Ensuring High Quality Postpartum Care in the Period Covered by Illinois' Postpartum Medicaid Extension

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Background

Medicaid's role in providing coverage for women's reproductive and pregnancy health has expanded greatly since its enactment in 1965.[1] Changes beginning in the mid-1980s ultimately led to the decoupling of cash assistance receipt from Medicaid coverage during pregnancy through 60 days postpartum (PP). Expansions continued with the mid-1990s Family Planning Medicaid expansion,[2] and the provision of Medicaid coverage to low-income non-pregnant adults through the Affordable Care Act (2014).[1]

Given increased attention to the maternal health crisis,[3,4] its heavy toll on Black birthing persons, and recognizing most pregnancy-related deaths occur in the extended postpartum period,[3,5] the latest Medicaid expansion permits states to extend Medicaid coverage beyond 60 days to 12 months postpartum. While states could implement a postpartum Medicaid extension with their own funds or a 1115 waiver,[6] the American Rescue Plan Act passed during the COVID-19 pandemic allowed states to temporarily extend Medicaid coverage through 12 months postpartum using a State Plan Amendment (SPA), with significant advantages over waivers.[6–8] Postpartum Medicaid Extension (PME) via a SPA became a permanent option through the Omnibus Reconciliation Act of 2022.[9]

In April 2021, Illinois became the first state to have a 1115 waiver approved by the Centers for Medicare and Medicaid Services (CMS), providing 12 months postpartum full benefit Medicaid coverage (effective through 12-25). In September 2021, CMS approved a Title XXI (CHIP) Health Services Initiative (HSI) SPA that enabled Illinois to extend coverage to immigrants who did not qualify under the 1115 waiver. These postpartum extension authorities were estimated to cover almost 10,000 persons annually. Although Illinois maintained the distinction of having the first approved PME, this waiver never went into effect due to the COVID-19 Public Health Emergency (PHE) in which coverage automatically continued for all Medicaid recipients. During this period, a SPA was approved by CMS, which replaced the 1115 waiver authority. When the PHE ended in May 2023, Illinois' PME SPA (rather than waiver) went into effect.

Lessons learned from earlier Medicaid expansions must be considered as the PMEs are rolled out across the nation including that expanded coverage is not tantamount to additional systems changes needed to ensure access to and quality of care. Zephyrin and Johnson[24] note that providing additional months of Medicaid coverage through the PME is only one component of what must happen to improve outcomes. Because PME coverage is full benefit coverage, the opportunity to provide birthing persons benefits beyond what might be provided in a more limited expansion should be leveraged. Most importantly, an extensive outreach and communications campaign is necessary so birthing persons covered by Medicaid and their providers know that postpartum coverage continues through 12 months. The processes for continuous eligibility should be simple without requiring additional enrollment steps by beneficiaries. Beyond this, to maximize the benefits of the PME, new approaches to care are needed, including elevation of the medical care home for women's primary/interconception care,[29] and postpartum care models such as the Two- Generation approach.[30] Promoting enhanced postpartum care packages that include reimbursement for services to address the structural/social determinants of

health is also essential.[8,31] Furthermore, to ensure that postpartum persons actually receive the appropriate services in the extended postpartum period to maximize their health, measuring the delivery and utilization of services for postpartum persons is essential.

This document outlines the content of care delineated in the Illinois Medicaid contract for Managed Care Organizations (MCOs) related to the postpartum period. Based on the components included in the Illinois MCO contract, we offer a summary of recommendations for care in the **extended postpartum period.** We propose a package of measures that the Illinois Department of Healthcare and Family Services (HFS) should collect from the MCOs to ensure alignment with the postpartum care components included in the IL managed care contract. For the most part, the proposed measures are already collected by HFS; however, we are proposing these measures be specifically collected on **a postpartum population**. We also offer a summary of recommended measures to be included in the consumer facing **HealthChoice Illinois** report cards which compare Illinois Managed Care plans.

