NORTH CAROLINA AHEC

PRACTICE SUPPORT

Improving Timeliness and Access for Prenatal and Postpartum Care

Why is this important?

Guidelines published by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) recommend a prenatal visit in the first trimester for all women. ACOG also recommends that all women have contact with their obstetrician-gynecologists or other obstetric providers within 3 weeks postpartum, followed by ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth. *Source: Prenatal and Postpartum Care (PPC) - NCQA*

Studies show that prevention of up to 60% of all pregnancy-related deaths could be obtained if women had better access to health care, received better quality of care and made changes in their health and lifestyle habits (1). Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants. *Source: Prenatal and Postpartum Care (PPC) - NCQA*

NC Medicaid's goal is to increase statewide Medicaid rates from 36% in 2019 to 37% in 2022. Providers should consider setting their own improvement goals. Check with each Medicaid health plan you are contracted with to understand their performance incentive payments, if applicable.

Measure Definition (NQF #1517):

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:

- Rate 1: Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization.
- Rate 2: Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Numerator (Prenatal Care):

The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization.

Numerator (Postpartum Care):

A postpartum visit for a pelvic exam or postpartum care on or between 7 and 84 days after delivery. Any of the following meet criteria:

- A postpartum visit (Postpartum Visits Value Set)
- Cervical cytology (Cervical Cytology Value Set)
- A bundled service (Postpartum Bundled Services Value Set) where the state can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered). *Source: Measure Details (cms.gov)*

Denominator:

Patients who delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Include women who delivered in any setting. *Multiple births*: Women who had two separate deliveries (different dates of service) within one reporting period should be counted twice. Women who had multiple live births during one pregnancy should be counted once. *Source: Measure Details (cms.gov)*

Exclusions:
Patients are excluded if their deliveries do not result in live births.

Documentation Required for Measure Completion:

Prenatal care:
For visits to an OB/GYN or other prenatal care practitioner or PCP, **a diagnosis of pregnancy must be present**. Documentation in the medical record must include a note indicating the **date when the prenatal care visit occurred**, and **evidence of one of the following**:

- Documentation indicating pregnancy or reference to pregnancy (use of a standardized prenatal flow sheet, documentation of last menstrual period [LMP], **estimated due date [EDD]**, gestational age [GA], positive pregnancy test, gravidity and parity, a complete obstetrical history, prenatal risk assessment or counseling/education).
- A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundal height.
- Evidence that a prenatal care procedure was performed (e.g., OB panel, ultrasound).

Postpartum Care:
Postpartum visit to an OB/GYN or other prenatal care practitioner or PCP. Documentation in the medical record must include a note indicating the **date when the postpartum care visit occurred**, and **evidence of one of the following**:

- Pelvic exam: colposcopy is not acceptable for a postpartum visit.
- Evaluation of weight, blood pressure (BP), breasts, and abdomen: Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component.
- Notation of postpartum care, including, but not limited to: notation of "postpartum care," "PP care," "PP checks," "six-week check."
- A preprinted postpartum care form in which information was documented during the visit.
- Perineal or cesarean incision/wound check.
- Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders.
- Glucose screening for women with gestational diabetes.
- Documentation of any of the following: infant care or breastfeeding; resumption of intercourse, birth spacing (recommended time between births), family planning; sleep/fatigue; resumption of physical activity; attainment of healthy weight.

Denominator and Numerator Codes:

The following information was extracted from "Guidelines for Access/Availability of Care Measures," HEDIS MY 2022, Volume 2, pages 445-452 and the HEDIS MY 2022 Volume 2 Value Set Directory:

Measure Portion	Value Set	Code System	Codes
Denominator	Deliveries	CPT	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622
Numerator - Prenatal	Prenatal Bundled Services	CPT	59400, 59425, 59426, 59510, 59610, 59618
		HCPCS	H1005
	Prenatal Visits	CPT	99201-99205, 99211-99215, 99241-99245, 99483
		HCPCS	G0463, T1015
	Stand Alone Prenatal Visits	CPT	99500
		CPT-CAT-II	0500F, 0501F, 0502F
		HCPCS	H1000-H1004
	Telephone Visits	CPT	98966-98968, 99441-99443
	Online Assessments	CPT	98969-98972, 99421-99444, 99457
		HCPCS	G0071, G2010, G2012, G2061-G2063
Numerator - Postpartum	Postpartum visits	CPT	57170, 58300, 59430, 99501
		CPT-CAT-II	0503F
		HCPCS	G0101
	Cervical Cytology	CPT	88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175
		HCPCS	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091
	Postpartum Bundled Services	CPT	59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622

Things to Note:

- For NC Medicaid beneficiaries, Providers will continue to be exempt from prior approval on ultrasounds.
- For NC Medicaid beneficiaries, Providers will continue to receive pregnancy risk screen and postpartum visit incentives for completion of those services.
- The NC Medicaid Pregnancy Management Program requirement is for a postpartum visit to occur within 56 days of delivery, however the numerator for the postpartum care measure is 7-84 days.
- **Presumptive Eligibility (PE)**
    - A provider (community health centers, health departments, rural health clinics and other providers who receive maternal and child health funding) enrolled as a Presumptive Eligibility Provider has the responsibility to determine presumptive eligibility and notify the county DSS in the pregnant woman's county of residence.
        - The county DSS cannot determine PE.
        - The county DSS cannot refuse to authorize presumptive eligibility.
    - Presumptive Eligibility Determination Form (DMA-5032) is used for limited Medicaid benefits based on:
        - Pregnancy must be medically verified.
        - Family income, based on her statement, must be equal to or below the 196% poverty income level.
        - Pregnant person cannot be an inmate of a public institution.
    - Presumptive Eligibility allows for limited Medicaid coverage:
        - Ambulatory prenatal services provided by any Medicaid enrolled provider.
        - Prescription drugs, doctor visits and medical services related to pregnancy.
    - Pregnant woman must apply for Medicaid no later than the last workday of the month following the month she is determined presumptively eligible.
    - If pregnant woman does not apply in the time period, PE and limited Medicaid will end on the last calendar day of the month following the month she is determined PE. If she does apply for Medicaid during this time frame, she has limited Medicaid until her Medicaid application is approved or denied (up to 45 days).
    - Limited to one PE period per pregnancy.

Coverage/Benefits:

- Medicaid and Medicaid for Pregnant Women (MPW)
    - Prenatal care, labor and delivery and 12 months postpartum care
    - Services to treat medical conditions that could complicate pregnancy
    - Behavioral Health Services
    - Childbirth Classes
    - Family Planning Services
    - Individual PHPs may have additional benefits
- Presumptive Eligibility
    - Ambulatory antepartum care; including pharmacy, labs, and diagnostic tests
    - Limited to one Presumptive eligibility period per pregnancy
- Undocumented Aliens
    - Emergency Medical services; includes labor and vaginal or cesarean section delivery

Potential Interventions:

AHEC coaches are available to assist with improvement work:

- Educate on the appropriate CPT, CPT II and HCPCS codes.
- Review practice data - compare Medicaid claims data versus internal reports.
    - Can EHR reports pull in all codes?
    - Are EHR reports accurate?
- Ensure front office staff and schedulers have a written process on policies/procedures/workflows in place around patients coming in uninsured or with Medicaid; how to communicate Presumptive Eligibility and Pregnancy Medicaid applications, and when to schedule NEMT (Non-Emergent Medical Transportation).
- Pediatricians and family medicine practices — if mom brings child(ren) in for primary care and mom self-identifies as pregnant, establish workflows to enable mom to initiate Medicaid eligibility determination with DSS and help her schedule prenatal care visit.
- Pediatricians and family medicine practices — have a workflow and plan for teenagers who self-identify as pregnant to enable her to initiate Medicaid eligibility determination with DSS and help her schedule a prenatal care visit.

- Understand the population the practice serves and do outreach or provide education
    - Least likely to begin care in first trimester (younger women, less education, high gravida, non-Hispanic Native Hawaiian or other Pacific Islander).
    - Be aware of and accommodate for cultural preferences in prenatal care (e.g. some cultures may have a fear or mistrust of medical providers, resulting in delayed care).
- Have a list available of healthcare services in the community for high-risk prenatal patients.
    - MFM, Specialists (Fetal echo's, MRI, Urology, neonatology)
- Screen for SDOH, Depression and Postpartum depression to identify barriers.
- Create a list of Practice barriers and do PDSAs around the individual barriers (i.e. SDOH knowledge/interventions, educational opportunities, time, appointment availability times).
- Determine what relationships exist between the primary care practice(s) and OB/GYN practice(s). Create a list of OB/GYN practices, or PCP offices, with large number of referrals. Create co-management agreements between these offices to ensure care.
- Patients are more likely to follow through on scheduling prenatal care when recommended by their regular/PCP provider. Assist patients with scheduling prenatal care visits before they leave their primary care sick or well visit.
- Ensure Midwives/Birthing Centers are part of the referral system and utilize as appropriate.
- Know the Community-based care options, particularly in rural and remote communities.
- Provide education on community supports
    - March of Dimes support - prenatal education, support and care (https://www.marchofdimes.org/)
    - NICU Initiatives and family support, Healthy Babies
- Establish Peer Supports, CHW and/or doulas as Community Liaisons to identify and educate women in the community about importance of early prenatal care and postpartum care.
- Actively engage with Pregnancy Management Program (PMP) by adhering to the requirements, especially providing risk screening at the initial pregnancy visit and the postpartum visit. *(Formally known as Pregnancy Medical Home)*
- Engage with Care Management for High Risk Pregnant Women (CMHRP). *(Formally known as Obstetric Care Management-OBCM)*
- Engage assistance with Care Management for At-Risk Children (CMARC) to promote awareness of the importance of early prenatal visits and postpartum visits to parents. *(Formally known as Care Coordination for Children-CC4C)*
- Offer Reproductive Life Planning to both women and men for preparation of pregnancy or pregnancy prevention.
- Screen and provide intervention for Preconception Care and Pregnancy Intendedness at annual physical appointments.

