MEASURE PPC-CH: PRENATAL AND POSTPARTUM CARE: TIMELINESS OF PRENATAL CARE

National Committee for Quality Assurance

A. DESCRIPTION

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 that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in Medicaid/CHIP.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- For HEDIS, this measure includes a Timeliness of Prenatal Care rate and a Postpartum Care rate. The Child Core Set includes the Timeliness of Prenatal Care rate and the Adult Core Set includes the Postpartum Care rate.
- States may use vital records as an alternative data source for this measure if they have confidence in the completeness and accuracy of these data. States can use Medicaid/CHIP administrative data to determine the measure-eligible population (including the requirement of continuous eligibility from 43 days before delivery through 56 days after delivery) and then link the Medicaid/CHIP records to vital records data to identify the information needed to calculate the numerator, including gestational age at delivery and the timing of these visits in relation to the gestational age. States using vital records should document this data source in the "Additional Notes/Comments on Measure" section. States should also provide information about the proportion of measure-eligible beneficiaries who were identified in Medicaid/CHIP administrative data but for whom a birth certificate could not be found in vital records data.
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.
- Refer to Appendix C for definitions of a PCP, OB/GYN, and other prenatal care practitioners.

The following coding systems are used in this measure: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

First trimester	280-176 days prior to delivery (or estimated date of delivery [EDD]).
Last enrollment segment	The period of continuous enrollment (with no gaps in enrollment) during the pregnancy with the start date that is closest to the delivery date.

C. ELIGIBLE POPULATION

Age	None specified.
Continuous enrollment	43 days prior to delivery through 60 days after delivery.
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	Date of delivery.
Benefit	Medical.
Event/diagnosis	Delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include women who delivered in any setting. Multiple births. Women who had two separate deliveries (different dates of service) between October 8 of the year prior to the measurement year and October 7 of the measurement year count twice. Women who had multiple live births during one pregnancy count once. Follow the steps below to identify the eligible population, which is the denominator for the rate. Step 1 Identify deliveries. Identify all women 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. Step 2 Exclude non-live births (Non-live Births Value Set). Step 3 Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 60 days after delivery, with no gaps.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

A prenatal visit during the required timeframe. Follow the steps below to identify numerator compliance.

Step 1

Identify women whose last enrollment segment started before, on, or between 280 and 219 days before delivery (or EDD).

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

Step 2

Identify women whose last enrollment segment started less than 219 days before delivery (or EDD).

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

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

Step 3

Identify prenatal visits that occurred during the required timeframe (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 state 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; Telephone Visits Value Set; Online Assessments Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set)

E. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Child Core Set for additional information.

For FFY 2021 Core Set reporting (measurement year 2020), the state may reduce the sample size using the current year’s administrative rate. Due to specification changes, the prior year’s reported rate (FFY 2020 Core Set reporting) may not be used when reducing the sample size for FFY 2021 Core Set reporting.

Numerator

A prenatal visit during the required timeframe. Refer to the Administrative Specification to identify the required timeframe for each woman based on the date of enrollment and the gaps in enrollment during the pregnancy.

Administrative Data

Refer to Administrative Specification to identify positive numerator hits from the administrative data.

Medical Record Review

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 woman is pregnant or references to the pregnancy; for example:

  - Documentation in a standardized prenatal flow sheet, or
  - Documentation of 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

F. ADDITIONAL NOTES

- Criteria for identifying prenatal care for women who were not continuously enrolled during the first trimester allow more flexibility than criteria for women who were continuously enrolled.
- For women whose last enrollment segment started before, on or between 280 and 219 days before delivery, the state has sufficient opportunity to provide prenatal care by the end of the first trimester.
- For women whose last enrollment segment started less than 219 days before delivery, the state has sufficient opportunity to provide prenatal care within 42 days after enrollment.
- 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 the measure.
- For each woman, the state must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the state must define a method to determine which EDD to use, and use that date consistently. If the state elects to use EDD, and the EDD is not on or between October 8 of the year prior to the measurement year and October 7 of the measurement year, the woman is excluded as a valid data error and replaced by the next woman of the oversample. The LMP may not be used to determine the first trimester.
- The state may use EDD to identify the first trimester.
- A Pap test does not count as a prenatal care visit for the administrative and hybrid specification. A colposcopy alone is not numerator compliant.
- 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.

- The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events. Services provided during a telephone visit, e-visit, or virtual check-in are eligible for use in reporting.