Prenatal and Postpartum Care
(PPC, CMIT #581)

Measure Basic Information

This specification sheet contains information for both Timeliness of Prenatal Care and Postpartum Care, the two rates associated with the NQF measure Prenatal and Postpartum Care. Starting in 2019, the Metrics and Scoring Committee decided to incentivize the Postpartum Care rate performance with hybrid specifications. However, CCOs are required to report on both parts of the measure for the Quality Incentive Program.

Name and date of specifications used: OHA follows HEDIS® MY2026 Technical Specifications for Health Plans (Volume 2).

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

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

URL of Specifications: This measure is selected in the CMS Medicaid Adult Core Set, as well as the CHIP Medicaid Child Core Set; the detail manual and Value Set Dictionary can be found on the CMS resource page: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-core-set-reporting-resources/index.html

Measure Type:

■HEDIS ☐Survey ☐Other Specify:

Measure Utility:

■CCO Incentive (Postpartum) ■CMS Adult Core Set (age 21 and older) ■CMS Child Core Set (age under 21) ☐Other Specify:

Data Source: Hybrid - MMIS/DSSURS, medical records

Measurement Period: The measure looks for live births with estimated delivery date (EDD) October 8, 2025 - October 7, 2026.

PPC_Post	2024^	2025^	2026^
Benchmark for OHA measurement year	85.9%	87.0%	91.1%
Improvement target for OHA measurement year	MN method with 3 percentage point floor	MN method with 3 percentage point floor	MN method with 2 percentage point floor
Source:	MY2022 CCO 90th percentile (hybrid)	MY2023 CCO 90th percentile (hybrid)	MY2023 National commercial 75th percentile

^This measure is selected for the Challenge Pool.

Note on telehealth: This measure is telehealth eligible for both prenatal and postpartum care, as long as the required service components are identified. For further information specific to Oregon, the Health Evidence Review Commission (HERC) has provided this guideline on telehealth services.

Changes in specifications from MY2025 to MY2026:

- Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.
- Added instructions on allowable adjustments to the race and ethnicity stratifications.
- HEDIS MY2026 specifications restructured the sections related to denominator criteria, but the requirements remain the same.
- Eliminated the legacy Anchor Date rule; the existing requirement is included in the allowable enrollment gap criteria.
- Updated the allowable adjustments for the Numerator using administrative calculation: Timeliness of Prenatal Care to allow visits any time during the pregnancy (if Prenatal Care numerator step 1 and 2 continuous enrollment during pregnancy is not used).
- OHA added the administrative method specs for the numerator section to provide better reference if the CCO uses claims data as a part of the hybrid review process.

OHA continues to adopt the full HEDIS hybrid specifications for MY2026/CMS Core Set measurement years. It is the CCO's responsibility to identify numerator compliance using any of the data sources allowed under the HEDIS hybrid method. Information may be abstracted from administrative data (claims), paper medical records, and audited supplemental databases or from automated systems such as electronic medical records (EMR/EHR), registries or claims systems.

1) If using administrative data to identify numerator compliance, CCOs must follow HEDIS MY2026/CMS Core Set specifications for allowable codes and measure logic.
2) If using medical record data to identify numerator compliance, CCOs must follow HEDIS MY2026/CMS Core Set specifications to conduct the chart review.

See the annual chart review guidance document for additional information on allowable data sources. OHA will provide sampling frames and updated guidance to CCOs on the hybrid methodology for MY2026 in fall 2026. Guidance will be posted online at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

Denied claims: Included ■ Not included ☐

CCO coverage type: ■CCOA ■CCOB ☐CCOE ☐CCOF ☐CCOG

Starting MY2024, CCO members under the Basic Health Plan (BHP) anytime during the required continuous enrollment period are excluded from the incentive quality rates. Note that the Cover All Kids (CAK) and Healthier Oregon Program (HOP) recipients have also been excluded from the incentive quality rates.

For legislative reporting purposes, HOP and BHP members are still included in the random sampling and the CCOs are required to perform hybrid reporting when HOP or BHP members are sampled.

Measure Details

Definitions:

First trimester	280–176 days prior to delivery (or estimated delivery date [EDD]).

Initial population:

Measure item count: Episode.

Attribution basis: Enrollment.

- *Benefits:* Medical.
- *Continuous enrollment:* 43 days prior to delivery through 60 days after delivery.
- *Allowable gap:* None.

Ages: None.