Postpartum Care Content included in the Illinois MCO Contract

Illinois' Managed Care Organization (MCO) model contract (2018) appears to include all components necessary for the delivery of a robust model of care in the extended postpartum period (through 12 months postpartum). The current Illinois MCO language contract which delineates the required components in the delivery of early and extended postpartum care is provided below. Of note, this listing does not include every requirement in the model contract but rather includes the most salient components of care:

1) **3.1.3 Family Planning and reproductive healthcare**...Contractor shall cover and offer **all Food and Drug Administration (FDA)–approved birth control methods with education and counseling on the safest and most effective methods, if clinically appropriate for a particular patient**. Contractor shall provide education and counseling for the following Family Planning and reproductive health services and offer clinically safe and appropriate services, drugs, and devices: **3.1.3.1** a reproductive 18 life plan, which may include a preconception care risk assessment (see HFS Form 27, Preconception Screening Checklist, which can be found on Illinois.gov/hfs under the Medical Programs Forums section) and preconception and interconception care discussions; **3.1.3.2** all safe, effective and clinically appropriate contraceptive methods, with emphasis on the most effective methods first. and encourage use of long-acting reversible contraceptives (LARCS), such as IUDs and implants when clinically appropriate, and consistent with FDA approved product information label…

2) **3.1.3.13.3.5** …..visits close to the third (3rd) trimester should include… options for **postpartum Family Planning** for selection of **most appropriate and safe contraceptive method** with informed consent obtained prior to labor and delivery when indicated…. **transition of maternal healthcare after the postpartum visit**. MCO/Contractor shall have all protocols in place to **facilitate appropriate continuity of care after the current pregnancy**. (p. 311, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract) **3.1.3.13.5 Contractor shall enable Enrollees to receive timely and evidence-based postpartum care**. At a minimum, Contractor shall provide and document the following services: …. **3.1.3.13.5.1 postpartum visits**, in accordance with the Department's approved schedule, to assess and provide education on areas such as perineum care, breastfeeding/feeding practices, nutrition, exercise, immunization, sexual activity, effective **Family Planning**, pregnancy intervals, physical activity, SIDS, and the importance of **ongoing well-woman care**, and **referral to parenting classes, maternity education tools, platforms and materials and WIC**; **3.1.3.13.5.2 postpartum depression screening during the one (1)–year period after delivery to identify high-risk mothers who have an acute or long-term history of depression, using an HFS-approved screening tool (refer to the Handbook for Providers** of Healthy Kids Services for a list of approved screening tools.) After delivery and discharge, the **Enrollee shall have a mechanism to readily communicate with her health team and not be limited to a single six (6)–week postpartum visit; 3.1.3.13.5.3 Contractor must**

continue to engage the Enrollee in health promotion and Chronic Health Condition maintenance by supporting the postpartum mother **with seamless referrals, if Medically Necessary, to avoid interruption of care; 3.1.3.13.5.4** Contractor shall assure that Enrollees are **transitioned to a medical home for ongoing well-woman care, as needed. After the postpartum period**, Contractor shall identify and **closely follow Enrollees who delivered and who are at risk of or diagnosed with diabetes, hypertension, heart disease, depression, alcohol, tobacco or other substance use, obesity, or renal disease**; and **3.1.3.13.5.5** Contractor shall **provide or arrange for interconception care management services for identified high-risk women for twenty-four (24) months following delivery**. (pp. 312- 313, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract).

3) **3.1.3.14 Well-woman exam**: Contractor shall ensure provision of evidence-based annual well- woman care to female Enrollees, which will include preconception care, **interconception care**, and reproductive life planning. **3.1.3.14.2 Appropriate referrals should be made to support services including WIC, interconception core management, and classes that enhance pregnancy, labor and delivery and parenting experiences and outcomes**. (p. 313, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, Effective 2018, State of IL Model Contract).

