancy begins with the individual in optimal health. Maintaining or improving health after or between pregnancies is an important strategy to reduce maternal risk factors and improve birth outcomes.^{57, 58} The need for enhanced access to primary care after delivery is substantial (Box 11).

Box 11. The quality gap in access to primary care

- Less than 60 percent of postpartum individuals with continuous Medicaid or commercial health insurance, including those with chronic illnesses or pregnancy complications, received primary care within one year after delivery. Disparities in primary care use were particularly evident for Black postpartum individuals compared with their White counterparts.⁵⁹

In addition to managing longer term chronic conditions during the postpartum visit, providers should also assess for and develop a referral and management plan for diabetes and hypertension identified during pregnancy. Experts recommend screening individuals with gestational diabetes for diabetes at six weeks postpartum, again at one year, and then every one to three years for those that had normal postpartum screening test results.^{60, 61} The Working Group on High Blood Pressure in Pregnancy recommends that providers re-assess individuals with a recent hypertensive disorder in pregnancy (chronic hypertension, gestational hypertension, preeclampsia, and eclampsia) and counsel them about future pregnancies and their elevated personal risk of cardiovascular disease.⁶²

Postdelivery primary care provides an opportunity to educate patients about the long-term risks of diabetes and cardiovascular disease. Coverage alone might not be sufficient to improve postpartum individuals' use of appropriate preventive and primary care. States have used Section 1115 demonstrations to focus on individuals who have had an adverse pregnancy outcome and provide access to outpatient primary care and case management, with the goal of reducing risks that could affect a future pregnancy and long-term health outcomes.⁶³

To support transitions from postpartum care to primary care, states and their managed care partners may implement outreach and case management processes to support (1) care transition to primary care, including federally qualified health centers, for individuals who lose coverage after the postpartum period, (2) transition to family planning Medicaid coverage, (3) mental health resources for postpartum individuals with depression and other mental health or behavioral disorders, and (4) other specialty care as needed. Coordination with community-based organizations, resources, and other state programs, like those mentioned above, to establish mechanisms for “warm handoffs” may facilitate transition to ongoing preventive and chronic care, as well as services to address social drivers of health.

The postpartum visit is also an important time to address modifiable risk factors, such as obesity, tobacco use, and substance use. See below for more information on smoking cessation.

Postpartum depression screening, referral, and treatment strategies

PPD is a health condition with serious short-term and long-term consequences if left untreated. It can last for several months to more than a year. Compared with individuals who do not have PPD, those with PPD are less likely to maintain their physical health, maintain employment, and engage with and be responsive to their infants.^{64, 65} Children of individuals with PPD have a higher risk of delays in cognitive, socioemotional, and behavioral development as well as mental health issues, starting in infancy through adulthood.⁶⁶ Providers should also screen for other mental health conditions, such as anxiety and substance use disorder, as these are often co-occurring conditions.

PPD is also one of the most treatable mental health disorders, when identified early. Postpartum visits are an opportune time to conduct a PPD screening. ACOG recommends that everyone receiving well-woman, prepregnancy, prenatal, and postpartum care be screened for depression and anxiety using standardized, validated instruments.⁶⁷ The American Academy of Pediatrics considers screening postpartum individuals for depression a best practice for primary care pediatricians and recommends conducting this screening at well-child visits.⁶⁸ The use of case managers, text messaging, and home visits in pediatric and postpartum care settings that screen for and provide follow-up on PPD leads to higher rates of postpartum individuals engaged in treatment.⁶⁹ In addition, using douglas might decrease PPD through earlier identification and improvement in parent-infant interaction.⁷⁰

Recommended treatment for PPD depends on the severity of symptoms and functional impairment. Mild depression is generally responsive to psychosocial strategies, whereas moderate depression tends to respond to psychological counseling, and severe depression might respond to antidepressant medications.⁷¹ As shown in Box 12, individuals covered by Medicaid have substantial unmet needs for PPD treatment.

Box 12. The quality gap in PPD treatment

- Among postpartum individuals covered by Medicaid, 23 to 35 percent screen positive for PPD compared with about 20 percent of other postpartum individuals.⁷²
- Only 30 to 42 percent of low-income postpartum individuals who have major depressive episodes receive any treatment for depression.⁷³

Providers should either initiate treatment or refer individuals who screen positive for PPD to their primary care provider or other appropriate provider for ongoing support and treatment. Providers can proactively identify resources for individuals who lose Medicaid eligibility 60 days after delivery by coordinating with community mental health programs, FQHCs, or other community programs. They can also identify resources via the Substance Abuse and Mental Health Services Administration’s behavioral health treatment service locator

(<https://findtreatment.samhsa.gov/>) and connect individuals to HRSA’s [National Maternal Mental Health Hotline](#) (1-833-TLC-MAMA).

PPD screening could be covered as a service under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit during a well-child visit or claimed under an appropriate state plan benefit for Medicaid-eligible individuals (Box 13). Treatment for PPD could be covered under an array of Medicaid benefits for eligible individuals. Since the PPD depression screening is for the direct benefit of the child, state Medicaid agencies may allow such screenings to be claimed as a service for the child as part of the EPSDT benefit. Diagnostic and treatment services directed solely at the postpartum individual would be coverable under the Medicaid program only if that individual is Medicaid eligible. However, in some cases, PPD treatment services can be covered as services for a Medicaid-eligible child because they are for the direct benefit of the child (in some cases, these services treat the health and well-being of the child), even if the postpartum individual is not Medicaid eligible. To be claimed as a direct service for the child, PPD treatment must be for the direct benefit of the Medicaid-eligible child and must be delivered to the child and postpartum individual together. As one example, if these conditions are met, states could cover family therapy to reduce the effects of the PPD on the child as a direct service for a Medicaid-eligible child.