Event: **Deliveries.**
Live birth deliveries in any setting on or between October 8 of the year prior to the measurement period and October 7 of the measurement period.

Step1: Identify deliveries. Identify all persons with a delivery (Deliveries Value Set) on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.

> Note: The intent is to identify the date of delivery (the date of the "procedure"). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge.

Step2: Remove non-live births using Non-live Births Value Set.

Step3: Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 60 days after delivery, with no gaps.

Step4: Remove multiple deliveries in a 180-day period. If a person has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period.

Note: The initial population for this measure is based on deliveries, not on persons. All eligible deliveries that were not removed in steps 1–4 remain in the initial population.

For adopting the HEDIS hybrid method, OHA identifies the live birth deliveries from administrative data and provide CCOs with a random sample delivery list for the chart review. CCOs should perform hybrid record review for all cases in the sample, for both prenatal and postpartum measures. OHA only includes CCO-paid live birth deliveries when sampling, therefore Fee-for-Service paid deliveries such as approved out-of-hospital births are not included in the CCO sample frame.

In the hybrid review data submission, OHA allows CCOs to report the original EDD from the prenatal care providers' perspective, which would help address early or late delivery issues. When a different

EDD is reported by the CCO, the eligible window for timely prenatal care is recalculated. If the CCO self-reported EDD is outside of the intake period, the case is excluded.

Denominator exclusions:

Persons with a date of death.
Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.

Persons in hospice or using hospice services.
Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.

OHA also allows CCOs to report 'no confirmed live birth' in the data submission and excludes the cases accordingly.

Hybrid review sample size: OHA follows the HEDIS sample size guidance to randomly draw 411 cases per CCO (if the CCO has more than 411 total live births in the intake period), but uses the additional steps below to compensate the HOP/BHP exclusion from the incentive program rate:

Step1: OHA randomly draws 411 cases for each CCO, across all CCO-paid live birth deliveries (following the HEDIS steps to identify live birth deliveries) to create the initial sample.

Step2: Among the initial sample, OHA identifies the number of HOP and BHP members and samples the same number of additional non-HOP/BHP members to the final sample. The goal is to reach 411 total cases non-HOP/BHP members to use for the incentive rate. The CCO is still responsible for reviewing and reporting PPC measure results for the HOP/BHP members in the initial sample.

For example, if there are 40 HOP/BHP members randomly selected among the CCO's initial sample of 411 cases, OHA will randomly select additional 40 non-HOP/BHP members to CCO's final sample. The CCO is responsible for reviewing and reporting on all 451 cases in the final sample, where only the results from the 411 non-HOP/BHP members are used for the incentive program. If the CCO has fewer than 40 remaining non-HOP/BHP cases after the initial sample, all the remaining non-HOP/BHP cases will be added to the final sample and included in the incentive rate.

Note that if the CCO has 411 or fewer total live birth deliveries in the year, all cases need to be reviewed and reported, with HOP/BHP members being excluded from the incentive rate.

Denominator:

ADMINISTRATIVE - The initial population minus denominator exclusions.

HYBRID - A systematic sample drawn from the administrative denominator

Deviations from cited specifications for denominator:
See sections above that OHA allows CCOs to self-report EDD and no confirmed birth.

Timeliness of Prenatal Care Numerator:

ADMINISTRATIVE

Numerator 1: Timeliness of prenatal care.
A prenatal visit during the required time frame. Follow the steps below to identify numerator compliance.

Step 1. Identify persons who were continuously enrolled (with no gaps) from at least 219 days before delivery (or EDD) through 60 days after delivery.

These persons must have a prenatal visit during the first trimester.

Step 2. Identify persons who were not continuously enrolled from at least 219 days before delivery (or EDD) through 60 days after delivery.

These persons must have a prenatal visit any time during the period that begins 280 days prior to delivery and ends 42 days after the enrollment start date.

Do not count visits that occur on or after the date of delivery. Visits that occur prior to the person's enrollment start date during the pregnancy meet criteria.

Step 3. Identify prenatal visits that occurred during the required time frame (the time frame identified in step 1 or 2). Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria for a prenatal visit:

- A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
- A visit for prenatal care (Stand Alone Prenatal Visits Value Set†).
- A prenatal visit (Prenatal Visits Value Set) ***with*** a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).

Numerator 2*:* Postpartum care.
A postpartum visit on or between 7 and 84 days after delivery. Any of the following meet criteria:

- A postpartum visit (Postpartum Care Value Set†).
- An encounter for postpartum care (Encounter for Postpartum Care Value Set*).
- Cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set).
- A bundled service (Postpartum Bundled Services Value Set) where the organization 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).