4) **3.1.3.13.2** MCO/Contractor shall have systems and protocols in place to handle regular appointments; early prenatal care appointments; after-hours care with emergency appointment slots; a seamless process for timely transmittal of prenatal records to the delivering facility; and a Provider Network for social services support, and specialty care referrals including those for complex maternal and fetal health, genetic, emotional and Behavioral Health consultations, if indicated. **Contractor must refer all pregnant Enrollees to the Women, Infants, and Children's (WIC) Supplemental Nutrition Program and have or be linked to case management services for identified high-risk Enrollees**…. Contractor must put in place and be able to demonstrate that various evidence-based strategies and interventions (including 17 P and **referral to substance use, alcohol and tobacco abstinence programs**, when indicated) to reduce adverse maternal and birth outcomes are operational; **3.1.3.13.3.2 screening for diagnosing, and treating depression before, during, and after pregnancy with a standard screening tool**.

5) At a minimum, the following areas shall be **monitored** for pregnant women: **1.1.3.1.14** timeliness and frequency of prenatal visits; **1.1.3.1.15 postpartum care rate**; **1.1.3.1.16** provision of American Congress of Obstetricians and Gynecologists (ACOG) recommended prenatal screening tests;**1.1.3.1.17** birth outcomes; **1.1.3.1.18** birth intervals; **1.1.3.1.19** early elective delivery (EED) policies of contracted hospitals of delivery; 1.1.3.1.20 development of reproductive life plans; **1.1.3.1.21** utilization of 17P; **1.1.3.1.22** referral to the Perinatal Centers, as appropriate; **1.1.3.1.23** length of hospitalization for the mother; **1.1.3.1.24** length of hospital stay for the infant; **1.1.3.1.25 utilization of postpartum Family-Planning services, including LARC; and 1.1.3.1.26 assistance to Enrollees in finding an appropriate primary care Provider**/pediatrician for the infant (pp.228-229, Attachment XI: Quality Assurance, Effective 2018, State of IL Model Contract).

6) **4 3.1.2.** Preventive medicine schedule (services to Enrollees age twenty-one [21] years or older). Contractor shall ensure that a complete health history and physical examination is provided to each Enrollee initially within the first twelve (12) months of his or her Effective Enrollment Date. … For purposes of this section, a "complete health history and physical examination" shall include, at a minimum, the following health services regardless of age and gender of each Enrollee: **3.1.2.5 assessment of social and economic determinants of health: housing, transportation availability, and employment**. (pp. 306-307, Effective 2018, ATTACHMENT XXI: REQUIRED MINIMUM STANDARDS of CARE, State of IL Model Contract).

Summary and Recommendations related to the Postpartum Care based on the Illinois Medicaid Managed Care Contract

Based on the requirements of the model Illinois MCO contract as delineated in part above, MCO providers must:

1) Ensure all birthing persons have a **primary care medical home and** appropriate continuity of care after the current pregnancy with a warm hand-off and seamless referrals between delivery care and postpartum care, and between postpartum care and well-woman care.

In Illinois, women and birthing persons are allowed to choose a **woman's principal care provider** in addition to a **primary care provider.** A woman's principal health care provider is a physician licensed to practice medicine in all its branches specializing in obstetrics or gynecology or specializing in family practice and may be seen for care without referrals from the primary care physician.

Postpartum persons with pregnancy related morbidities and chronic health problems may need clinical supervision by a non-OB-GYN provider in the early or extended postpartum period. If the postpartum person's principal care provider is an OB-GYN, it is essential that there be coordination with the non-OB-GYN provider regarding transfer of services or referrals.

2) Identify and closely follow enrollees who delivered and who are at risk of or diagnosed with **diabetes, hypertension, heart disease, depression, alcohol, tobacco or other substance use, obesity, or renal disease**; and, **provide or arrange for interconception care management services for identified high-risk women for twenty-four (24) months following delivery**.

3) Transfer women **without chronic conditions or with no unresolved conditions** from a recent pregnancy to ongoing well-woman care. The Women's Preventive Services Initiative (WPSI) (2016) recommends that a well-woman visit be conducted annually and include multiple health promotion, health education, and preventive services.

4) **Ensure well-woman care** in the extended postpartum period includes:

- Interconception care;
- Reproductive life planning and Family planning counseling and services;
- Screening for depression during the one (1)–year period after delivery to identify high-risk mothers who have an acute or long-term history of depression, using an HFS-approved screening tool;
- Treatment for any identified depression;
- Referrals to support services including but not limited to WIC, parenting classes, home visiting, and case management services, postpartum doula support etc.;
- Screening and treatment for identified substance use;
- Screening for SDOH and appropriate referrals as necessary.