Several states, including Colorado, Illinois, North Dakota, and Minnesota, cover PPD screening during a Medicaid well-child visit.⁷⁴ States may instruct providers to claim this activity either as a service for the child or for the postpartum parent, depending on the postpartum parent’s Medicaid eligibility. State Medicaid agencies have flexibility in determining reimbursement approaches for the pediatric provider conducting the PPD screening. See Box 14 for Minnesota’s approach to covering PPD screening during well-child visits and helping providers conduct screening in the pediatric setting.

Box 13. Summary of federal guidance and state actions to support depression PPD screening, referral, and treatment

Federal guidance:

- [CMCS Informational Bulletin, May 11, 2016, Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children.](#)

State actions:

- Identify clinical resources for individuals losing Medicaid coverage 60 days postpartum.
- Provide guidance to pediatric providers on screening for PPD during well-child visits using the child’s or postpartum individual’s Medicaid number under EPSDT.
- Develop a mechanism to reimburse pediatric providers for PPD screening during well-child visits.

Box 14. Focus on Minnesota: Improving screening for PPD during well-child visits

The Minnesota Department of Human Services (DHS) covers [maternal depression screening](#) during infant well-child checks or other pediatric visits. Providers must use a standardized screening instrument, which can be administered by any appropriately trained staff. DHS allows up to six maternal depression screenings for each child younger than 13 months. Providers bill for screening using the same claim as a child's developmental screening or immunization administration.

Minnesota DHS developed a Quality Improvement Learning Collaborative (QILC) to focus on improving the use of screenings and referrals to treatment. The QILC helped clinics develop workflow protocols, coached teams to overcome implementation challenges, and provided content expertise throughout the project. At the end of the QILC, all participating clinics had successfully implemented universal screening and referrals.

By testing implementation in diverse clinic settings, the Minnesota Department of Health, with the help of an advisory group, was able to develop tools to help sustain and spread efforts to improve PPD screening at the state and national levels, including the Clinical Guidelines for Implementing Universal Postpartum Depression Screening in Well-Child Checks.

Smoking cessation strategies

Tobacco use among pregnant individuals is a leading preventable cause of poor pregnancy outcomes, health problems in the neonate and infant, and maternal morbidity.⁷⁵ People are more likely to quit smoking during pregnancy than at any other time, especially if smoking cessation interventions begin early in pregnancy. However, rates of relapse to smoking after delivery are high, from up to 60 percent of quitters within six months after delivery to 80 percent one year after delivery.⁷⁶

Besides the health risks for the people who smoke, infants in homes with smokers have higher rates of respiratory illnesses, ear problems, and sudden infant death.⁷⁷ Nicotine is transferred to breast milk and is associated with a change in respiration and oxygen levels in nursing infants. People who stopped smoking during pregnancy should continue to abstain from tobacco use, and those who were not able to stop or who relapse should continue their efforts to stop.

Smoking cessation approaches that combine multiple components (such as cognitive and behavioral techniques, incentives, pharmacotherapy, personal follow-up by clinicians, and home visits) have shown the most success in smoking cessation during pregnancy and extending abstinence to the postpartum period. Using a mix of cognitive behavioral therapy and incentives, such as cash or vouchers for retail items, leads to higher abstinence rates in the longer-term postpartum period compared to a single intervention.⁷⁸

As shown in Box 15, there are substantial gaps in tobacco use and cessation rates between individuals covered by Medicaid versus private insurance.

Box 15. The quality gap in tobacco use and cessation

- Among people covered by Medicaid, 17 to 20 percent smoke during pregnancy. Only 5 percent of those who have private insurance smoke during pregnancy.
- Individuals who smoke during pregnancy are more likely to be non-Hispanic White or American Indian/Alaska Native, to be younger than 25, and to have lower levels of education than nonsmokers.⁷⁹

Coverage of smoking cessation services significantly increases the likelihood that smokers will obtain treatment and successfully quit smoking.⁸⁰ Recognizing the importance of tobacco cessation counseling and pharmacotherapy for pregnant individuals, Medicaid covers comprehensive smoking cessation services for those who are pregnant, without cost sharing. These services include diagnostic services, counseling services, cognitive behavioral therapy, tobacco quitlines, and pharmacotherapy for pregnant individuals who use tobacco products or who are being treated for tobacco use. See Box 16 for federal guidance.

Tobacco quitlines typically include additional tailored protocols for pregnant and postpartum individuals, including a personal coach, motivational interviewing customized for pregnant and postpartum individuals, and access to additional counseling sessions. Medicaid agencies can partner with state and territorial health agencies that run tobacco quitlines to expand access and decrease barriers to tobacco cessation counseling. States may claim coverage of tobacco quitline services provided to Medicaid members as a Medicaid administrative expense.⁸¹

Most studies show that interventions to promote cessation and maintain abstinence after pregnancy do not have a lasting effect. But addressing postpartum individuals' social and mental health conditions may be an effective way to maintain abstinence. Some states, recognizing that postpartum individuals with newborns might attend only their infant's well-child visit and not their own postpartum visit, have developed models that pay pediatric providers to screen postpartum individuals for depression, tobacco use, and other risk factors. See Box 17 for details on Illinois's tobacco cessation strategies.