Exclude services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set).

Note: *The practitioner requirement only applies to the Hybrid Specification. The organization is not required to identify practitioner type in administrative data.*

Coding Guidance

*Do not include laboratory claims (claims with POS code 81).

†Do not use codes with a modifier (CPT CAT II Modifier Value Set).

Allowable adjustment for numerator using administrative data:

Organizations may remove the continuous enrollment criteria in steps 1 and 2 and assess for a prenatal care visit that occurs any time during the pregnancy. Value sets may not be changed. If the delivery-date range is changed, all numerator events must be measured in relation to the new range.

Note: The allowable adjustment does not apply to the hybrid review. Use caution when making adjustments to the timeliness of the prenatal visit. Assessing for visits outside of the first trimester should be used to assess gaps in care for the patient.

Hybrid Medical Record Review – Prenatal care services:
A prenatal visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment, depending on the date of enrollment in the organization and gaps in enrollment during the pregnancy. Do not count visits that occur on the date of delivery.

Prenatal care visit to an OB/GYN or other prenatal care practitioner, or PCP. For visits to a 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 the member is pregnant or references to the pregnancy; for example:
  - Documentation in a standardized prenatal flow sheet, ***or***
  - Documentation of last menstrual period (LMP), EDD or gestational age, ***or***
  - A positive pregnancy test result, ***or***
  - Documentation of gravidity and parity, ***or***
  - Documentation of complete obstetrical history, ***or***
  - Documentation of prenatal risk assessment and counseling/education.
- A basic physical obstetrical examination that includes auscultation for fetal heart tone, ***or*** pelvic exam with obstetric observations, ***or*** measurement of fundus height (a standardized prenatal flow sheet may be used).
- Evidence that a prenatal care procedure was performed, such as:
  - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), ***or***
  - TORCH antibody panel alone, ***or***
  - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, ***or***
  - Ultrasound of a pregnant uterus.

Eligible window for timely first prenatal visit:

For members continuously enrolled during the first trimester (176-280 days before delivery with no gaps), the organization has sufficient opportunity to provide prenatal care in the first trimester. Any enrollment gaps in the second and third trimesters are incidental.

For members who were not continuously enrolled in the first trimester:

- For members who were enrolled at least 219 days before delivery, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.
- For members who were not enrolled at least 219 days before delivery, the organization has sufficient opportunity to provide prenatal care within 42 days after enrollment. Note the qualifying period begins at the start of the first trimester, 280 days prior to delivery.

Postpartum Care Numerator:

Administrative method – A postpartum visit for a pelvic exam or postpartum care on or between 7 and 84 days after delivery. See HEDIS® MY2026 Technical Specifications for Health Plans (Volume 2) or CMS Adult/Child Core Set manual for details. Adjustments not allowed.

Hybrid Medical Record Review – Postpartum Care:
Postpartum visit to an OB/GYN or other prenatal care practitioner, or PCP on or between 7 and 84 days after delivery. Do not include postpartum care provided in an acute inpatient setting.

Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and *one* of the following:

- Pelvic exam.
- Evaluation of weight, 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 check," "6-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 persons with gestational diabetes.
- Documentation of any of the following topics:
  - Infant care or breastfeeding.
  - Resumption of intercourse, birth spacing or family planning.
  - Sleep/fatigue.
  - Resumption of physical activity.
  - Attainment of healthy weight.

Eligible window for postpartum care visit:

On or between 7 and 84 days after delivery.

Notes:

- *A Pap test does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate.*
- *Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure.*
- *The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.*
- *HEDIS allows using EDD for identifying the first trimester for timeliness of prenatal care, and the delivery date for the postpartum care. OHA allows CCOs to confirm live births and submit*

different dates for EDD and the date of delivery. When different EDD or delivery date is report by the CCO, the original claims-based EDD is not used.

- *The intent is that a prenatal visit is with a PCP or OB/GYN or other prenatal care practitioner. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. Nonancillary services (e.g., fetal heart tone, prenatal risk assessment) must be delivered by the required provider type.*
- *Refer to HEDIS Appendix 3 for the definition of PCP and OB/GYN and other prenatal practitioners.*
- *For both rates and for both Administrative and Hybrid data collection methods, services provided during a telephone visit, e-visit or virtual check-in are eligible for use in reporting.*