Development of a Postpartum Performance Measurement Dataset

While all components in the recommendations above are delineated in the Illinois MCO model contract, it is important to have a mechanism to ensure MCO compliance with the contract's postpartum requirements. We propose that HFS require all MCOs to report on performance measures specifically for the Illinois Medicaid postpartum population, in other words, we propose the development of a **Postpartum Performance Measurement Dataset**. Importantly, many of these performance measures are already collected by MCOs for the adult general population. However, reporting on these measures with a specifically **designated postpartum denominator** will provide a much clearer picture of the care delivered to postpartum persons through 12 months postpartum. (**Note**: if HFS is not able to require the collection of **Performance Measures** that are not already collected for the general adult population, we recommend that at a minimum, the **Postpartum Performance Measurement Dataset** consist of the Adult Measures already collected using the suggested postpartum denominator).

Postpartum Denominator: For each calendar year, include all postpartum persons who have had at least 12 months of postpartum coverage and no more than 14 months of total coverage in the period after delivery.

Postpartum Performance Measures: CMS requires each state that contracts with managed care plans and other organized plans "must ensure that a qualified External Quality Review Organization (EQRO) performs an annual External Quality Review (EQR) for each such contracting managed care plan." The EQR is an analysis of aggregated information on quality, timeliness, and access to the health care services that a managed care plan, or its contractors, furnish to Medicaid beneficiaries."[32]

Based on the measures already collected by MCOs for the adult general population, **Table 1** below delineates each indicator that we propose be monitored as part of a **Postpartum Performance Measurement Data Set**. We provide a definition for each indicator and whether or not it is already reported by IL MCOs and documented on the External Quality Review Technical Report. Measures highlighted in gold indicate whether the measure is an Illinois Pay for Reporting (P4R) or Pay for Performance (P4P) Measure as part of HFS' managed care quality improvement efforts.[33] These measures will ultimately be included in the EQR starting in 2024-2025 (Dawn Wells, Bureau Chief of Quality Management, IL HFS, February 1, 2024).

Table 1. Proposed Postpartum Performance Measures for Illinois

Performance Measure Name [34]	Currently Reported on the EQR?	Definition
Primary Care Access and Preventive Care		
Adult Body Mass Index Assessment (ABA)	No	The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.
Adult Immunization Status (AIS)	No	The percentage of members 19 years of age and older who are up-to-date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.
Adults' Access to Preventive/Ambulatory Health Services (AAP)	Yes	The percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line. • Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year. • Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.
Flu Vaccinations for Adults (FVA)	No	The percentage of adults 18–64 years of age in commercial and Medicaid plans who report receiving an influenza vaccination between July 1 of the measurement year and the date when the commercial CAHPS 5.1H survey was completed.
Screening for Depression and Follow-Up Plan (CDF)	Not on EQR but is a P4P/P4R Performance Measure	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.
Maternal and Perinatal Health		
Contraceptive Care – All Women (CCW)	Not on EQR but is a P4P/P4R Performance Measure	Among women ages 15 to 44 at risk of unintended pregnancy, the percentage that: 1. Were provided a most effective (i.e., sterilization, implants, IUD/IUS) or moderately effective (i.e., injectables, oral pills, patch, or ring) contraceptive method. 2. Were provided a long-acting reversible contraceptive (LARC) method (i.e. implants or IUD/IUS).
Contraceptive Care – Postpartum Women (CCP)	No	Among women ages 15 to 44 who had a live birth, the percentage that: 1. Were provided a most effective (i.e., sterilization, implants, IUD/IUS) or moderately effective (i.e., injectables, oral pills, patch, or ring) contraceptive method within 3 and 60 days of delivery. 2. Were provided a LARC method (i.e. implants or IUD/IUS) within 3 and 60 days of delivery.
Prenatal and Postpartum Care (PPC)	Yes	Assesses access to prenatal and postpartum care: • Timeliness of Prenatal Care. The percentage of deliveries in which women had 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 in which women had a postpartum visit on or between 7 and 84 days after delivery.
Care of Acute and Chronic Conditions		
Ambulatory Care (AMB)	Yes	AMB summarizes utilization of ambulatory care in the following categories: • Outpatient Visits • ED Visits •
Asthma Medication	Not on EQR	Assesses adults and children 5–64 years of age who were identified as having