Box 16. Summary of federal guidance and state actions to support smoking cessation

Federal guidance:

- [State Medicaid Director Letter #11-07 / ACA #17, June 24, 2011, New Medicaid Tobacco Cessation Services.](#)
- [CMCS Informational Bulletin, November 18, 2011, Tobacco Cessation Telephone Quitlines.](#)

State actions:

- Design smoking cessation services so that the covered benefit is "sufficient in amount, duration, and scope to reasonably achieve its purpose."
- Partner with a tobacco telephone quitline that follows evidence-based protocols to qualify for Medicaid reimbursement.

Box 17. Focus on Illinois: State tobacco cessation strategies

The Illinois Department of Healthcare and Family Services covers [tobacco cessation counseling services](#) for pregnant and postpartum individuals through separately billable services. Coverage includes a maximum of three quit attempts per calendar year, with up to four face-to-face counseling sessions per quit attempt. The sessions must be provided by, or under the supervision of, a physician or another health care professional who is authorized to furnish the services and is a Medicaid provider. The department covers nicotine replacement therapies approved by the Food and Drug Administration. The department encourages all providers to take advantage of the resources available to address smoking cessation, including information from the Illinois Department of Public Health at the Illinois Tobacco Quitline website.

Strategies to improve lactation services

Increasing breastfeeding rates among people covered by Medicaid is an important quality-of-care goal.^{82, 83} The 2011 U.S. Surgeon General’s Call to Action to Support Breastfeeding describes the many benefits of breastfeeding.⁸⁴ The American Academy of Pediatrics recommends feeding infants breast milk exclusively for the first six months of life; after the first six months, individuals should continue to provide breast milk while introducing solids as long as mutually desired for two years or beyond.⁸⁵ Although these guidelines represent ideal behavior, studies show that any amount of breastfeeding provides a benefit. But many people struggle to begin and maintain breastfeeding. Although about three-quarters of individuals begin breastfeeding, the rate of breastfeeding steadily declines with the baby’s age; only about 10 percent exclusively breastfeed at six months.⁸⁶ See Box 18 for more information on breastfeeding among beneficiaries with Medicaid coverage.

Box 18. The quality gap in breastfeeding rates

- Individuals covered by Medicaid are among the least likely to have ever breastfed, at 69 percent. The rate of ever breastfeeding among Medicaid beneficiaries is 10 to 20 percentage points lower than among people with other types of insurance coverage.
- Rates of breastfeeding among Medicaid beneficiaries remain well below the [Healthy People 2030](#) objectives to increase the share of infants (1) breastfed exclusively through 6 months to 42.4 percent, and (2) breastfed to any extent through 12 months to 54.1 percent.

There is strong evidence that educating providers about strategies to talk to pregnant individuals during prenatal visits about breastfeeding increases breastfeeding rates. In addition, providing lactation consultation in the hospital after delivery and by telephone or in the home during the postpartum period substantially boosts breastfeeding rates among low-income individuals.⁸⁷

To address barriers to breastfeeding, Medicaid programs can adopt policies to finance breastfeeding support and counseling services in three major service categories: (1) breastfeeding education, (2) individual lactation consultation, and (3) equipment rentals. Although support for breastfeeding should begin before delivery, these services are also important during the postpartum period. States may separately reimburse for a broad array of lactation services as “pregnancy-related services.” The services of a lactation consultant, if licensed by the state, could be covered under the state plan’s “other licensed practitioner” benefit.⁸⁸

States have several mechanisms for working with MCPs to support breastfeeding. Examples include reviewing MCP policies and aligning coverage for lactation support services across Medicaid and CHIP MCPs, and encouraging MCPs to provide breastfeeding education, either through referrals to the WIC program or by directly providing the services through their provider network. Box 19 provides examples of policies in three states.

Box 19. Examples of state Medicaid lactation support policies

California

California's Medicaid program has included coverage of breastfeeding services and supplies since 1999. Coverage is determined by location and provider (such as nurse, registered dietitian under the direction of a physician, or clinic). Many third-party Medicaid contractors cover breastfeeding services with International Board-Certified Lactation Consultants (IBCLCs).

New York

With approved state plan authority, the New York State Department of Health requires Medicaid to reimburse for evidence-based breastfeeding education and lactation counseling consistent with the recommendations of the U.S. Preventive Services Task Force. The state Medicaid program pays for lactation services and breast pumps, along with lactation counseling delivered by licensed, registered, or certified health care professionals (physicians, nurse practitioners, midwives, physician assistants, or registered nurses) who are IBCLCs. New York's regulations are available at https://www.health.ny.gov/health_care/medicaid/program/update/2022/no07_2022-06.htm#lactationcertifications and https://www.health.ny.gov/community/pregnancy/breastfeeding/medicaid_coverage/minimum_breast_pump_specifications.htm

Oklahoma

Oklahoma Medicaid pays for outpatient lactation services. The benefit allows for six visits prenatally or postpartum, and an IBCLC who is a licensed nurse or dietitian can bill for the services. Services must be provided in an office, the home, or an outpatient clinic setting. Oklahoma's lactation services policies are available at <https://oklahoma.gov/ohca/providers/types/prenatal-and-perinatal-services/lactation-consultants.html> and <https://oklahoma.gov/ohca/policies-and-rules/xpolicy/medical-providers-fee-for-service/individual-providers-and-specialties/lactation-consultants/eligible-providers.html>.