- Screen and provide interventions for Interconception Care — Staying healthy between pregnancies and birth spacing between pregnancies.
- Offer Telehealth visits (interactive audio-visual) for prenatal visits, risk screening or postpartum visits.
- Offer group prenatal visits (e.g., Centering Pregnancy program).
- Establish practice workflow to support Women who might have substance abuse issues and are scared about their care and their baby — connect with Project CARA
    - Coordinate care with Neonatal/NICU
- Perform outreach within a week after discharge. Identify any issues with breastfeeding, anxiety, depression, and connect supports if needed; encourage postpartum visit and emphasize importance.
- Schedule postpartum care visit late in third trimester or before discharge from hospital/birthing center.

Special Considerations for Diversity, including Race, Ethnicity, and Language:

- Black, American Indian, and Alaska Native (AI/AN) women are two to three times more likely to die from pregnancy-related causes than white women. https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html
- The pregnancy-related mortality ratio for black women with at least a college degree is 5.2 times that of their white counterparts:
    - https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html
- Run reports on prenatal visits and postpartum visits stratified by race, ethnicity, and preferred language:
    - Ensure patients' preferred language is being documented and care and education is provided in preferred language.
- Use spatial mapping and Health IT to identify access gaps for prenatal care. If there are areas where prenatal care is lacking, use QI and interventions mentioned above to address the care gaps.
- Implement standardized protocols in quality improvement initiatives, especially among facilities that serve disproportionately affected communities
- If staff is not racially/ethnically/linguistically congruent with patients, ensure training in best communication practices and knowledge of specific barriers to care.

- Identify and address implicit bias in healthcare that would likely improve patient-provider interactions, health communication, and health outcomes:
    - Historical acts against BIPOC have caused mistrust of the healthcare industry.
    - Implicit bias from HCPs causes mistrust and misdiagnosis.
- Quarterly reports by race/ethnicity/language presented at full clinic meetings with data presented to the entire group:
    - Patients getting a timely prenatal visit.
    - Birth outcomes (live birth weights, NQF 1382).
    - Postpartum visits.
- Enhanced communication, including:
    - Use medical translators for patients of whom English is not their preferred language. Medical translators have been trained to speak medical terminology in a specific language for translation purposes.
    - Explain what is involved in a prenatal visit during each trimester and the postpartum visit in preferred language.
    - Education materials should be in various formats explaining the need for an early prenatal visit and a postpartum visit (posters, brochures, verbal discussions with patient).
    - Be aware of how the clinic's marketing materials are perceived by various populations, especially those known to skip early prenatal appointments (younger women, less education, high gravida, non-Hispanic, Native Hawaiian, or other Pacific Islander) and postpartum appointments.
- Identify the patients not showing for needed appointments, by name and according to race/ethnicity/language:
    - Provide follow up phone calls.
    - Offer telehealth appointments if available.
    - Reschedule when possible.

References:

1. CDC Review to Action. (2018). Building U.S. Capacity to Review and Prevent Maternal Deaths. Report from nine maternal mortality review committees. Retrieved from http://reviewtoaction.org/Report_from_Nine_MMRCs.
2. American College of Obstetricians and Gynecologists (ACOG). (2018). Optimizing Postpartum Care. ACOG Committee Opinion No. 736. Obstet Gynecol, 131:140-150.
3. American Academy of Pediatrics, American College of Obstetricians and Gynecologists. (2017). Guidelines for perinatal care. 8th ed. Elk Grove Village, Ill. American Academy of Pediatrics, and Washington, DC.
4. Weigel, G., Frederiksen, B., Ranji, U., Telemedicine and Pregnancy Care, KFF, Feb. 26, 2020. https://www.kff.org/womens-health-policy/issue-brief/telemedicine-and-pregnancy-care/ February 18, 2022.
5. https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html.

Resources:

- Racial Equity Institute
- NC AHEC Diversity, Equity, and Inclusion (DEI) for Primary Care Clinical Providers and Non-clinical Staff Online Modules
- Medical Interpreter Series
- The Preconception / Women's Wellness Preconception Health Care modules
- Presumptive Eligibility Form DMA 052