Ratio (AMR)	but is a P4P/P4R Performance Measure	persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
Asthma in Younger Adults Admission Rate (PQI-15)	No	Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.
Comprehensive Diabetes Care (CDC)	Yes	Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: • Hemoglobin A1c (HbA1c) testing. • HbA1c poor control (>9.0%). • HbA1c control (<8.0%). • Eye exam (retinal) performed. • Medical attention for nephropathy. * • BP control (<140/90 mm Hg). *This indicator is only reported for the Medicare product line.
Concurrent Use of Opioids and Benzodiazepines (COB)	No	The percentage of individuals ≥18 years of age with concurrent use of prescription opioids and benzodiazepines. (NQF #3389)
Controlling High Blood Pressure (CBP)	Yes	Assesses adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).
Behavioral Health Care		
Antidepressant Medication Management (AMM)	No	Assesses adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications. Two rates are reported: • Effective Acute Phase Treatment: Adults who remained on an antidepressant medication for at least 84 days (12 weeks). • Effective Continuation Phase Treatment: Adults who remained on an antidepressant medication for at least 180 days (6 months).
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	Yes	Assesses emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported: • ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). • ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Yes	Assesses emergency department (ED) visits for adults and children 6 years of age and older with a diagnosis of mental illness or intentional self-harm and who received a follow-up visit for mental illness within 7 and 30 days.
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Yes	Assesses the percentage of inpatient, residential treatment and detoxification visits or discharges for a diagnosis of substance use disorder (SUD) among patients 13 years of age and older that resulted in follow-up care for a diagnosis of SUD within 7 and 30 days.
Follow-Up After Hospitalization for Mental Illness (FUH)	Yes	Assesses the percentage of inpatient discharges for a diagnosis of mental illness or intentional self-harm among patients aged 6 years and older that resulted in follow-up care with a mental health provider within 7 and 30 days.
Identification of Alcohol and Other Drug Services (IAD)	No	This measure summarizes the number and percentage of members who had a service for alcohol and other drug (AOD) abuse or dependence (i.e., a claim with both a diagnosis of AOD abuse or dependence and a specific AOD-related service) during the measurement year. The measure is reported using the following service categories:

		• Inpatient. • Intensive outpatient or partial hospitalization. • Outpatient or an ambulatory medication-assisted treatment (MAT) dispensing events. • Emergency department (ED). • Telehealth. • Any service In each category, the organization reports by age and sex the number of members with an AOD diagnosis who received the service and the percentage of members who received the service out of all members with a chemical dependency benefit.
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Yes	Assesses adults and adolescents 13 years of age and older with a new episode of alcohol or other drug (AOD) dependence who received the following: • Initiation of AOD Treatment: Adolescents and adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-assisted treatment (MAT) within 14 days of diagnosis. • Engagement of AOD Treatment: Adolescents and adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit.
Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	No	The three components of this survey measure assess different facets of providing medical assistance with smoking and tobacco use cessation. • Advising Smokers and Tobacco Users to Quit: Adults 18 years of age and older who are current smokers or tobacco users and who received cessation advice during the measurement year. • Discussing Cessation Medications: Adults 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. • Discussing Cessation Strategies: Adults 18 years of age and older who are current smokers or tobacco users who discussed or were provided cessation methods or strategies during the measurement year.
Mental Health Utilization (MPT)	Yes	This measure summarizes the number and percentage of members receiving the following mental health services during the measurement year: • Inpatient. • Intensive outpatient or partial hospitalization. • Outpatient. • Emergency department (ED). • Telehealth. • Any service.
Pharmacotherapy for Opioid Use Disorder (POD)	Yes	Assesses the percentage of opioid use disorder (OUD) pharmacotherapy treatment events among members aged 16 and older that continue for at least 180 days (6 months).
Dental and Oral Health Services		
Annual Dental Visits (ADV)	Yes	Assesses Medicaid members 2 – 20 years of age with dental benefits, who had at least one dental visit during the year.
Experience of Care		
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H (CPA/CPC)	Yes	The CPA and CPC are tools for measuring consumer healthcare satisfaction with the quality of care and customer service provided by their MCOs. These survey tools include four composites asked of members (CPA) or parents of child members (CPC): • Getting Needed Care • Getting Care Quickly • Customer Service • How Well Doctors Communicate