Contraceptive care strategies

About one-third of all U.S. pregnancies occur less than 18 months after a previous pregnancy. Adverse outcomes, including low birth weight and preterm birth, correlate with between-pregnancy intervals of less than 18 months.⁸⁹ Rapid repeat pregnancy within 12 to 18 months after delivery can occur if individuals do not initiate effective contraception shortly after delivery.⁹⁰ Increasing access to effective postpartum contraception, including long-acting reversible contraceptives (LARCs) such as intrauterine devices (IUDs) and implants, reduces short pregnancy intervals and mistimed or unintended pregnancies.⁹¹

All postpartum individuals should receive patient-centered counseling about the full range and effectiveness of contraceptive options. State Medicaid and CHIP programs can play a key role by educating individuals about the importance of reproductive life planning and birth spacing and by removing barriers to contraceptive care after a delivery. As shown in Box 20, individuals covered by Medicaid are more likely to have shorter inter-pregnancy intervals.⁹²

Box 20. The quality gap in between-pregnancy intervals

- An estimated 35 percent of pregnancy intervals are less than 18 months.
- Individuals covered by Medicaid are about 40 percent more likely than others to have a short between-pregnancy interval.⁹³

Medicaid policies to support access to contraceptive care

The standard state Medicaid benefit package must cover family planning services and supplies, including education; counseling; and medical visits for contraceptive methods. Individuals must have access to all contraceptive methods available under a state's approved Medicaid plan or family planning state plan option without any cost sharing. See Box 21 for CMS's guidance on and state actions to support contraceptive care access.

States have flexibility in which contraceptive methods to cover as long as the options are sufficient in amount, duration, and scope to prevent pregnancy and accommodate choice. States cannot require individuals to try step therapy as an approach to establish their most effective means of contraception, and providers cannot prevent removal of a device.

Beneficiaries are free to choose their method of family planning without coercion or pressure from payers or providers, including MCPs. Providers must receive prompt payment in both the fee-for-service and managed care delivery systems, including for out-of-network managed care providers.

Coverage and payment policies to support use of LARCs in the postpartum period

Postpartum LARCs are effective and safe contraceptives, including when inserted immediately after delivery. LARC methods, including the IUD and the single-rod progestin subcutaneous implant, are the most effective reversible contraceptives.^{94, 95} However, there are barriers to immediate postdelivery placement of IUDs, including ensuring the device is available in the delivery room and ensuring the provider is paid for both the device and for the procedure to insert the device.

Box 21. Summary of federal guidance and state actions on improving postpartum contraceptive care

Federal guidance:

- [State Health Official Letter #16-008, June 14, 2016, Medicaid Family Planning Services and Supplies.](#)
- [CMCS Informational Bulletin, April 8, 2016, State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception.](#)

State actions:

- Cover full range of family planning services and supplies, including education and counseling on Medicaid benefit package
- Provide access to contraceptives in state plan, family planning waiver, or family planning state plan option without cost sharing

Payment for the immediate insertion of LARCs during the hospital admission for delivery, placement during the postpartum visit, and stocking of LARC devices are essential strategies to improve LARC access, thereby reducing unintended pregnancy, and lowering rates of rapid repeat pregnancy.^{96, 97} State Medicaid and CHIP programs can direct providers to policies that support the appropriate use of LARCs in the postpartum period. States have implemented a variety of approaches to paying for LARCs during this period, including:

- Paying for counseling and education on all contraception options, including LARCs, in the prenatal and postpartum periods
- Paying the additional costs of LARC placement while the individual is still in the hospital after delivery, including the cost of the device and insertion, which are not accounted for in the single global/bundled payment for maternity care (see Box 22 for one state’s approach)
- Paying for replacement or reinsertion of expelled IUDs that are placed immediately postpartum as well as removal upon request
- Identifying manufacturers that provide LARCs without requiring upfront payment, enabling hospitals to stock LARCs and pay for devices only if they are used
- Establishing a replacement program, via a direct payment arrangement between state Medicaid and CHIP programs and pharmacies, that enables providers to obtain LARC devices without having to pay up-front acquisition and stocking costs
- Encouraging providers to implement same-day LARC insertion protocols during the postpartum visit⁹⁸

Box 22. Focus on Washington State: Policies to increase access to postpartum LARC

The Washington State Medicaid program increased provider payments for the provision of LARCs and started to provide separate payments for immediate postpartum placement of LARCs. After this policy change, the postpartum use of LARCs increased significantly at 3 and 60 days after delivery.

- The proportion of individuals receiving LARCs within three days of delivery doubled.
- The trend of postpartum LARCs use within 60 days of delivery reversed from downward to upward.
- A larger proportion of Hispanic individuals received LARCs within 60 days of delivery compared with individuals from other racial and ethnic groups.

More information on Washington’s policy and results is available at <https://www.dshs.wa.gov/sites/default/files/rda/reports/research-13-04.pdf>.

Section IV. Strategies to Address Disparities in Postpartum Care

Not all postpartum individuals receive high-quality postpartum care. Factors such as health coverage type, geographic location, and race and ethnicity impact receipt of appropriate care.⁹⁹ Furthermore, postpartum individuals, especially Black individuals, also note that respectful care in which providers validate their experiences is necessary for ensuring high-quality reproductive health care.¹⁰⁰ See Box 23 for examples of the equity gap in high-quality postpartum care.