Recommendations related to the HealthChoice IL Report Cards

HealthChoice Illinois (IL) is Illinois' statewide Medicaid managed care program.[35] Depending on where an individual lives, they can choose from a variety of health plans. HealthChoice IL provides two consumer-facing Report Cards one for Cook County, and one for all other counties across the state that compare care and services in key performance areas across the health plans.[36] The purpose of the Report Cards is to help individuals select the best plan for their needs, and for women and birthing persons in particular, how health plans can best meet their reproductive and maternal health needs. The Report Cards contain a section on Women's Health with five performance measures:

- Breast cancer screening.
- Cervical cancer screening.
- Chlamydia screening in women.
- Moms got care before babies were born.
- Moms got care after babies were born.

Utilizing performance measures already collected by HFS (**Table 1**), we recommend expanding the Women's Health section of the Report Card. For the expanded Women's Health section, we recommend **continuing to include breast cancer screening, chlamydia screening, and cervical cancer screening**. In addition to those performance measures, we recommend including:

- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Contraceptive Care – All Women (CCW).

Given the current maternal health crisis in IL with rising and increasing inequities in rates of maternal morbidity and mortality,[37] we also recommend creating a separate **Maternal Health** section, with inclusion of the following performance measures, most of which are already collected by HFS. For some, we recommend that these be generated with the postpartum denominator described above:

- Prenatal and Postpartum Care (PPC) **Note**: Because these measures are currently reported in the **Women's Health** section, we recommend these two measures be transferred to the new **Maternal Health** section.
- Screening for Depression and Follow-Up Plan (CDF): proposed new postpartum denominator
- Contraceptive Care – Postpartum Women (CCP): proposed new postpartum denominator
- Adults' Access to Preventive/Ambulatory Health Services (AAP): proposed new postpartum denominator
- Identification of Alcohol and Other Drug Services (IAD) or Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET): proposed new postpartum denominator.

Note: All new Report Card measures will need to be rewritten in more consumer-friendly language (e.g., *Moms screened for depression during the postpartum period*).

Conclusion

In order to ensure the effectiveness of the Illinois Postpartum Medicaid Extension (PME) with respect to improving maternal health outcomes and reducing maternal morbidity and mortality inequities in IL, it is essential that both Illinois providers and consumers be made aware of this benefit and the rights of birthing persons to receive comprehensive health care in the 12 months postpartum.

Because PME coverage is full benefit coverage, it is imperative that Illinois take advantage of the opportunity to provide birthing persons benefits beyond what might be provided in a more limited Medicaid expansion. Fortunately, the IL MCO contract delineates a comprehensive set of benefits for the extended postpartum period including that all birthing persons should have a **primary care medical home** and appropriate continuity of care after the current pregnancy. The contract also delineates care for high-risk persons as well as those without chronic conditions.

To ensure care is delivered to the population eligible for 12 months of postpartum care, a **Postpartum Performance Measurement Dataset** for the postpartum population is proposed. Additionally, to ensure pregnant and postpartum people can choose the best health care plan for their needs, changes to the HealthChoice IL report cards to include both women's health and maternal health sections are proposed.

Monitoring MCO and provider performance is one of the most powerful ways to hold Managed Care Organizations and their provider networks accountable for reaching out to and delivering high quality care to the postpartum population. With increased accountability for the quality of the care delivered, it is hoped that the benefits of the Illinois PME for birthing persons will be fully realized.

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