Box 23. The equity gap in the quality of postpartum care

- Thirteen percent of postpartum individuals experienced depression, with higher rates among people of color and low-income individuals.¹⁰¹
- Seventy-five percent of people reported being asked about depression during postpartum visits in Louisiana, compared with 96 percent in Vermont.¹⁰²
- Rates of postpartum follow-up among people with diabetes and/or hypertension ranged from 5.7 percent to 95.4 percent, with disparities linked to race, ethnicity, and lower levels of education.¹⁰³

Achieving equity in rates of postpartum care visits requires an understanding of the populations experiencing disparities and finding strategies to reduce disparities in the context of an overall goal. This focused approach, tied to a universal goal, can enhance postpartum care for all Medicaid and CHIP beneficiaries. Using this approach, states can explore the gaps among individuals, groups, and geographic locations to identify who will benefit from policy or program changes to achieve the overall goal. The objective is to clarify and identify the barriers to achieving the universal goal for different groups of beneficiaries, an approach known as targeted universalism.¹⁰⁴ The focus on gaps, although important, can be measured by reference to the universal goal, not just between groups.

Partner with managed care plans to address disparities

Managed care is an important delivery system for Medicaid and CHIP beneficiaries because more than 70 percent are enrolled in comprehensive risk-based managed care.¹⁰⁵ States can engage MCPs as partners to improve rates of postpartum care visits and to advance health equity, specifically by using managed care quality strategies, requests for proposals, and subsequent contracts with MCPs to set priorities related to maternal health outcomes. Such tools can be used to drive better, more equitable outcomes through requirements and incentives, including requiring quality measures that would illuminate health disparities. Section V identifies quality measurement strategies that states can implement to identify disparities.

Establish performance improvement projects focused on health equity to address identified racial, ethnic, language, geographic, or other disparities

States can work with their MCPs and their EQROs, where applicable, to develop and implement PIPs aimed at increasing postpartum visit rates or other relevant quality improvement activities

and identifying effective interventions. States can take full advantage of the contracting process to reflect their state goals and align innovations and activities to promote equity. A compendium of relevant contract language is available in the resource [Medicaid Managed Care Contract Language: Health Disparities and Health Equity](#). In addition, Louisiana issued a white paper, [Paving the Way to a Healthier Louisiana: Advancing Medicaid Managed Care](#), describing how the state uses MCP contracts to (1) identify potential high-risk populations; (2) require data reporting from multiple sources that includes race, ethnicity, and language; and (3) address social drivers of health. Box 24 highlights efforts in two states to address disparities by engaging with managed care partners.

Box 24. Examples of state managed care efforts to address disparities in postpartum care visits

California

The California Department of Health Care Services (DHCS) contracted with its EQRO to study health disparities using the accountability measures reported by the 25 full-scope Medi-Cal MCPs. These measures reflect clinical quality, timeliness, and access to care provided by the MCPs to their beneficiaries, and each plan must report audited measure results to DHCS annually. The state issues a [Health Disparities Report](#), which aims to improve health care for Medi-Cal beneficiaries by evaluating the disparities affecting beneficiaries enrolled in Medi-Cal MCPs. Postpartum individuals who are American Indian or Alaska Native, Black or African American, and Native Hawaiian or Other Pacific Islander had postpartum visit rates in 2019 that were below the minimum performance level in 2019. The rates for these three racial and ethnic groups were also lower than the rates for the White group for all three reporting years (2017 to 2019).

Michigan

The Medicaid Quality Improvement and Program Development Section of the Michigan Medicaid Managed Care Plan Division implemented the [Medicaid Health Equity Project](#) in 2010. All Michigan MCPs report race and ethnicity data on several measures, including the postpartum care visit rate. The plan-specific data are reported in a public statewide report. Race and ethnicity data are collected based on Medicaid enrollment forms, which use self-identification to determine race and ethnicity. The visit rate for African American postpartum individuals increased from 43.3 to 54.1 over five years. However, this rate was still 9.2 percentage points lower than the postpartum visit rate for White postpartum individuals in 2017. The state was planning to implement PIPs with its MCP to address documented disparities.

Provide access to culturally appropriate providers, information, and care

There are many ways states can support beneficiary access to culturally appropriate postpartum providers, information, and care. This section focuses on involving community members and providing language and translation services, but there may also be relevant state-specific provider licensing or credentialing requirements that states can promote. Additionally, states can consider including relevant language in MCP contracts, such as implicit and explicit bias training for MCP staff.¹⁰⁶

Involve community members to help connect individuals to postpartum care

Community members trained as peer educators, doulas, navigators, or community health workers are important for connecting individuals to postpartum care.¹⁰⁷ For example, community-based

doulas are often specially trained to bridge language gaps, promote culturally sensitive care, and act as navigators. Social workers and community health workers have been shown to increase postpartum care visits among urban residents enrolled in a New York MCP.¹⁰⁸ In addition, community-based doula care has been associated with higher rates of postpartum care visits among adolescents.¹⁰⁹ Latinx individuals supported by community-based workers trained as prenatal partners or peer supports had a rate of postpartum visits that was 20 percentage points higher than the rate for individuals without peer supports.¹¹⁰

CMS has issued guidance to states on paying for services delivered by doulas and other nonlicensed practitioners (Box 25). States may pay for services delivered by nonlicensed practitioners whose qualifications states define and recognize. States may recognize nonlicensed practitioners to deliver preventive services, including pregnancy-related services, if recommended by a licensed provider. Preventive services could include education about certain health conditions, such as care during pregnancy and the postpartum period.¹¹¹

States may submit a SPA summarizing the qualifications for practitioners who furnish preventive services but are not physicians or licensed providers. States may also use section 1115 demonstrations or SPAs to cover the services of traditional health workers, as Oregon has done (Box 26). Furthermore, states may encourage Medicaid MCPs to include support for trained doulas and other health workers as a covered service.¹¹²

Box 25. Summary of federal guidance and state actions to use nonlicensed practitioners

Federal guidance:

- [CMCS Informational Bulletin, November 27, 2013, Update on Preventive Services Initiatives.](#)
- [State Medicaid Director Letter #07-011, August 15, 2007, on peer support services.](#)
- [Clarifying guidance on peer support services policy, May 1, 2013.](#)

State actions:

- Submit a SPA summarizing the qualifications for nonlicensed practitioners who may, with a physician's or licensed practitioner's recommendation, provide preventive services that meet the requirements for the benefit.
- Explore the use of Medicaid Section 1115 demonstrations to cover services provided by doulas or community health workers.

Box 26. Focus on Oregon: Expanding access to traditional health workers

- In 2011, the Oregon legislature passed House Bill 3311, which directed the Oregon Health Authority to explore options for providing or using doulas in the state Medicaid program to improve birth outcomes for people who face a disproportionately greater risk of poor birth outcomes.
- Oregon subsequently used state plan authority to cover the services of traditional health care workers under the supervision of a licensed health care professional.
- The Oregon Health Authority created the Traditional Health Worker (THW) Program to promote better health outcomes and greater health equity. Oregon covers doula services as a preventive service for pregnant individuals. Doulas are eligible for Medicaid [reimbursement](#) if they are [certified](#) and registered as THWs.
- The THW Program is responsible for certifying, training, and registering THWs.
- Oregon recognizes five types of THWs: doulas, peer support specialists, peer wellness specialists, personal health navigators, and community health workers. Definitions of these terms are available at <https://www.oregon.gov/oha/OEI/Pages/About-Traditional-Health-Workers.aspx>.

Several state Medicaid programs or MCPs have involved doulas to engage individuals in their care. For example, Minnesota’s Medicaid program covers [doula services in its state plan](#) as an extended service for pregnant individuals. New Jersey Medicaid covers services by doulas who complete an approved community-based doula training, as described in its [SPA](#) and a [newsletter to providers](#). Healthy Blue, a Nebraska Medicaid MCP, covers [doula services for pregnant youth](#) in foster care. [Two MCPs in Kentucky](#) provide doula services as extra benefits. Studies have modeled the efficacy and cost effectiveness of doula care on outcomes in Medicaid; states and MCPs continue to expand access to doula services for Medicaid beneficiaries to realize the potential impact.^{113, 114}

State partnerships with MCPs are particularly important because MCP structures such as internal case management teams, care coordination, and outreach teams can help postpartum individuals engage in their care, navigate benefits and services, and communicate with care delivery teams. States can also use contract language to encourage or require MCPs to support care coordination using community members or other person-centered models of care.^{115, 116}

Provide language translation and interpretation services

Engaging postpartum individuals in their care might require providing access to interpreters and to written materials in languages other than English. 42 CFR 435.905(a)(2) and (b)(1) require that information on “available Medicaid services” be provided to individuals who are limited English proficient through the provision of language services including oral interpretation and written translations at no cost to the individual. CMS provided guidance to states in the July 1, 2010, State Medicaid Director and State Health Official Letter (Box 27) about claiming for translation and interpretation services.

The increased federal match for translation or interpretation services differs for Medicaid and CHIP.¹¹⁷ For Medicaid, the increased match is 75 percent of allowable expenditures. For CHIP, the increased match is 75 percent, or the state’s enhanced federal medical assistance percentage (FMAP) plus 5 percent, whichever is higher, but subject to the 10 percent

Box 27. Translation and Interpretation Services Revised Federal Guidance

Federal guidance:

- The Children’s Health Insurance Program Reauthorization Act of 2009 [increased administrative funding](#) to facilitate access, enrollment, and services used by children for whom English is not their first language, including children who use American Sign Language and Braille.

State actions:

- States and providers can [obtain the increased match](#) by (1) entering into a contract or employing staff to provide only translation or interpretation services, and claim the related costs as administrative activities, or (2) separately paying for translation or interpretation services to help the medical provider, as an administrative expenditure (in addition to paying for the medical service).

statutory limit on CHIP administrative costs. The increased federal match is available only for eligible expenditures claimed for administration of the Medicaid or CHIP plan, not for expenditures claimed for benefits.¹¹⁸ Medicaid managed care regulations specify that payments made under a managed care contract are considered medical assistance services and may be matched only at the FMAP rate.¹¹⁹ States have the option to carve out translation or interpretation from the capitated rate and contract separately for these services as an administrative activity.

Section V. Strategies to Implement Quality Measurement and Improvement Approaches

This section of the toolkit aims to help state Medicaid and CHIP programs develop a plan for measuring their progress with increasing access, quality, and equity in postpartum care. As states begin their planning process, they can use quality measures to assess baseline performance, identify disparities, and set performance goals. As they implement new postpartum care strategies, such as those identified in the [Checklist](#), they can use quality measures to monitor their progress and assess remaining gaps. Some states use quality measures to promote accountability by MCPs and providers, such as through public reporting of performance or by offering financial incentives for higher performance. A measurement strategy is also foundational to assessing the effectiveness of quality improvement efforts through learning collaboratives or PIPs.

Although a range of measures are available to assess the care delivered to individuals and populations, states may consider using the CMS Core Set of Maternal and Perinatal Health Measures for Medicaid and CHIP (known as the Maternity Core Set) to track state progress with improving access and quality during the perinatal period.¹²⁰ See the [Appendix](#) for a list of the 2023 Maternity Core Set measures.¹²¹

Implement a quality measurement approach

States can strengthen accountability and support improvement by establishing a measurement approach with defined measures, data collection periods, and reporting intervals. States may identify such measures at the state, plan, and/or provider levels to monitor system performance on postpartum visit rates and quality of clinical care during the postpartum visit. A robust measurement approach is contingent on access to high-quality data that allows for stratification of measures to assess progress toward achieving health equity.

The measurement approach can provide insights necessary to identify and eliminate barriers to care, understand population risk, enhance treatment, and reveal partnership opportunities to reach postpartum care goals. Building upon a measurement approach, states can establish collaborative learning opportunities for plans and providers to implement rapid cycle tests of change to drive improvement.

Calculate and report state-level rates of postpartum care

The [Child and Adult Core Sets](#) include the following measures of postpartum care access and quality:

- **Prenatal and Postpartum Care: Postpartum Care (PPC-AD)** measures the percentage of deliveries of live births that had a postpartum visit on or between 7 and 84 days after

delivery. These visits are essential to assess recovery from childbirth as well as physical and psychological well-being, treatment of chronic conditions, and general preventative care.

- **Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH) and Ages 21 to 44 (CCP-AD)** measure the percentage of women who had a live birth that: (1) were provided a most effective or moderately effective method of contraception within 3 and 90 days of delivery, and (2) were provided a long-acting reversible method of contraception (LARC) within 3 and 90 days of delivery. The aim is to measure access to postpartum contraception. There is no benchmark for this measure. Patient autonomy should always be respected.
- **Well-Child Visits in the First 30 Months of Life (W30-CH)** measures the percentage of children who had well-child visits with a primary care practitioner, including (1) children who turned age 15 months during the measurement year who had six or more well-child visits in the first 15 months of life, and (2) children who turned age 30 months during the measurement year who had two or more well-child visits between ages 15 months and 30 months.¹²² These visits are an important touchpoint for both the parent and the child to interact with the healthcare system and a provider during the postpartum period and infancy.

States and territories voluntarily report these measures each year. Reporting resources for the [Child Core Set](#) and [Adult Core Set](#) include technical specifications and guidance for reporting as well as information about the CMS [Technical Assistance and Analytic Support Program](#) to support states' efforts to collect, report, and use quality measures to improve health care delivery and outcomes. State-level rates for these and other measures in the Maternity Core Set are posted publicly on Medicaid.gov in the [Maternity Core Set Chart Pack](#).

States can also consider other data sources that could inform efforts to improve postpartum care access and quality. For example, the [Medicaid and CHIP Beneficiary Profile: Maternal and Infant Health](#) provides an overview of Medicaid and CHIP beneficiaries by demographic characteristics, health status, insurance coverage, risk factors, health care utilization, and outcomes.

Stratify state-level rates of postpartum care by race, ethnicity, language, disability, geographic location, and other relevant characteristics

Measuring access, utilization, and outcomes stratified by race, ethnicity, language, disability, geographic location, and other relevant characteristics is necessary for understanding where to focus improvement efforts and for measuring progress toward reducing disparities.^{123, 124} States are encouraged to stratify their Core Set measures and report stratified rates to CMS. Stratification of Core Set measures can support state program planning and inform their quality improvement priorities.

The [Reporting Stratified Results in the Quality Measure Reporting System for the 2021 and 2022 Child, Adult, and Health Home Core Sets](#) Technical Assistance Resource details the stratification

categories and subcategories used in CMS reporting systems, and provides additional guidance and resources for collecting stratified data accurately and consistently.

Calculate rates of postpartum care at the plan, provider, or program level

State-level data are often insufficient to focus quality improvement initiatives. States that contract with MCPs for delivery of maternal and infant health care can more effectively monitor performance by calculating postpartum care rates at the plan level, including rates stratified by population characteristics. Similarly, states with PCCM programs can assess performance at the provider level. In addition, some states incentivize higher performance by requiring quality measure reporting and linking payment to MCP or provider performance on postpartum quality measures. See Box 28 for an example on use of quality incentive payments in Ohio.

Box 28. Ohio Comprehensive Maternal Care Program

[Comprehensive Maternal Care \(CMC\)](#) in Ohio is a statewide program for moms, infants, and families covered by Medicaid. The program supports obstetrical practices in establishing a network of community partners and culturally aligned support services for individuals with Medicaid in prenatal and postpartum care. The CMC model leverages a value-based per-member-per-month payment structure based on the individual risk levels of enrolled Medicaid members. The program requires reporting on perinatal quality measures. Additionally, quality incentive payments are available to organizations actively participating in health disparity reduction activities. Quality incentive payment award criteria include (1) participation in Perinatal Quality Improvement Collaborative OR implementing patient safety practices or bundles; (2) integration and support of community partners; (3) integration of information from patient feedback processes; and (4) performance on key outcome metrics including postpartum care.

Link quality measurement and quality improvement

The [Improving Postpartum Care Measurement Strategy](#) provides guidance for building a family of measures for a QI initiative, including outcome measures, process measures, and balancing measures, as well as examples of measures that can be used to monitor postpartum care QI projects. Taken together, outcome, process, and balancing measures make up a family of measures that may be used to track progress on an intervention, program, or policy.

- **Outcome measures** capture the goal to be accomplished. It is the endpoint or the achievement sought. The outcome may represent a specific clinical metric, event, or patient-reported perspective.
- **Process measures** capture the incremental changes that will collectively improve (or modify) the outcome measure(s). Process measures should relate to the outcome and may be calculated more frequently (for example, monthly). An example might be the percentage of beneficiaries with a scheduled postpartum visit before discharge from the delivery or a completed health assessment during the postpartum visit.

- **Balancing measures** capture other consequences, both intended and unintended, that might result as part of the intervention. An example is beneficiary satisfaction with postpartum care.

Implement a quality improvement approach

As states identify postpartum care gaps and barriers, several strategies and tools are available to help design and implement projects aimed at driving improvement in programs, policies, and practices. CMS developed a set of technical assistance tools, including [QI resources and background materials](#), to help states get started improving postpartum care visits rates and reducing disparities. Another CMS resource, [Building an Organizational Response to Health Disparities](#), provides guidance on data collection, data analysis, creation of a culture of equity, quality improvement, and interventions, including resources for improving equity and reducing disparities.

To carry out QI projects, states can partner with their MCPs, providers, other state agencies, and other interested parties to establish collaborative learning opportunities focused on implementing rapid-cycle tests of change to address a specific aim (such as improving the timeliness of postpartum care visits or increasing postpartum depression screening and referral). The CMS [Resources on Strategies to Improve Postpartum Care Among Medicaid and CHIP Populations](#) Technical Assistance Resource includes examples of strategies implemented by state Medicaid agencies, MCPs, and clinics to improve the postpartum care visit rate and the content of care, along with corresponding data and outcomes.

States also can work with their MCPs and EQRO to implement and validate PIPs related to postpartum care quality. More information on implementing and validating PIPs is available in CMS's [External Quality Review Protocols](#). Finally, states can identify opportunities to partner with perinatal quality collaboratives (PQCs) to coordinate postpartum care.¹²⁵ PQCs implement many tools and resources to improve care, and they provide technical assistance, coaching, and support facilities across states. PQCs convene key stakeholders, and help facilities navigate the challenges and opportunities of improving postpartum care. For example, PQCs are involved in the implementation and dissemination of the HRSA funded Alliance for Innovation on Maternal Health (AIM) program designed to address factors associated with severe maternal morbidity and mortality.¹²⁶

For more information on quality improvement technical assistance, please reach out to MedicaidCHIPQI@cms.hhs.gov.

Concluding Remarks

This toolkit provides states with information they can use to assess their current approaches to postpartum care delivery in Medicaid and CHIP programs, examples of successful programs and policies states have implemented, and strategies to improve care delivery and outcomes. States that identify low rates of postpartum care visits for individuals in Medicaid and CHIP can focus on strategies to increase access to these visits and approaches to engaging individuals in care.

Medicaid and CHIP beneficiaries have significant gaps in their quality of care related to screening, referral, and treatment for depression; smoking cessation; starting and maintaining breastfeeding; contraceptive care; and management of chronic medical conditions such as diabetes and hypertension. Although beneficiary and provider education are important strategies for improving quality of care, changes in the way care is delivered and paid are increasingly recognized as effective ways to promote coordinated, person-centered care that focuses on quality and efficiency. State Medicaid and CHIP agencies can promote improvements in care delivery to enhance maternal and infant health outcomes and advance equity. States can consider using a combination of the strategies presented in this toolkit to achieve higher rates of postpartum care visits, to enhance the overall content and quality of the visits, and improve health outcomes. CMS is committed to improving postpartum care and health outcomes for people covered by Medicaid and CHIP and can provide state Medicaid agencies and their partners with tools, resources, and one-on-one technical assistance. For more information and assistance please reach out to MedicaidCHIPQI@cms.hhs.gov.

Appendix: 2023 Core Set of Maternal and Perinatal Health Measures for Medicaid and CHIP (Maternity Core Set)

To support CMS’s maternal and perinatal health-focused efforts, CMS identified a core set of nine measures for voluntary reporting by state Medicaid and CHIP agencies. CMS will use this Core Set, which consists of six measures from the Child Core Set and three measures from the Adult Core Set, to measure and evaluate progress toward improving maternal and perinatal health in Medicaid and CHIP.

NQF #	CMS Core Set	Measure steward	Measure name	Data collection method
1382	Child	CDC/ NCHS	Live Births Weighing Less than 2,500 Grams (LBW-CH)	State vital records
1392	Child	NCQA	Well-Child Visits in the First 30 Months of Life (W30-CH)*	Administrative
1517**	Child	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	Administrative or hybrid
1517**	Adult	NCQA	Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	Administrative or hybrid
2902	Child	OPA	Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)	Administrative
2902	Adult	OPA	Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)	Administrative
2903/ 2904	Child	OPA	Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)	Administrative
2903/ 2904	Adult	OPA	Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)	Administrative
NA	Child	CDC/ NCHS	Low-Risk Cesarean Delivery (LRCD-CH)	State vital records

*The Well-Child Visits in the First 15 Months of Life (W15-CH) measure was modified by the measure steward. It now includes two rates: (1) six or more well-child visits in the first 15 months and (2) two or more well-child visits from 15 to 30 months. The NQF number refers to the endorsement of the W15-CH measure.

**This measure is no longer endorsed by NQF.

CDC = Centers for Disease Control and Prevention; CHIP = Children’s Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; NA = measure is not NQF endorsed; NCHS = National Center for Health Statistics; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OPA = U.S. Office of Population Affairs.

The complete list of 2023 Child Core Set measures is available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-child-core-set.pdf>.

The complete list of 2023 Adult Core Set measures is available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-adult-core-set.pdf>.

ENDNOTES

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